ISTANBUL PROTOCOL

PROFESSIONAL TRAINING SERIES No. 8/Rev. 2

Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

UNITED NATIONS
HUMAN RIGHTS
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FOREWORD

In 2001, the Office of the United Nations High Commissioner for Human Rights (OHCHR) published the first edition of the Istanbul Protocol, which was subsequently updated in 2004. It has since been used in medico-legal and other contexts worldwide as a valuable practical tool to effectively guide the investigation and documentation of torture and ill-treatment, protection of victims and advocacy work of civil society on behalf of victims. Building on years of experience of using the Istanbul Protocol in practice, practitioners and academics worldwide have now collected their experiences, identified good practices and highlighted the lessons learned from its use, limitations, misinterpretation or even deliberate misuse. This rich collective effort has helped to further reflect advances in the understanding of the practices and effects of torture and ill-treatment, resulting in a comprehensive update of the Istanbul Protocol.

I am therefore pleased to present the 2022 edition of the Istanbul Protocol, which builds upon the previous 2004 edition. This multi-stakeholder and multidisciplinary road map is based on a large-scale international consultation that was carried out by more than 180 experts, including health, legal and human rights professionals from all regions of the world. Based on relevant provisions of international law, it provides even more concrete, clearly defined and well-understood guidelines to assist Member States, national human rights institutions, national preventive mechanisms, civil society, legal and health professionals and other relevant experts in implementing the Istanbul Protocol standards.

This new edition is the result of the cooperation among civil society, practitioners, academics and members of all United Nations anti-torture mechanisms, namely the Committee against Torture, the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment and the United Nations Voluntary Fund for Victims of Torture. The concerns of victims and a gender-based approach are placed at the centre of the revised version.

Despite good examples of legal, policy and institutional progress in law and practice, the work to combat and prevent torture is far from finished. A continuous commitment from every State is required to ensure that the legal safeguards preventing torture and ill-treatment are fully and properly implemented, that accountability for such violations is guaranteed and that the victims are provided with full and adequate reparations. The new edition of the Istanbul Protocol is a valuable tool to combat and prevent torture and an essential reference to elaborate and implement policies, as well as to train and guide a wide spectrum of actors working with victims of torture.

OHCHR remains committed to assist States to eradicate torture and ill-treatment, to implement international human rights standards effectively and to place redress for victims, including rehabilitation, at the centre of their efforts. I therefore encourage States and non-State actors, civil society, individual practitioners and everyone concerned in preventing and protecting against torture and ill-treatment to use the new edition of the Istanbul Protocol. In particular, I invite States to make the Istanbul Protocol an essential part of training for all relevant public officials and medical professionals engaged in the custody, interrogation and treatment of persons subjected to any form of arrest, detention or imprisonment. I hope that, through collaborative and collective efforts, we can combat and overcome one of the biggest challenges of our times and build a better and safer future for humanity.

Michelle Bachelet

United Nations High Commissioner for Human Rights

BACKGROUND NOTE

This is an updated edition of the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)*. The Istanbul Protocol sets out international standards on how effective legal and medico-legal investigations into allegations of torture or ill-treatment should be conducted. The Istanbul Protocol was developed by 75 experts in law, health and human rights from 40 organizations in 15 countries. It was officially endorsed by the former United Nations High Commissioner for Human Rights, Mary Robinson, on 9 August 1999 and included in the Professional Training Series of the Office of the United Nations High Commissioner for Human Rights in 2001 and later updated in 2004. The Istanbul Protocol contains a series of "Istanbul Principles", which articulate minimum standards for State adherence to ensure the effective investigation and documentation of torture and ill-treatment, which are further elaborated in the manual. The Istanbul Principles were promoted in resolutions of the General Assembly[1] and the former Commission on Human Rights in 2000[2] and States were called upon to disseminate the Principles widely and use them in efforts to combat torture.

The Istanbul Protocol and its Principles are routinely used as a point of reference for measuring the effectiveness of investigations into torture by the Committee against Torture, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment and the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. In addition, the standards laid out in the Istanbul Protocol have been applied by regional human rights bodies, including the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the African Commission on Human and Peoples' Rights and the European Court of Human Rights, as well as many national institutions. In his annual report to the General Assembly in October 2014, the Special Rapporteur on torture, Juan E. Méndez, recognized the critical role of forensic and medical sciences in the investigation and prevention of torture and other ill-treatment. He stated that "The Istanbul Protocol standards serve as a standard for evaluation of medical evidence, as a reference tool for experts delivering expert opinions, as a benchmark for assessing the effectiveness of the domestic fact-finding and as a means of redress for victims" and that: "Quality forensic reports are revolutionizing the investigation of torture."[3] Such recognition by United Nations human rights bodies, regional human rights courts and United Nations Special Rapporteurs has facilitated the widespread use and acceptance of the Istanbul Protocol in medico-legal and other contexts worldwide. During the past 20 years, the Istanbul Protocol and its Principles have been increasingly used by State and non-State actors to guide their investigations into torture and ill-treatment.

1 General Assembly resolution 55/89.
2 Commission on Human Rights resolution 2000/43.
3 A/69/387, paras. 59 and 64.

This present publication seeks to update and strengthen the Istanbul Protocol, through a project involving more than 180 participants from 51 countries. The project was led by representatives of four civil society organizations (Physicians for Human Rights, the International Rehabilitation Council for Torture Victims, the Human Rights Foundation of Turkey and the Redress Trust) and four core United Nations anti-torture bodies (the Committee against Torture, the Subcommittee on Prevention of Torture, the Special Rapporteur on torture and the United Nations Voluntary Fund for Victims of Torture). The Istanbul Protocol Editorial Committee of this project consists of representatives of all four civil society organizations and all four core United Nations anti-torture bodies. The project received support from Dignity – Danish Institute against Torture and the United Nations Voluntary Fund for Victims of Torture, but it was otherwise supported through the dedicated commitment and time of the individual experts and organizations involved.

This large-scale international effort was undertaken to update the Istanbul Protocol in order to reflect advances in our understanding of the practices and effects of torture and ill-treatment as well as the practical experiences and lessons learned in using the Istanbul Protocol during the past 20 years. It included regional coordination meetings in Bishkek, Mexico City and Copenhagen and a survey of more than 200 individuals who have substantial experience using the Istanbul Protocol in anti-torture activities. In addition to updating the six original chapters of the Istanbul Protocol, this edition includes two new chapters: chapter VII provides guidance on the role of health professionals in various contexts in which documentation may be necessary and chapter VIII provides guidance on the steps needed for effective implementation of the Istanbul Protocol by States.

The 2022 edition of the Istanbul Protocol will be made available in all six official United Nations languages on the website of the Office of the United Nations High Commissioner for Human Rights (www.ohchr.org).

CONTRIBUTORS AND PARTICIPANTS

ISTANBUL PROTOCOL EDITORIAL COMMITTEE

Dr. Vincent Iacopino former Senior Medical Adviser, Physicians for Human Rights; Adjunct Professor of Medicine, University of Minnesota Medical School

James Lin Istanbul Protocol Programme Coordinator, International Rehabilitation Council for Torture Victims; Adjunct Professor of Law, National Yang Ming Chiao Tung University

Dr. Şebnem Korur Fincancı President, Turkish Medical Association; Executive Board Member, Human Rights Foundation of Turkey; Emeritus Professor of Forensic Medicine, Istanbul University Faculty of Medicine

Chris Esdaile Legal Adviser/Solicitor, Redress Trust

Dr. Jens Modvig Director, Health Department, Dignity – Danish Institute against Torture; Head of the International Accountability Platform for Belarus; former Chair, Committee against Torture

Nora Sveaass Professor Emerita, University of Oslo; Member, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Nils Melzer former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

Dr. Vivienne H. Nathanson Chair, United Nations Voluntary Fund for Victims of Torture; former Director of Professional Activities, British Medical Association

ISTANBUL PROTOCOL CHAPTER EDITORS

Juan E. Méndez former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (2010–2016); Professor of Law, American University Washington College of Law

Dr. Vincent Iacopino former Senior Medical Adviser, Physicians for Human Rights; Adjunct Professor of Medicine, University of Minnesota Medical School

Dr. Lutz Oette Professor of International Human Rights Law, Centre for Human Rights Law, School of Oriental and African Studies, University of London

Dr. Rohini J. Haar Adjunct Professor, School of Public Health, University of California, Berkeley; Medical Adviser, Physicians for Human Rights

Dr. Juliet Cohen former Head of Doctors, Freedom from Torture

Felicitas Treue Psychologist, Colectivo contra la Tortura y la Impunidad, Mexico; Independent Forensic Expert Group

Nora Sveaass Professor Emerita, University of Oslo; Member, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Dr. Rusudan Beriashvili Associate Professor, Tbilisi State Medical University

ISTANBUL PROTOCOL WORKING GROUP MEMBERS

Dr. Uju R. Agomoh Executive Director, Prisoners' Rehabilitation and Welfare Action; Founder, Development Voice

Dr. Ameena T. Ahmed Physician, Permanente Medical Group

Dr. Ahmed Mohammed Amin Ahmed Director, Wchan Organization for Victims of Human Rights Violations; Lecturer, Sulaimani Polytechnic University – Technical College of Health, Kurdistan Region of Iraq

Dr. Joanne Ahola Medical Director Emeritus, Weill Cornell Center for Human Rights; Trainer, Physicians for Human Rights

Dr. Dina A. al-Shafie Psychiatrist and Psychosocial Forensic Consultant, Synergy for Justice; Expert and Investigator on sexual violence and torture in post-conflict areas and Istanbul Protocol trainer, Médecins Sans Frontières, Egypt

Dr. Aida S. Alayarian Chair and Clinical Lead for the Refugee Therapy Centre, Royal Society of Medicine; Fellow, United Kingdom Council for Psychotherapy and British Psychological Society

Djordje Alempijevic Professor of Forensic Medicine, School of Medicine, University of Belgrade; Foundation Member, Faculty of Forensic and Legal Medicine, Royal College of Physicians, London

Federico Allodi Associate Professor, University of Toronto; former Chair, Canadian Centre for Victims of Torture

Dr. Yahya Alrahal Medical adviser, Lawyers and Doctors for Human Rights

Dr. Kerem Altiparmak Chair, Human Rights Centre, Ankara Bar Association; Deputy Chair, Human Rights Association, Turkey

George J. Annas Warren Distinguished Professor, Boston University; Director, Center for Health Law, Ethics and Human Rights, Boston University School of Public Health

Jorge G. Aroche Chief Executive Officer, New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; President, International Rehabilitation Council for Torture Victims, Australia

Ulugbek Azimov former Chair, National Preventive Mechanism Coordination Council; Legal Expert, Kyrgyzstan

Ioanna Babassika Lawyer, Athens Bar Association; Human Rights Expert, Greece

Dr. Kenneth Daniel Bagonza Doctor, African Centre for Treatment and Rehabilitation of Torture Victims; Mbarara University of Science and Technology, Uganda

Dr. Metin Bakkalcı Medical Doctor, Human Rights Foundation of Turkey

Dr. Turkcan Baykal Medical Doctor, Human Rights Foundation of Turkey; Clinical Psychologist, Turkey

Dr. Smadar Ben-Natan Doctor, Tel Aviv University

Dr. Ahmed Benasr Forensic Physician, Nebras, Tunisia

Barbara Bernath Secretary-General, Association for the Prevention of Torture, Geneva

Dr. Jonathan Beynon Independent Expert on documentation of torture and conditions of detention, Geneva

Moritz Birk Head of Department, Human Dignity and Public Security, Ludwig Boltzmann Institute of Fundamental and Human Rights, Vienna

Dr. Bettina Birmanns Neurologist, Public Committee against Torture in Israel

Jean-Sébastien Blanc Scientific Adviser, Swiss Centre of Expertise in Prison and Probation; former Director, Thematic Programmes, Association for the Prevention of Torture, Geneva

Dr. Anissa Bouasker Psychiatrist and Assistant Professor, School of Medicine of Tunis

Dr. Marie Brasholt Senior Medical Officer, Dignity – Danish Institute against Torture; Member, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Dr. Nicole Bürli Senior Human Rights Adviser, World Organisation against Torture, Geneva

Sofia C. Candeias Team of Experts on the Rule of Law and Sexual Violence in Conflict

Lotta Carlsson Case Manager, Counsellor, Centre for Psychotraumatology, Helsinki Deaconess Foundation; Independent Consultant, Radicalization Awareness Network and Council of Europe, Finland

Jim Cavallaro Professor of Law, Stanford International Human Rights and Conflict Resolution Clinic and Stanford Human Rights Center; former Commissioner and President, Inter-American Commission on Human Rights

Sirikan Charoensiri Thai Lawyers for Human Rights

Tatiana Chernobil Independent Legal Expert, Kazakhstan

Elena Olga Christidi Psychologist, former Scientific Coordinator, Certification of Victims of Torture, METAdrasi; Scientific Director, Orlando LGBT+ Mental Health Beyond the Stigma, Greece

Guy Coffey Clinical Psychologist and Lawyer, Victorian Foundation for Survivors of Torture, Australia

Dr. Keren Cohen Senior Lecturer, Goldsmiths, University of London; Counselling Psychologist, United Kingdom

Dr. Sondra S. Crosby Associate Professor of Medicine and Public Health, Boston University; Medical Expert and Torture Documentation Adviser, Physicians for Human Rights,

Dr. Malabika M. Das Integrative Social Work Consultant, Adjunct Assistant Professor, National Taiwan University

María de Lezcano-Mújica González former Consultant, International Bar Association's Human Rights Institute

Clarisse Delorme Senior Policy Adviser, World Medical Association

Ana Deutsch Psychologist, Program for Torture Victims, Los Angeles

Dr. Carole Dromer former Health Care in Detention Programme Coordinator, International Committee of the Red Cross

Vanessa Drummond Assistant Project Director, Anti-Torture Initiative, Center for Human Rights and Humanitarian Law, American University Washington College of Law

Helen Duffy Director, Human Rights in Practice; Professor, University of Leiden, Netherlands

Dr. Maximo Alberto Duque Piedrahita Medical Doctor, CES University; Specialist in Forensic Medicine, National University, Colombia

Dr. Pierre Duterte Psychotherapist, France

Dr. Alice J. Edwards Head of Secretariat, Convention against Torture Initiative, Geneva

Dr. Ingrid Elliott Expert on international criminal justice and sexual and gender-based violence, Synergy for Justice; Team of Experts on the Rule of Law and Sexual Violence in Conflict

Chris Esdaile Legal Adviser/Solicitor, Redress Trust

Sir Malcolm D. Evans Professor of Public International Law, University of Bristol; former Chair, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Ravindra Fernando Emeritus Professor, University of Colombo; Senior Professor, General Sir John Kotelawala Defence University, Sri Lanka

Dr. Carla Ferstman Senior Lecturer, University of Essex

Dr. Şebnem Korur Fincancı President, Turkish Medical Association; Executive Board Member, Human Rights Foundation of Turkey; Emeritus Professor of Forensic Medicine, Istanbul University Faculty of Medicine

Barbara A. Frey Director, Human Rights Program, University of Minnesota; Senior Lecturer, Institute for Global Studies, University of Minnesota

Christy C. Fujio Senior Technical Adviser, Access to Justice and Protection, Heartland Alliance International; Director, Synergy for Justice, United States of America

Sarah Fulton Lawyer and Human Rights Consultant, Sydney; former International Legal Adviser, Redress Trust

Fiona Gabbert Professor of Psychology, Goldsmiths, University of London; Director, Forensic Psychology Unit, Goldsmiths, University of London

Felice Gaer Director, Jacob Blaustein Institute for the Advancement of Human Rights; former Member and Vice-Chair, Committee against Torture

Katherine Gallagher Senior Staff Attorney, Center for Constitutional Rights, United States

Dr. Andrés Gautier Doctor, Instituto de Terapia e Investigación sobre las secuelas de la tortura y violencia estatal, Bolivia (Plurinational State of)

Dr. Yuval Ginbar Legal Adviser, Amnesty International, United Kingdom

Maartje L. Goudswaard Forensic Doctor, Forensic Department Amsterdam; Medical Doctor

Edith Escareño Granados Psychologist, Independent Expert, Mexico

Dr. Peter G. Green Designated Doctor for Child Safeguarding, Wandsworth Clinical Commissioning Group, United Kingdom

Charles W. Greenbaum Professor of Social Psychology, Hebrew University of Jerusalem

Dr. Dadimos Haile Associate Professor of Law, Bahir Dar University, Ethiopia

Dr. Sana Hamzeh Clinical Adviser, Restart Center for Rehabilitation of Victims of Violence and Torture, Lebanon

Dr. Steen Holger Hansen Forensic Pathologist, University of Copenhagen

Dr. Lilla Hárdi Doctor, Cordelia Foundation for the Rehabilitation of Torture Victims, Hungary

Dr. Karin Helweg-Larsen Senior Researcher, University of Copenhagen

Edeliza Pescante Hernandez Executive Director, Medical Action Group; Council Member for Asia, International Rehabilitation Council for Torture Victims, Philippines

Verónica Hinestroza Arenas Independent Expert on international human rights law, Colombia; former Senior Programme Lawyer, International Bar Association's Human Rights Institute

Jonathan Horowitz Senior Legal Officer, National Security and Counterterrorism, Open Society Justice Initiative, United States

Andrea Huber Head, Human Rights Department, and Deputy Chief, Rule of Law Unit, Office for Democratic Institutions and Human Rights of the Organization for Security and Cooperation in Europe, Poland

Dr. Vincent Iacopino former Senior Medical Adviser, Physicians for Human Rights; Adjunct Professor of Medicine, University of Minnesota Medical School

Dr. Bayazit Ilhan Former President, Turkish Medical Association

Dr. Jim Jaranson Consultant, United States

Dr. Amar Jesani Editor, *Indian Journal of Medical Ethics*; Independent Consultant and Teacher on public health and bioethics, India

Carlos A. Jibaja Psychologist, Centro de Atención Psicosocial; Psychoanalytical Psychotherapist, Asociación de Psicoterapia Psicoanalítica, Peru

Dr. Mariam Jishkariani Medical Doctor, Director, RCT/EMPATHY; Psychiatrist, Tbilisi State Medical University, Georgia

Nuriana A. Kartanbaeva Director, Law Programme, Soros Foundation-Kyrgyzstan

Dr. Marianne C. Kastrup Consultant, Denmark

Dr. Allen S. Keller Associate Professor, New York University School of Medicine; Founder, Bellevue/ New York University Program for Survivors of Torture

Pornpen Khongkachonkiet Director, Cross Cultural Foundation, Thailand

Coleen Kivlahan Professor, Family Medicine, and Executive Director, Primary Care Services, University of California, San Francisco

Asger Kjaerum Director of Advocacy, International Rehabilitation Council for Torture Victims

Vincent O. Kodongo Director, Shield for Justice Foundation, Kenya

Elsbeth J. Kors Clinical Psychologist, Institute for Human Rights and Medical Assessment, Netherlands

Dr. Debabrata R. Laifungbam Director, Human to Humane Transcultural Centre for Torture Victims, Centre for Organisation Research and Education; Member, Health Advisory Committee, International Rehabilitation Council for Torture Victims, India

Josephine Acuna Lascano Executive Director, Balay Rehabilitation Center, Philippines

Peter M. Leth Professor, University of Southern Denmark; Chief Forensic Physician, Institute of Forensic Medicine

Iain Levine former Deputy Executive Director for Programs, Human Rights Watch, United States

Dr. Birgit Lie Clinic for Psychosomatic, Trauma and Immigrant Health, Sørlandet Hospital, Kristiansand, Norway

James Lin Istanbul Protocol Programme Coordinator, International Rehabilitation Council for Torture Victims

Dr. Elizabeth Lira Dean, Faculty of Psychology, University of Alberto Hurtado; Psychologist, Pontificia Universidad Católica de Chile

Maria Lisitsyna Senior Managing Legal Officer, Open Society Justice Initiative, United States

Dr. Nicole Littenberg Medical Doctor, Pacific Survivor Center; Forensic Examiner, Sex Abuse Treatment Center, United States

Dr. June Caridad Pagaduan Lopez Doctor, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; retired Professor of Psychiatry, University of the Philippines

Said Louahlia Forensic Pathologist, Casablanca

Dr. Frances A. Lovemore Director, Counselling Services Unit, Zimbabwe

Dr. Stuart L. Lustig National Medical Executive for Behavioral Health, Cigna; Legal-Medical Adviser, University of California Hastings College of the Law, Center for Gender and Refugee Studies

Andreas Malm Psychologist, Swedish Red Cross

Elisa C. Massimino Senior Fellow, Carr Center for Human Rights Policy, Harvard Kennedy School; Practitioner-in-Residence, Walsh School of Foreign Service, Georgetown University

Nils Melzer former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

Niv Michaeli Project Coordinator, Physicians for Human Rights Israel

Dr. Ranit Mishori Professor of Family Medicine, Georgetown University School of Medicine; Senior Medical Adviser, Physicians for Human Rights

Dr. Jens Modvig Director, Health Department, Dignity – Danish Institute against Torture; Head, International Accountability Platform for Belarus; former Chair, Committee against Torture

Dr. Sergey Nikolayevich Molchanov Director of the public fund "Doctor SN"; Psychiatrist, Kazakhstan

Dr. Benito E. Molino Medical Doctor, Medical Action Group, Philippines

Dr. María Dolores Morcillo Méndez Specialist in forensic medicine and Forensic Pathology and Forensic Coordinator, International Committee of the Red Cross

Dr. Alejandro Moreno Assistant Dean for Clinical Skills Integration and Associate Professor of Medicine and Medical Education, University of Texas at Austin Dell Medical School

Valeria Moscoso Urzúa Independent Psychosocial Expert, Coordinator, National Network of Independent Experts against Torture, Mexico

Annah Yvonne Moyo Advocacy Programme Manager, Centre for the Study of Violence and Reconciliation, South Africa

Dr. Maya Mukamel Counselling Psychologist, Director of Studies, Metanoia Institute, United Kingdom

Lia Mukhashavria Human Rights Lawyer, Attorney at Law, LLM; Executive Director NGO Human Rights Priority, Georgia

Karen Naimer Director of Programmes and Director of the Programme on Sexual Violence in Conflict Zones, Physicians for Human Rights

Dr. Yadira M. Narváez Medical Doctor, Ecuador

Parvina Navruzova Head, Access to Justice and Judicial Reform Programme, Human Rights Centre, Tajikistan

Dr. Anne Nesbitt Paediatrician, Freedom from Torture, United Kingdom

Andra Nicolescu Senior Adviser, Law and Policy, Association for the Prevention of Torture, Geneva

Manfred Nowak Professor of International Human Rights, University of Vienna; Secretary General, European Inter-University Centre for Human Rights and Democratization, Vienna

Samuel H. Nsubuga Chief Executive Officer, African Centre for Treatment and Rehabilitation of Torture Victims, Uganda

Dr. Janus Oomen Medical Anthropologist, Netherlands Institute for Human Rights and Medical Assessment

Gabriel Oosthuizen Programme Director, Institute for International Criminal Investigations, Netherlands

Dr. Resmiye Oral Professor of Clinical Pediatrics, Geisel School of Medicine; Director, Child Advocacy and Protection Center, Children's Hospital at Dartmouth-Hitchcock, United States

Dr. Önder Özkalipci Forensic Physician, Independent Expert; Associate Professor of Forensic Medicine, Temporary Consultant for OHCHR, Geneva

Dimitrios Pantazis Clinical Psychologist, Cyprus

Nimisha Patel Professor of Clinical Psychology, University of East London; Director, International Centre for Health and Human Rights, United Kingdom

Dr. Beatrice M. Patsalides Hofmann Clinical Psychologist, Centre Primo Levi; Psychoanalyst, Paris

Jason Payne-James Consultant in Forensic and Legal Medicine, Forensic Healthcare Services; Lead Medical Examiner, Norfolk and Norwich University Hospitals NHS Foundation Trust, United Kingdom

Dr. Michael Peel Doctor, General Practitioner, Somerset, United Kingdom

Dr. Clifford P. Perera Senior Lecturer and Head, Department of Forensic Medicine, Faculty of Medicine, University of Ruhuna; Consultant on forensic issues and human rights, Asian Human Rights Commission, Hong Kong, China

Dr. Pau Pérez-Sales Psychiatrist, Clinical Director, SiR[a], Member of the International Rehabilitation Council for Torture Victims; Editor-in-Chief, *Torture*

Dr. Hans Draminsky Petersen former Member and Vice-Chair, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Mikolaj Pietrzak former Chair, United Nations Voluntary Fund for Victims of Torture; Dean, Warsaw Bar Association, Poland

Laura Pitter Deputy Director, US Program, Human Rights Watch, United States

Dr. Katherine A. Porterfield Psychologist, Bellevue/New York University Program for Survivors of Torture; Clinical Instructor, New York University School of Medicine

Dr. José Quiroga former Medical Director, Program for Torture Victims; former Vice-President, International Rehabilitation Council for Torture Victims

Dr. Steven Reisner Co-Founder, Coalition for an Ethical Psychology; Adviser on psychology and ethics, Physicians for Human Rights

Dr. Ricardo Restrepo-Guzmán Associate Clinical Professor, University of California, Irvine

Dr. Hernán Reyes Human Rights Center, University of California, Berkeley; Obstetrician-Gynaecologist, Swiss Medical Association

Sidsel Rogde Professor, University of Oslo; Forensic Pathologist, Senior Physician, Oslo University Hospital

Dr. Barry H. Roth Medical Doctor, Program in Psychiatry and the Law, Harvard Medical School; Distinguished Life Fellow, American Psychiatric Association

Leonard S. Rubenstein Senior Scientist, Johns Hopkins Bloomberg School of Public Health; Director, Program on Human Rights, Health and Conflict, Center for Public Health and Human Rights

Olga Sadovskaya Vice-Chair, Committee against Torture, Russian Federation

Antti Sajantila Professor, Department of Forensic Medicine, University of Helsinki; Senior Medical Officer, Forensic Medicine Unit, Finnish Institute of Health and Welfare

Yubaraj Sangroula Executive Director, Kathmandu School of Law

Caroline Schlar Psychologist-Psychotherapist, Geneva

Stephanie Selg former Adviser on torture prevention, Office for Democratic Institutions and Human Rights of the Organization for Security and Cooperation in Europe, Poland

Mandira Sharma Human Rights Practitioner, Advocacy Forum, Nepal

Dr. Julian Sheather Specialist Adviser on ethics and human rights, British Medical Association

Derrick Michael Silove Emeritus Professor, University of New South Wales and Visiting Professorial Fellow, Phoenix Australia, University of Melbourne

Susannah Sirkin Director of Policy/Senior Adviser, Physicians for Human Rights

Elna Søndergaard Senior Legal Adviser, Dignity – Danish Institute against Torture; Associate Professor, Denmark

Ruth Ssekindi Director, Complaints, Investigations and Legal Services; Uganda Human Rights Commission

Eric Stover Faculty Director, Human Rights Center, School of Law, University of California, Berkeley

Dr. Wilder Tayler Director, National Human Rights Institution; Commissioner, International Commission of Jurists, Uruguay

Jørgen L. Thomsen Professor, University of Southern Denmark; Doctor of Medical Science, Department of Forensic Medicine

Dr. Morris V. Tidball Binz Special Rapporteur on extrajudicial, summary or arbitrary executions; Visiting Professor, Universities of Coimbra and Milan; Forensic Manager, Missing Persons Project, International Committee of the Red Cross

Lela Tsiskarishvili Executive Director, Georgian Centre for Psychosocial and Medical Rehabilitation of Torture Victims; Clinical Psychologist, Mental Health Master's Programme, Ilia State University, Georgia

Hulya Ucpinar Lawyer, Human Rights Foundation of Turkey

Danaé L. van der Straten Ponthoz Senior Adviser, Global Survivors Fund, Switzerland

Dr. Adriaan Van Es Physician, International Federation of Health and Human Rights Organizations, Netherlands

Peter Vanezis Professor of Forensic Medical Sciences, Queen Mary University of London

Dr. Homer Drae Venters Clinical Associate Professor, New York University College of Global Public Health; Senior Health and Justice Fellow, Community Oriented Correctional Health Services, United States

Alejandra Vicente Head of Law, Redress Trust

Duarte Nuno Vieira Full Professor, Faculty of Medicine, University of Coimbra; Chair, Coimbra University Centre for Humanitarian and Human Rights Forensic Research and Training

Ravi Prakash Vyas Assistant Professor, Kathmandu School of Law

Steven M. Watt Senior Staff Attorney, American Civil Liberties Union

Dr. Mechthild Wenk-Ansohn Medical Doctor, Psychotherapist, Supervisor; former Head, Ambulant Sector, Centre Überleben, Berlin; Independent Consultant, European Centre for Constitutional and Human Rights, and in the field of international cooperation, Germany

Thomas Wenzel Psychiatrist, Section on Psychological Aspects of Persecution and Torture, World Psychiatric Association; Professor, Medical University of Vienna

Dr. Zeev Wiener Psychiatrist and Family Physician, Physicians for Human Rights Israel

Dr. Cynthia Willard Director, Keck Human Rights Clinic, University of Southern California

Şahika Yüksel Psychiatrist, Human Rights Foundation of Turkey; Professor, Istanbul University (retired)

ADDITIONAL CONTRIBUTORS

Sarah Bakir Master of Public Health Candidate, School of Public Health, University of California, Berkeley

Josina Bothe Consultant, International Rehabilitation Council for Torture Victims, Germany

Alice Chin-Huei Chiu Lawyer, Huang's Law Office; former Consultant, International Rehabilitation Council for Torture Victims

Makaila Heifner former Research Assistant, Human Rights Center, School of Law, University of California, Berkeley

Una Marquard-Busk Project Manager, Dignity – Danish Institute against Torture

Julia Nee former Research Assistant, Human Rights Center, School of Law, University of California, Berkeley; Bachelor of Arts Candidate, Gallatin School of Individualized Study, New York University

Also acknowledged are several OHCHR colleagues whose efforts contributed towards the realization of this publication. In accordance with OHCHR policy, contributions to its publications are not attributed to those employed by the Office.

INTRODUCTION

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which was adopted by the General Assembly in 1984, has been ratified by almost every country in the world. The Convention against Torture provides, in article 1 thereof, an internationally agreed legal definition of torture, namely:

> 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.

Torture is one of the most heinous crimes known to humanity not only because it involves the intentional infliction of severe physical and mental pain, but because it is committed by officials or with the acquiescence of a State and often concealed effectively to prevent justice and accountability. As a result of torture, victims endure profound physical and mental pain and suffering, while the reality of the crime perpetrated against them is often dismissed in judicial and administrative proceedings and unpunished. Torture is a profound concern for the world community because it seeks to destroy not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of families and entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future.[4] Although international human rights and humanitarian law consistently prohibit torture and other cruel, inhuman or degrading treatment or punishment ("torture and ill-treatment") under any circumstance (see chap. I), these acts continue to be practised with impunity throughout the world.[5] The striking disparity between the absolute prohibition of torture and its prevalence in the world today demonstrates the continued need for States to identify and implement effective measures to protect individuals from torture and ill-treatment. This manual was developed to enable States to address one of the most fundamental concerns in protecting individuals from torture – effective investigation and documentation. Documentation brings evidence of torture and ill-treatment to light so that perpetrators may be held accountable for their actions and the interests of justice may be served. During the past 20 years, the investigation and documentation standards of the Istanbul Protocol have served to bridge the gap between the obligations of States under the Convention against Torture and international law to investigate and document torture and ill-treatment and the lack of normative guidance, particularly in relation to medico-legal investigation and documentation of torture. The Istanbul Protocol is an effective instrument to address impunity for torture and ill-treatment, as it sets out specific provisions on how effective legal and clinical investigation and documentation into allegations of torture or ill-treatment should be carried out, which is necessary to bring perpetrators to justice. The Istanbul Protocol contains a series of Principles that articulate minimum standards for State adherence to ensure the effective investigation and documentation of torture and ill-treatment, which are further elaborated in the manual.[6] The investigation and documentation standards contained in the Istanbul Protocol are not presented as an inflexible or exhaustive protocol, but represent minimum standards that should be applied taking into account specific contexts. While the Istanbul Protocol initially served to elaborate the obligations of States under the Convention against Torture and international law to investigate and document torture and ill-treatment, it has been used in a broad range of anti-torture activities throughout the past 20 years including advocacy, training and capacity-building, policy reform, prevention, and treatment and rehabilitation of torture survivors.[7] It is important to note that the documentation methods contained in the Istanbul Protocol are applicable to many contexts, such as human rights investigations and

4 Vincent Iacopino, "Treatment of survivors of political torture: commentary", *Journal of Ambulatory Care Management*, vol. 21, No. 2 (1998), pp. 5–13.

5 Amnesty International, *Torture in 2014: 30 Years of Broken Promises* (London, 2014), p. 10. See also A/73/207, para. 76.

6 The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment are annexed to General Assembly resolution 55/89.

7 Rohini Haar and others, "The Istanbul Protocol: a stakeholder survey on past experiences, current practices and additional norm setting", *Journal on Rehabilitation of Torture Victims and Prevention of Torture*, vol. 29, No. 1 (2019).

monitoring, asylum evaluations, defending the rights of individuals who are coerced to give confessions through torture or ill-treatment, and needs assessments for the care of torture victims. Moreover, the Istanbul Protocol's investigation and documentation standards and methods are applicable whether activities are conducted in-person or remotely. This manual also provides an international point of reference to prevent neglect, misinterpretation, deliberate misuse or falsification of torture evidence by health professionals, either willingly or under coercion.

It is important that all actors use the Istanbul Protocol in good faith and take measures to prevent its misuse,[8] including to exonerate perpetrators on the basis of the absence of physical and/or psychological findings of torture or ill-treatment, to arbitrarily disqualify independent, non-governmental clinical experts from testifying in judicial proceedings and to misrepresent its guidance on the formulation of clinicians' interpretations of findings and their conclusions regarding the possibility of torture or ill-treatment.

8 The Istanbul Protocol is not intended as a method for excluding the possibility of torture and ill-treatment. See, for example, CAT/C/MEX/CO/7, paras. 26–27.

1. The right to be free from torture is firmly established under international law.[1] It is also rooted in international humanitarian law, international criminal law and in customary international law. Furthermore, the prohibition of torture is a *jus cogens*[2] norm of international law, binding on all States even if they are not party to treaties containing the provision. Because of its *jus cogens* status, the prohibition of torture is absolute and non-derogable and cannot be limited under any circumstances.[3] The absolute and non-derogable character of the prohibition against torture is further reinforced by the provisions of article 2 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,[4] which were elaborated on in general comment No. 2 (2007) of the Committee against Torture. The Convention against Torture also recognizes universal jurisdiction for the crime of torture. The prohibition of torture applies extraterritorially, and States' obligations flowing from the absolute nature of the prohibition – including the obligations to investigate, prosecute and punish acts of torture – are rules of customary international law. The prohibition against cruel, inhuman or degrading treatment or punishment (ill-treatment) is similarly absolute under both treaty and customary international law.[5] States that follow the Istanbul Protocol to assess allegations of torture or ill-treatment during an investigation in good faith and with due diligence indicate that they are striving to meet their obligations to examine such allegations properly.

A. International human rights law

1. Norms and standards developed at the United Nations

2. States Members of the United Nations have sought for many years to develop universally applicable standards to ensure adequate protection for all persons against torture and ill-treatment. The treaties, declarations, resolutions and other instruments adopted by Member States clearly state that there is no exception to the prohibition of torture and ill-treatment and establish other safeguards against these abuses, including instruments applicable to specific populations such as women, persons with disabilities and children.[6]

3. Article 1 of the Convention against Torture defines torture (for the purposes of the Convention) as:

> 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.

1 Universal Declaration of Human Rights, art. 5; International Covenant on Civil and Political Rights, art. 7; Convention against Torture, art. 2; Convention on the Rights of the Child, art. 37; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, art. 10; and Convention on the Rights of Persons with Disabilities, art. 15, all expressly prohibit torture and ill-treatment. Regional instruments that establish the right to be free from torture include: Inter-American Convention to Prevent and Punish Torture, art. 1; Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará), art. 4; American Convention on Human Rights (Pact of San José), art. 5; African Charter on Human and Peoples' Rights, art. 5; and Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights), art. 3. Additionally, the International Convention for the Protection of All Persons from Enforced Disappearance and the Inter-American Convention on Forced Disappearance of Persons prohibit enforced disappearances, which various regional and international tribunals have concluded amount to torture, and oblige States to investigate, prosecute and punish such acts.

2 A/74/10, pp. 146–147, conclusion 23 of the draft conclusions on peremptory norms of general international law (*jus cogens*), adopted by the International Law Commission on first reading, and the annex thereto.

3 The absolute and non-derogable nature of the prohibition of torture is expressly stated in the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 3; the Convention against Torture, art. 2 (2); and the Inter-American Convention to Prevent and Punish Torture, art. 5. Furthermore, the right to be free from torture is non-derogable during states of emergency (International Covenant on Civil and Political Rights, art. 4; European Convention on Human Rights, art. 15; and American Convention on Human Rights, art. 27).

4 The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (New York, 10 December 1984), United Nations, *Treaty Series*, vol. 1465, No. 24841, p. 85, entered into force on 26 June 1987.

5 In its general comment No. 2 (2007), para. 6, the Committee against Torture elaborates that prohibitions against torture are likewise applied to ill-treatment, including those articles of the Convention that establish universal jurisdiction (arts. 5–9).

6 These instruments include: Universal Declaration of Human Rights; Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; International Covenant on Civil and Political Rights; Code of Conduct for 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; Convention against Torture; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment; Basic Principles for the Treatment of Prisoners; Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules); United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules); Convention on the Rights of Persons with Disabilities; Convention on the Rights of the Child; United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules); and United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules).

> The list of other purposes is non-exhaustive and the relevant purposes are not limited to coercive statements or confessions.

4. State responsibility for torture and ill-treatment extends to individuals acting in an official capacity, as well as to non-State actors acting with the consent or acquiescence of the State. As stated under article 1, torture involves acts "by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity". The term acquiescence necessitates a rather broad interpretation, under which States are responsible for the actions of public officials and non-State actors who "have awareness of such activity and thereafter breach [their] legal responsibility to interfere to prevent such activity".[7] The principle of official capacity therefore keeps States accountable for more than just State officials and creates a wider understanding of the definition of torture.[8] The Committee against Torture has explained that where officials:

> know or have reasonable grounds to believe that acts of torture or ill-treatment are being committed by non-State officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors consistently with the Convention, the State bears responsibility and its officials should be considered as authors, complicit or otherwise responsible under the Convention for consenting to or acquiescing in such impermissible acts.[9]

5. While the definition of torture in the Convention against Torture excludes "pain or suffering arising only from, inherent in or incidental to lawful sanctions", the legality of a sanction under national law in and of itself is insufficient to render it lawful under article 1 of the Convention.[10] The Committee against Torture applies this provision by determining the lawfulness of a sanction with reference to both national and international law and standards, including the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) and the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules).[11] The lawfulness of any sanction will be determined by reference to national and international law, with international law taking precedence in case of conflict with domestic legislation.[12] This requirement explains why corporal punishment and the death penalty are arguably prohibited under the Convention against Torture as interpreted by the Committee and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, despite being acceptable under the domestic legislation of certain States.[13]

6. According to article 1 of the Convention against Torture, the substantive concept of "torture" comprises, most notably, the intentional and purposeful infliction of severe pain or suffering "whether physical or mental". Therefore, all methods of torture are subject to the same prohibition and give rise to the same legal obligations, regardless of whether the inflicted pain or suffering is of a "physical" or "mental" character, or a combination thereof.

7. Article 16 of the Convention against Torture addresses the prevention of "acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1". As a broadly written provision, article 16 covers forms of ill-treatment that do not amount to torture as they lack elements of the definition of torture, whether they relate to purpose, intention, or pain or suffering that differs in severity.[14] While the term "cruel, inhuman or degrading treatment or punishment" is not defined in the Convention against Torture or other international (or regional) instruments, under international standards it "should be interpreted so as to extend the widest possible protection against abuses".[15]

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7 Manfred Nowak and Elizabeth McArthur, *The United Nations Convention against Torture: A Commentary* (Oxford and New York, Oxford University Press, 2008), p. 78. See A/74/148, para. 6; and A/HRC/22/53, para. 17.

8 On the concept of "acquiescence", see Committee against Torture, *Dzemajl et al. v. Yugoslavia* (CAT/C/29/D/161/2000), para. 9.2.

9 General comment No. 2 (2007), para. 18.

10 Lawful sanctions refer to legitimate practices widely accepted by the international community. See E/CN.4/1997/7.

11 General Assembly resolutions 70/175, 65/229 and 40/33, respectively.

12 Human Rights Committee, *Osbourne v. Jamaica*, communication No. 759/1997, para. 9.1. See also CAT/C/AFG/CO/2, para. 24 (e); CAT/C/PAK/CO/1, para. 39; and CAT/C/MNG/CO/2, para. 26

13 E/CN.4/1997/7, paras. 7–8; and A/67/279, paras. 26–27. See also CAT/C/ATG/CO/1, para. 44; CAT/C/KOR/CO/3-5, para. 30; and CAT/C/TLS/CO/1, para. 23.

14 Committee against Torture, general comment No. 2 (2007), para. 10; and Human Rights Committee, general comment No. 20 (1992), para. 3.

15 The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 6, footnote.

8. The emphasis on preventing cruel, inhuman or degrading treatment is explained through its interrelated relationship with torture. As observed by the Committee against Torture, "in practice, the definitional threshold between ill-treatment and torture is often not clear … [and] the conditions that give rise to ill-treatment frequently facilitate torture and therefore the measures required to prevent torture must be applied to prevent ill-treatment."[16] In that regard, other forms of ill-treatment are also absolutely prohibited.

9. Various United Nations human rights mechanisms have taken action to develop standards for the prevention of torture, including clarifying the obligation of States to investigate allegations of torture.

(a) Obligations related to the prevention of torture

10. The international instruments cited above establish certain obligations with which States must comply to ensure the prevention of torture and other forms of ill-treatment. These include:

(a) Taking effective legislative, administrative, judicial or other measures to prevent acts of torture, whether committed by State or private actors in any territory under its jurisdiction. No exceptional circumstances whatsoever, including a state of war or threat of war, internal political instability or any other public emergency, may be invoked as justification for torture or ill-treatment;[17]

(b) Not forcibly expelling, returning (*refouler)* or extraditing a person to a country where there are substantial grounds for believing the person would be tortured or ill-treated.[18] See below (paras. 112–116) for a fuller explanation of non-refoulement;

(c) Criminalizing acts of torture, including complicity or participation therein, punishable by penalties accounting for the grave nature of the act; and ensuring acts of torture are not subject to prescription or any statutes of limitation or pardons, amnesties or immunities;[19]

(d) Undertaking to exercise universal jurisdiction, that is to investigate suspects under its jurisdiction and if necessary prosecute or extradite them, irrespective of where the torture was committed and of the nationality of the perpetrator or the victim, including through making torture an extraditable offence and assisting other States parties in connection with criminal proceedings brought in respect of torture;[20]

(e) Implementing, in law and in practice, fundamental legal safeguards from the outset of detention, by ensuring, among other things, that all detained persons are able, in practice, to have prompt access to a qualified independent lawyer or free legal aid, if necessary, especially during police interrogations; to notify a relative or other person of the detainee's choice of the reasons for and place of detention; to challenge, at any time during the detention, the legality or necessity of the detention before a magistrate who can order the detainee's immediate release and to receive a decision without delay; and to exercise the right to request and receive a medical examination by an independent medical doctor. In addition, States must establish procedural safeguards such as ensuring that detainees are held in officially recognized places of detention, keeping a full record of time, duration and location of arrest and detention; ensuring the names of persons responsible for detention are kept in registers readily available and accessible to those concerned, including relatives and friends; and recording the time and place of all interviews of suspects, witnesses or victims, together with the names of those present;[21]

(f) Establishing a system of regular visits carried out by independent international and national bodies to places in which persons are deprived of their liberty, including such places as prisons, police stations, hospitals, social care institutions, closed migration centres etc., with the aim of preventing torture and ill-treatment and

16 Committee against Torture, general comment No. 2 (2007), para. 3.

17 Convention against Torture, art. 2 (1) and (2); Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 3; and International Covenant on Civil and Political Rights, arts. 4 and 7.

18 Convention against Torture, art. 3; Committee against Torture, general comment No. 4 (2017), paras. 15–16 and 26; and International Covenant on Civil and Political Rights, art. 7.

19 Convention against Torture, art. 4; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 7; Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 7; and Committee against Torture, general comment No. 3 (2012), para. 40, and general comment No. 2 (2007), para. 5, "the Committee considers that amnesties or other impediments which preclude or indicate unwillingness to provide prompt and fair prosecution and punishment of perpetrators of torture or ill-treatment violate the principle of non-derogability."

20 Convention against Torture, arts. 5–9. Specifically, the duty to establish jurisdiction and jurisdiction by the State party (arts. 5–6); the obligation to prosecute or extradite (arts. 5 and 7); the duty to extradite (art. 8); and mutual judicial assistance (art. 9).

21 CAT/C/RUS/CO/6, para. 11 (a)–(b).

informing States about treatment and conditions in violation of human rights;[22]

(g) Ensuring that materials regarding the prohibition of torture are included in the training of law enforcement personnel (civil and military), medical personnel, public officials and other appropriate persons;[23]

(h) Ensuring that States parties keep under systematic review interrogation rules, methods and practices regarding the custody and treatment of persons deprived of their liberty;[24]

(i) Ensuring the inadmissibility of any evidence obtained as the result of torture. Any statement that is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made (this is known as the "exclusionary rule");[25]

(j) Ensuring that the competent authorities conduct prompt and impartial investigations and guarantee the right to make a complaint;[26]

(k) Ensuring that impartial and effective complaints mechanisms are established, known and accessible to the public, including to persons deprived of their liberty, and to persons belonging to vulnerable or marginalized groups or who have limited communication abilities.[27] In addition to ensuring that complainants and witnesses are protected against acts of retaliation or intimidation as a consequence of their complaints or any evidence provided;

(l) Ensuring that victims of torture have access to redress and an enforceable right to fair and adequate compensation;[28] redress must include effective remedy and reparation. Comprehensive reparation refers to the full scope of measures required to redress violations under the Convention against Torture and includes "restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition";[29]

(m) Ensuring that alleged offenders are subject to criminal proceedings if an investigation establishes that an act of torture appears to have been committed and provides sufficient, admissible evidence of individual culpability. If allegations of acts involving torture or ill-treatment are considered to be well founded, offenders should be subject to administrative and judicial penalties that take into account the grave nature of their acts[30] with no statutes of limitations.[31]

(b) United Nations mechanisms

11. The human rights mechanisms of the United Nations include treaty-based bodies, such as the Committee against Torture, as well as Charter-based bodies, such as the Human Rights Council and its special procedures.[32]

12. The Istanbul Protocol has been cited in a number of decisions adopted by United Nations treaty bodies pursuant to individual communications, including the Committee against Torture and the Human Rights Committee, on issues of torture, ill-treatment, non-refoulement, and arbitrary arrest and detention, among others.[33]

(i) Treaty bodies

13. The United Nations human rights treaty bodies are committees of independent experts charged with monitoring States parties' implementation of human rights treaties. Each treaty body is established

22 Optional Protocol to the Convention against Torture, arts. 2–4; and Nelson Mandela Rules, rules 83—85.

23 Convention against Torture, art. 10; Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 5; Committee against Torture, general comment No. 4 (2017), para. 18 (f)–(g); and Nelson Mandela Rules, rule 76; See also Committee against Torture, general comment No. 2 (2007), paras. 6 and 25.

24 Convention against Torture, art. 11.

25 Information extracted by torture is unreliable and prohibiting its use as evidence removes an important incentive for the use of torture. See Convention against Torture, art. 15; and Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 12. See also A/61/259; and A/HRC/25/60.

26 Convention against Torture, art. 13; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principles 33–34; Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 9; and Nelson Mandela Rules, rule 71.

27 Committee against Torture, general comment No. 3 (2012), para. 23.

28 Convention against Torture, arts. 13–14; and Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, art. 11.

29 Committee against Torture, general comment No. 3 (2012), para. 2.

30 A/HRC/28/68/Add.4, para. 109 (a).

31 Committee against Torture, general comment No. 3 (2012), para. 40; CAT/C/LVA/CO/6, para. 9; and CAT/C/UZB/CO/5, paras. 25–26.

32 See www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx.

33 See, for example, Committee against Torture, *Rakishev v. Kazakhstan* (CAT/C/61/D/661/2015), para. 8.2; *Asfari v. Morocco* (CAT/C/59/D/606/2014), para. 15; and *Elaïba v. Tunisia* (CAT/C/57/D/551/2013), para. 5.5.

by and acts in accordance with the mandate defined within the specific treaty it monitors.

a. Committee against Torture

14. The Committee against Torture monitors implementation by States parties of the Convention against Torture. The Committee's main functions include: examination of periodic reports;[34] consideration of individual complaints and inter-State communications;[35] inquiry procedure;[36] and the adoption of general comments, which all provide important interpretation of the provisions of the Convention against Torture and establish extensive jurisprudence on torture and ill-treatment.

15. Among the concerns addressed by the Committee against Torture in its concluding observations and decisions on individual complaints is the necessity of States parties to comply with articles 12 and 13 of the Convention against Torture to ensure that prompt and impartial investigations of all allegations of torture are carried out. The Committee has noted that article 13 does not require a formal submission of a complaint of torture, but that: "It is sufficient for torture only to have been alleged by the victim for [a State party] to be under an obligation promptly and impartially to examine the allegation."[37] Indeed, even without a complaint, the State is obliged to investigate ex officio if there are reasonable indications that an act of torture has taken place. The Committee's jurisprudence also emphasizes that under articles 12 and 13 of the Convention, investigations into torture should include a medical examination that complies with the Istanbul Protocol;[38] examine the possible complicity of medical personnel;[39] bring to justice those responsible for the torture; and provide redress and reparation to victims.[40]

16. Commenting on the exclusionary rule, the Committee has stated that: "One of the essential means in preventing torture is the existence, in procedural legislation, of detailed provisions on the inadmissibility of unlawfully obtained confessions and other tainted evidence."[41] The Committee has also confirmed that it is up to the State concerned to "ascertain whether or not statements admitted as evidence in any proceedings for which it has jurisdiction ... have been made as a result of torture"[42] and clear instructions must be given to the courts to enable them to rule that the statement is inadmissible.[43]

b. Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

17. The Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is a treaty body established under the framework of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The objective of the Optional Protocol is to prevent torture and ill-treatment by way of regular visits by independent international and national bodies to all places in which persons are or may be deprived of their liberty, including police stations, prisons, pretrial detention centres, immigration detention centres, juvenile justice establishments, military facilities, and mental health and social care institutions.

18. The nature of the Subcommittee's mandate allows it to make unannounced visits, have unrestricted access to all places of detention and be granted full access to all documentation, including medical documentation. The Subcommittee has the ability to access places that are otherwise off-limits, even to medical staff.

19. During visits, delegations should include medically qualified members that can – and do, with consent – carry out physical examinations of individuals alleged to have been subjected to torture or other ill-treatment. Members of the Subcommittee must also be granted unrestricted access to places of detention and full access to interviews

34 Convention against Torture, art. 19.
35 Ibid., arts. 21–22.
36 Ibid., art. 20.
37 A/50/44; and Committee against Torture, *Parot v. Spain*, communication No. 6/1990, para. 10.4.
38 Committee against Torture, *Elaïba v. Tunisia* (CAT/C/57/D/551/2013), para. 7.10.
39 Committee against Torture, *Rakishev v. Kazakhstan* (CAT/C/61/D/661/2015), para. 10.
40 Committee against Torture, *E.N. v. Burundi* (CAT/C/56/D/578/2013), paras. 7.7–9.
41 A/54/44, para. 45.
42 Committee against Torture, *G.K. v. Switzerland* (CAT/C/30/D/219/2002), para. 6.10.
43 CAT/C/RUS/CO/4, para. 21. The Human Rights Committee has further stated that the exclusionary rule applies at all times, including during times of emergency. See also Human Rights Committee, general comment No. 32 (2007), para. 6.

in private (no officials present) with persons deprived of their liberty and with relevant staff.

20. The Subcommittee's mandate also includes advising and assisting States parties regarding the establishment of their national preventive mechanisms – which are independent visiting bodies at the national level. As with the Subcommittee, national preventive mechanisms can make unannounced visits and have unrestricted access to all places in which persons are or may be deprived of their liberty, and should be granted full access to all documentation.

c. Human Rights Committee

21. The Human Rights Committee was established pursuant to article 28 of the International Covenant on Civil and Political Rights and is mandated with monitoring the implementation of the Covenant by States parties.

22. In its general comments, the Committee has, among other things, reinforced its reading of article 7 of the Covenant, which provides that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment", by stating that "Complaints must be investigated promptly and impartially by competent authorities so as to make the remedy effective."[44] It has outlined standards and rules applicable to the humane treatment of persons deprived of their liberty, noting that: "Article 10, paragraph 1 [of the International Covenant on Civil and Political Rights], imposes on States parties a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty, and complements for them the ban on torture or other cruel, inhuman or degrading treatment or punishment contained in article 7 of the Covenant."[45] The Committee has also explained how arbitrary detention creates risks of torture and ill-treatment and listed various safeguards that are essential to prevent torture.[46] Furthermore, it has noted that the mental and physical effects of torture and ill-treatment can generate a risk of deprivation of life and has linked torture and ill-treatment to enforced disappearances.[47]

23. Among the jurisprudence established by the Human Rights Committee under the first Optional Protocol to the International Covenant on Civil and Political Rights, which gives the Committee competence to examine individual complaints of violations of the Covenant, the Committee has emphasized and/or explained that, under article 7, States are obligated to conduct thorough and effective investigations into reports of torture, including medical investigations, followed by prosecution and punishment of those responsible and provision of compensation to the complainant.[48] Additionally, the Committee has recognized that a significant degree of suffering is involved in being held for prolonged periods in incommunicado detention and that this can amount to torture or ill-treatment.[49]

d. Committee on the Elimination of Discrimination against Women

24. The Committee on the Elimination of Discrimination against Women monitors State parties' compliance with the Convention on the Elimination of All Forms of Discrimination against Women.

25. In its concluding observations, the Committee has addressed the obligation to investigate, prosecute and punish State and non-State perpetrators of acts constituting torture or ill-treatment, including sexual violence and mutilation. It has also considered the obligation to provide victims of sexual violence with access to comprehensive medical treatment and psychosocial support provided by health professionals who are appropriately trained to detect sexual violence.[50] Additionally, the Committee has raised concerns about arbitrary detention, torture and ill-treatment, and sexual violence in prisons; the stigmatization of women when reporting sexual and gender-based violence and rape or other forms of torture or ill-treatment; and the obligation to provide victims of sexual violence with access to comprehensive medical treatment and psychosocial

44 Human Rights Committee, general comment No. 20 (1992), para. 14.
45 Human Rights Committee, general comment No. 21 (1992), para. 3.
46 Human Rights Committee, general comment No. 35 (2014), paras. 56–58.
47 Human Rights Committee, general comment No. 36 (2018), paras. 54–58.
48 Human Rights Committee, *Amarasinghe v. Sri Lanka* (CCPR/C/120/D/2209/2012), para. 8; and *Khelifati v. Algeria* (CCPR/C/120/D/2267/2013), para. 8.
49 Human Rights Committee, *El-Megreisi v. Libya*, communication No. 440/1990, para. 5.4.
50 CEDAW/C/BDI/CO/5-6, para. 27.

support provided by health professionals who are appropriately trained to detect sexual violence.[51]

26. The Committee's general recommendations have elaborated on issues such as violence against women[52] and access to justice, in which it reiterated that justice systems needed to be available, accessible, justiciable, accountable, of good quality and provide remedies for victims.[53]

27. In its consideration of individual communications pursuant to the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, the Committee has found violations of rights enshrined in the Convention, including cases concerning forced sterilization, domestic violence, violence in prison, forced continuation of pregnancy and a lack of provisions to effectively punish rape and sexual violence.[54]

e. Committee on the Rights of the Child

28. The Committee on the Rights of the Child was established pursuant to article 43 of the Convention on the Rights of the Child.

29. In its concluding observations, the Committee has repeatedly addressed torture and ill-treatment under article 37 of the Convention, which provides that "no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment". In so doing, the Committee has raised concerns about torture, extrajudicial executions and enforced disappearance of children at the hands of the police and armed forces and has recommended recording, investigating and prosecuting all allegations of torture or ill-treatment of children.[55]

30. The Committee has published general comments on corporal punishment and other cruel or degrading forms of punishment as well as on juvenile justice.[56] In its general comment No. 6 (2005) on treatment of unaccompanied and separated children outside their country of origin, the Committee affirmed that a child should not be returned to a country where there were substantial grounds for believing that there was a real risk of irreparable harm to the child.[57] In examining individual complaints, pursuant to the Optional Protocol to the Convention on the Rights of the Child on a communications procedure, the Committee has found that deporting a girl to a State where she is at risk of being subjected to female genital mutilation violates the Convention.[58]

f. Committee on the Rights of Persons with Disabilities

31. The Committee on the Rights of Persons with Disabilities was established pursuant to article 34 of the Convention on the Rights of Persons with Disabilities.

32. The Committee has addressed aspects of torture and ill-treatment as part of its mandate. For instance, the Committee found that Argentine authorities failed to ensure that a prisoner with disabilities was able to use prison facilities and services on an equal basis with other detainees and that the State was obliged to take steps to rectify the situation.[59] The Committee also emphasized the State's obligation to prevent torture when it found that the United Republic of Tanzania had failed to investigate and prosecute suspected perpetrators of an attack against an individual with albinism; the Committee noted that this failure resulted in a revictimization of the targeted individual, who had endured psychological ill-treatment and a violation of the individual's physical integrity.[60]

g. Committee on Enforced Disappearances

33. The mandate of the Committee on Enforced Disappearances is to monitor implementation of the International Convention for the Protection of All Persons from Enforced Disappearance by

51 CEDAW/C/IRQ/CO/4-6, paras. 48–49; CEDAW/C/MLI/CO/6-7, paras. 13–14; and CEDAW/C/BDI/CO/5-6, paras. 26–27.

52 Committee on the Elimination of Discrimination against Women, general recommendation No. 12 (1989); general recommendation No. 19 (1992); and general recommendation No. 35 (2017).

53 Committee on the Elimination of Discrimination against Women, general recommendation No. 33 (2015).

54 Committee on the Elimination of Discrimination against Women, *Szijjarto v. Hungary*, communication 4/2004; *A.T. v. Hungary*, communication No. 2/2003; *Vienna Intervention Centre against Domestic Violence and the Association for Women's Access to Justice on behalf of Akbak et al. v. Austria* (CEDAW/C/39/D/6/2005); *Abramova v. Belarus* (CEDAW/C/49/D/23/2009); *L.C. v. Peru* (CEDAW/C/50/D/22/2009); and *V.P.P. v. Bulgaria* (CEDAW/C/53/D/31/2011).

55 CRC/C/SLV/CO/5-6 and Corr.1, para. 24; and CRC/C/ARG/CO/5-6, paras. 21–22.

56 Committee on the Rights of the Child, general comment No. 8 (2006) and general comment No. 10 (2007).

57 Committee on the Rights of the Child, general comment No. 6 (2005), para. 27.

58 Committee on the Rights of the Child, *K.Y.M. v. Denmark* (CRC/C/77/D/3/2016).

59 Committee on the Rights of Persons with Disabilities, *X v. Argentina* (CRPD/C/11/D/8/2012), para. 8.5.

60 Committee on the Rights of Persons with Disabilities, *X v. United Republic of Tanzania* (CRPD/C/18/D/22/2014), paras. 8.6–8.7.

States parties. The Committee can also receive requests for urgent actions from the relatives of disappeared persons or their legal or other authorized representatives, as well as complaints from individuals claiming to be victims of a violation of the rights enshrined in the Convention.[61]

(ii) Human Rights Council special procedures

34. The Human Rights Council is an intergovernmental body responsible for promoting and protecting international human rights and for taking action to address human rights violations.

35. The Council administers a system of special procedures of independent experts working in their individual capacities with mandates to report and advise on human rights from a thematic or country-specific perspective.

36. Special Rapporteurs investigate human rights situations around the world from a thematic or country-specific perspective, regardless of a State's ratification of relevant human rights treaties.

37. Working groups transmit urgent appeals to Governments, conduct visits to develop a comprehensive understanding of the prevailing situations relative to their mandates in countries, provide deliberations on general issues to assist States in preventing violations and issue annual reports.

a. Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

38. The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment examines questions related to torture and other cruel, inhuman or degrading treatment or punishment. Pursuant to Human Rights Council resolution 43/20, the Special Rapporteur on torture is mandated to seek, receive, examine and act on information related to issues and alleged cases of torture or ill-treatment; to conduct country visits to enhance dialogue with Governments and follow up on recommendations made in visit reports; to study, in a comprehensive manner, trends, developments and challenges in relation to combating and preventing torture and ill-treatment, and make recommendations and observations concerning appropriate measures to prevent and eradicate such practices; to identify, exchange and promote best practices on measures to prevent, punish and eradicate torture and ill-treatment; to integrate a gender perspective and a victim-centred approach throughout the mandate; and to promote cooperation with national, regional and international actors.[62]

39. In his 1995 report, the Special Rapporteur on torture, Sir Nigel Rodley, made a series of recommendations, including:

> When a detainee or relative or lawyer lodges a torture complaint, an inquiry should always take place. … Independent national authorities, such as a national commission or ombudsman with investigatory and/or prosecutorial powers, should be established to receive and to investigate complaints. Complaints about torture should be dealt with immediately and should be investigated by an independent authority with no relation to that which is investigating or prosecuting a case against the alleged victim [of torture].[63]

40. Sir Nigel Rodley later pointed out that "both under general international law and under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, States are obliged to investigate allegations of torture".[64] Subsequently, his successor, Manfred Nowak, noted, "one of the major challenges in fighting impunity for torture is for the authorities to carry out effective investigations; investigations that are independent, thorough and comprehensive."[65] To this end, the Special Rapporteur emphasized the importance of forensic medical examiners in documenting and investigating torture and combating impunity, recommending that: "An independent forensic expert should be part of any credible fact-finding or prevention mechanism."[66]

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61 CED/C/COL/CO/1, paras. 29–30 (agreeing with the Committee against Torture that the State should ensure immediate access to a lawyer and all associated safeguards for persons deprived of their liberty as a way to prevent enforced disappearances); and A/HRC/45/13, paras. 61 (discussing allegations that victims of enforced disappearances had been subjected to torture during disappearance and then reappeared in front of a prosecutor) and 93 (noting the relationship among enforced disappearance, arbitrary detention and torture).

62 Mandate holders to date include: Peter Kooijmans (1985–1993), Nigel Rodley (1993–2001), Theo van Boven (2001–2004), Manfred Nowak (2004–2010), Juan E. Méndez (2010–2016) and Nils Melzer (2016–2022).

63 E/CN.4/1995/34, para. 926 (g).

64 E/CN.4/1996/35, para. 136.

65 A/62/221, para. 46.

66 Ibid., para. 53 (e).

41. The respective Special Rapporteurs on torture have stressed the importance of the investigation and documentation of allegations of torture, in accordance with the Istanbul Protocol, as a necessary tool in fighting impunity and reinforcing the rule of law. They have also identified situations, such as solitary confinement, and practices, such as forced confessions, that represent a heightened risk of torture and ill-treatment and recommended preventive measures against such situations and practices in their thematic as well as country visit reports. Recent elaborations on norms related to torture and ill-treatment have included commissions of inquiry,[67] conditions of detention and the Nelson Mandela Rules,[68] the exclusionary rule,[69] gender perspectives on torture,[70] torture in health-care settings,[71] solitary confinement,[72] the role of forensic expertise in combating impunity for torture[73] and extra-custodial use of force.[74]

b. Special Rapporteur on violence against women, its causes and consequences

42. In a 2013 report, the Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo, wrote about the "strong link between violence against women and women's incarceration, whether prior to, during or after incarceration".[75] In a 2015 report, she recounted the influence of the Inter-American Convention to Prevent and Punish Torture in the "conceptualization of rape as torture", affirming the influence of regional and international human rights mechanisms in the progressive interpretation of rape as torture.[76]

c. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

43. In 2005, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, reported that: "Where mental health care and support services are available, users are vulnerable to violations of their human rights within these settings. This is particularly true in segregated service systems and residential institutions, such as psychiatric hospitals, institutions for people with intellectual disabilities, nursing homes, social care facilities, orphanages, and prisons."[77] In 2017, the Special Rapporteur, Dainius Pūras, concluded that: "Mental health has often been neglected and when it does receive resources, it becomes dominated by ineffective and harmful models, attitudes and imbalances. … People of all ages, when they have mental health needs, too often suffer from either an absence of care and support or from services that are ineffective and harmful."[78]

d. Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism

44. The mandate of the Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism was established in April 2005 by the Commission of Human Rights. Mandate holders have consistently emphasized the absolute prohibition of torture and ill-treatment, including while States are facing terrorism.[79]

e. Special Rapporteur on extrajudicial, summary or arbitrary executions and the Minnesota Protocol on the Investigation of Potentially Unlawful Death

45. The Special Rapporteur on extrajudicial, summary or arbitrary executions often refers to the Minnesota Protocol on the Investigation of Potentially Unlawful Death[80] when carrying out the mandate to protect the right to life and to advance justice, accountability and the right to remedy, and when ensuring

67 A/HRC/19/61.
68 A/64/215; and A/68/295.
69 A/HRC/25/60.
70 A/HRC/7/3; and A/HRC/31/57.
71 A/HRC/22/53.
72 A/63/175; and A/66/268.
73 A/62/221; and A/69/387.
74 A/72/178.
75 A/68/340, para. 2.
76 A/HRC/29/27, paras. 54 and 58.
77 E/CN.4/2005/51, para. 8.
78 A/HRC/35/21, para. 84.
79 A/73/361, para. 40 (expressing concern that counter-terrorism regulation may do harm to the human right to be free from torture); and A/HRC/40/52, para. 55 (noting that multiple individual communications allege the use of torture as part of counter-terrorism efforts).
80 Office of the United Nations High Commissioner for Human Rights (OHCHR), *The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016): The Revised United Nations Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions* (New York and Geneva, 2017).

investigations are carried out in cases of potentially unlawful deaths or enforced disappearances. The Minnesota Protocol facilitates the work of States, as well as institutions and individuals, in carrying out these investigations and contains information ranging from the legal framework pertinent to cases of unlawful death and enforced disappearance to best practices and standards for recovering human remains, performing autopsies, interviewing witnesses, excavating graves and analysing skeletal remains.

f. Working Group on Arbitrary Detention

46. The Working Group on Arbitrary Detention investigates cases of deprivation of liberty imposed arbitrarily or inconsistently with the applicable international legal standards. Arbitrarily detained individuals are often subjected to various forms of torture or ill-treatment, a point that has been underscored by the Working Group. For instance, in 2009 the Working Group stated that "forced anal examinations contravene the prohibition of torture and other cruel, inhumane and degrading treatment, whether … they are employed with a purpose to punish, to coerce a confession, or to further discrimination".[81]

g. Working Group on Enforced or Involuntary Disappearances

47. The Working Group on Enforced or Involuntary Disappearances is mandated to examine questions relevant to enforced or involuntary disappearances of persons by seeking and receiving information from Governments, intergovernmental organizations, humanitarian organizations and other reliable sources.

48. The Working Group has contributed to the development of international standards on the issue of enforced disappearances, including the Declaration on the Protection of All Persons from Enforced Disappearance. It has produced a number of general comments on the Declaration and built its own doctrine on a number of issues, including the connection between enforced disappearances and torture. In its general comment on the definition of enforced disappearance, the Working Group stated:

> The Working Group considers that when the dead body of the victim is found mutilated or with clear signs of having been tortured or with the arms or legs tied, those circumstances clearly show that the detention was not immediately followed by an execution, but that the deprivation of liberty had some duration, even of at least a few hours or days. A situation of such nature, not only constitutes a violation to the right not to be disappeared, but also to the right not to be subjected to torture, to the right to recognition as a person before the law and to the right to life, as provided under article 1, paragraph 2, of the Declaration.[82]

49. On the right to truth, the Working Group elaborated on the impact of enforced disappearances on the relatives of the victim, stating that the right to truth about the fate of the disappeared person is an absolute right, not subject to limitation or derogation. This absolute character results from the fact that enforced disappearance causes suffering to the relatives that reaches the threshold of torture.[83]

h. Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity

50. The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity assesses the implementation of international human rights instruments with regard to ways to overcome violence and discrimination against persons on the basis of their sexual orientation or gender identity. In a 2018 report, the Independent Expert, Victor Madrigal-Borloz, remarked that the "lack of recognition of gender identity may … lead to violations of human rights in other contexts, including torture and ill-treatment in medical and detention settings, sexual violence, and coerced medical procedures."[84]

i. Special Rapporteur on the rights of persons with disabilities

51. The Special Rapporteur on the rights of persons with disabilities investigates barriers facing

81 A/HRC/16/47/Add.1 and Corr.1, opinion No. 25/2009, para. 28.
82 A/HRC/7/2, para. 26 (para. 9 of the general comment).
83 Working Group on Enforced or Involuntary Disappearances, general comment on the right to truth in relation to enforced disappearance, para. 4 (A/HRC/16/48, para. 39).
84 A/73/152, para. 18.

persons with disabilities that hinder their full participation as equal members of society.[85]

52. Persons with disabilities deprived of their liberty are in an extremely vulnerable position and are at higher risk of being subjected to torture or ill-treatment, including forced medication, electroshocks, use of restraints and solitary confinement.[86] They can be denied medical care and are often formally stripped of their legal capacity.[87] In a 2021 report, the Special Rapporteur, Gerard Quinn, expressed concern about the overrepresentation of persons with disabilities in the detention population and the need to consider reasonable accommodations with regard to their living conditions.[88] The Special Rapporteur expressed particular concern about the mental health issues that affected many prisoners with disabilities and the mental health impact of detention, which are related to minimum standards of detention and inhumane or degrading treatment.[89]

53. A 2019 assessment of United Nations action to mainstream accessibility and disability inclusion concluded that inclusion needed a human rights-based approach, which required adhering to and promoting all international human rights standards.[90] Such an approach requires moving away from a charitable or medial approach to persons with disabilities and viewing persons with disabilities as rights holders.

j. Working Group on discrimination against women and girls

54. The Working Group on discrimination against women and girls is mandated to apply a comprehensive and coherent human rights-based approach to ensuring that women and girls are at the centre of efforts to hold States accountable for implementing international standards for civil, political, economic, social and cultural rights.

55. The Working Group focuses on upholding legal guarantees to protect all women and girls and seeks to respond to the intersections of gender-based discrimination with other grounds of discrimination. The Working Group acknowledges that women and girls are not a uniform group. Women and girls, in their diversity and many different circumstances, are differently affected by discriminatory laws and practices.

56. The Working Group has noted that: "Deprivation of liberty … has devastating consequences for women's lives, putting them at risk of torture, violence and abuse, unsafe and unsanitary conditions, lack of access to health services and further marginalization. It cuts women off from educational and economic opportunities, from their families and friends, and from the possibility of making their own choices and directing the course of their lives as they see fit."[91]

k. United Nations Voluntary Fund for Victims of Torture

57. The United Nations Voluntary Fund for Victims of Torture receives voluntary contributions, mostly from States, and distributes them to civil society organizations providing psychological, medical, social, economic, legal and other forms of humanitarian assistance to victims of torture and members of their families. The Fund notably promotes a victim-centred approach aimed at making a difference at the individual level; it is a tool to promote and address accountability as a crucial element in the healing process for victims of torture. Indeed, the physical and psychological after-effects of torture can be devastating and last for years, affecting not only the survivors but also members of their families. Failure to provide effective rehabilitation can leave victims traumatized and destroy families and communities. Article 14 of the Convention against Torture stipulates that States parties must ensure that a victim of torture under their jurisdiction obtains redress, including the means for as full rehabilitation as possible. Assistance in recovering from the trauma suffered can be obtained from State institutions and civil society organizations that specialize in assisting victims of torture.

2. Regional human rights systems

58. Regional human rights bodies have made significant contributions to the development of standards for

85 Mandate holders to date include Gerard Quinn (2020–present) and Catalina Devandas Aguilar (2014–2020).
86 A/HRC/40/54, paras. 24 and 38.
87 Ibid., para. 24.
88 A/HRC/46/27, para. 110.
89 Ibid., para. 111.
90 A/75/186, paras. 6, 12 and 26.
91 A/HRC/41/33, para. 74.

the prevention of torture. These bodies include the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Court of Human Rights, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights.

(a) Inter-American system

59. Article I of the American Declaration of the Rights and Duties of Man[92] states that: "Every human being has the right to life, liberty and the security of his person." Article XXV of the Declaration provides that: "Every individual who has been deprived of his liberty … has the right to humane treatment during the time he is in custody." This is supplemented by the prohibition in article XXVI of "cruel, infamous or unusual punishment". In 1959, the Organization of American States created the Inter-American Commission on Human Rights, which was vested with the mandate to examine individual cases against the organization's member States in 1965.

60. Article 5 of the American Convention on Human Rights states that:

> 1. Every person has the right to have his physical, mental, and moral integrity respected.
>
> 2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.
>
> …

61. Article 33 of the American Convention on Human Rights provides competence to the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights with respect to the fulfilment of the obligations made by States parties under the Convention.[93] As stated in its rules of procedure, the Commission's principal function is to promote the observance and defence of human rights and to serve as an advisory body to the Organization of American States in this area.[94] In fulfilling this function, the Commission has looked to the Inter-American Convention to Prevent and Punish Torture to guide its interpretation of what is meant by torture under article 5 of the American Convention on Human Rights.

62. Article 2 of the Inter-American Convention to Prevent and Punish Torture defines torture as:

> any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.[95]

63. Under article 1 of the Inter-American Convention to Prevent and Punish Torture, States parties undertake to prevent and punish torture in accordance with the terms of the Convention. Article 6 provides that States must also take effective measures to prevent and punish ill-treatment within their jurisdiction. The Inter-American Convention to Prevent and Punish Torture does not, however, provide a definition of such conduct or indicate the circumstances that distinguish ill-treatment from torture. The Inter-American Court of Human Rights has indicated that the distinction rests in part on the severity of the treatment,[96] but has maintained that the distinction is not rigid and could evolve in light of growing demands for the protection of fundamental rights and freedoms.[97] Article 6 also establishes that States must ensure that torture is an offence under criminal

92 American Declaration of the Rights and Duties of Man (Bogotá, 2 May 1948).

93 The Inter-American Court of Human Rights is a judicial organ with a more limited mandate than that of the Inter-American Commission on Human Rights, as the former may only decide cases brought against the Member States of the Organization of American States that have specifically accepted the contentious jurisdiction of the Court and such cases must first be processed by the Commission. In addition, only States parties to the Convention and the Commission may refer cases to the Court.

94 Rules of procedure of the Inter-American Commission on Human Rights, art. 1 (1).

95 The definition of torture provided in the Inter-American Convention to Prevent and Punish Torture differs from the definition provided in the Convention against Torture in three aspects: (a) it does not make reference to "severity" as a qualification for torture; (b) it makes reference to "any other purpose" without qualifying such purpose as being based on discrimination; and (c) it includes methods intended to obliterate the personality of victims or diminish their capacities, independently of whether such methods cause pain or suffering. States that are parties to both treaties are obliged to apply the standards that most or better protect the right to be free from torture.

96 Inter-American Court of Human Rights, *Loayza-Tamayo v. Peru*, Judgment, 17 September 1997, para. 57.

97 Inter-American Court of Human Rights, *Cantoral-Benavides v. Peru*, Judgment, 18 August 2000, paras. 99–104.

law and that all acts of torture – and attempts to commit torture – are punishable by severe penalties.

64. Article 8 of the Inter-American Convention to Prevent and Punish Torture provides that States are required to conduct an immediate and proper investigation into any allegation that torture has occurred within their jurisdiction and guarantee that any person making an accusation of having been subjected to torture within such jurisdiction has the right to an impartial examination of the case. The duty to investigate arises as soon as State authorities become aware of allegations or grounds to believe that torture has occurred.[98] The Inter-American Commission on Human Rights has reiterated that the principles of independence, impartiality, competence, diligence, meticulousness and promptness should be the hallmarks of an investigation of alleged acts of torture.[99] Additionally, the investigation should take into consideration the international rules for documenting and interpreting elements of forensic evidence regarding the commission of acts of torture.[100]

65. The Inter-American Court of Human Rights has addressed the necessity of investigating claims of violations of the American Convention on Human Rights. In *Velásquez Rodríguez v. Honduras*, the Court stated that:

> The State is obligated to investigate every situation involving a violation of the rights protected by the Convention. If the State apparatus acts in such a way that the violation goes unpunished and the victim's full enjoyment of such rights is not restored as soon as possible, the State has failed to comply with its duty to ensure the free and full exercise of those rights to the persons within its jurisdiction.[101]

66. The Inter-American Court of Human Rights explicitly rejected the applicability of all provisions on prescription (statutes of limitation), amnesty and other measures designed to eliminate liability for serious human rights violations, including torture, as such provisions are intended to prevent the investigation and punishment of persons responsible for such violations and are prohibited as violations of non-derogable provisions of international human rights law.[102] Furthermore, the Court has found that the execution of sentences in cases of serious human rights violations is an integral part of the victims' rights to access justice and that the international obligation to punish those responsible for serious human rights violations, including torture, "cannot be unduly affected or become illusory during the execution of the sentence that imposed the sanction, in accordance with the principle of proportionality".[103] The Court has also established principles to ensure the integrity of the investigation into and the punishment of those responsible for human rights violations in transitional justice systems.[104]

67. In its jurisprudence, the Inter-American Court of Human Rights has cited the Istanbul Protocol in several decisions involving torture and ill-treatment, to call attention to the necessity of adopting appropriate legal frameworks and strengthening institutional capacities that will facilitate the effective investigation of grave human rights violations.[105]

68. Articles 12, 13 and 14 of the Inter-American Convention to Prevent and Punish Torture establish universal jurisdiction for the crime of torture, meaning that States are obligated to either extradite suspects or conduct investigations and, if appropriate, criminal prosecutions, regardless of the nationality of the suspect and whether the crime was committed within the State's jurisdiction. The Inter-American Court of Human Rights has considered that seeking extradition of suspects for the crime of torture is an obligation under customary international law.[106]

69. The Inter-American Court of Human Rights has also stated that mere threats of resorting to behaviour

98 Inter-American Court of Human Rights, *Servellón-García et al. v. Honduras*, Judgment, 21 September 2006, para. 119.

99 Inter-American Commission on Human Rights, *Democratic Institutions, the Rule of Law and Human Rights in Venezuela: Country Report* (2017), para. 251; and *Gross Human Rights Violations in the Context of Social Protests in Nicaragua* (2018), para. 192. See also Inter-American Commission on Human Rights, *Report on the Human Rights of Persons Deprived of Liberty in the Americas* (2011), para. 345; and Inter-American Court of Human Rights, *Bueno-Alves v. Argentina*, Judgment, 11 May 2007, para. 108.

100 Inter-American Court of Human Rights, *Vargas Areco v. Paraguay*, Judgment, 26 September 2006, para. 93.

101 Inter-American Court of Human Rights, *Velasquez-Rodriguez v. Honduras*, Judgment, 29 July 1988, para. 176.

102 Inter-American Court of Human Rights, *Barrios Altos v. Peru*, Judgment, 14 March 2001, para. 41.

103 Inter-American Court of Human Rights, *Barrios Altos and La Cantuta v. Peru*, Monitoring Decision, 30 May 2018, para. 47 (unofficial translation from Spanish).

104 Inter-American Court of Human Rights, *Barrios Altos v. Peru*, para. 41.

105 Inter-American Court of Human Rights, *Miguel Castro-Castro Prison v. Peru*, Judgment, 25 November 2006, para. 326; *González et al. ("Cotton Field") v. Mexico*, Judgment, 16 November 2009, paras. 502 and 542; *Rosendo Cantú et al. v. Mexico*, Judgment, 31 August 2010, paras. 239–243; and *Vélez Loor v. Panama*, Judgment, 23 November 2010, para. 270.

106 Inter-American Court of Human Rights, *La Cantuta v. Peru*, Judgment, 29 November 2006, paras. 159–160. See also Inter-American Court of Human Rights, *Goiburú et al. v. Paraguay*, Judgment, 22 September 2006, paras. 128–132.

prohibited by article 5 of the American Convention on Human Rights, if sufficiently real and imminent, may amount to torture. Moreover, psychological and moral suffering must also be considered when assessing whether article 5 has been violated.[107] Accordingly, the Court has determined that being held incommunicado or in prolonged isolation constitutes cruel and inhuman treatment.[108] The Court has also stipulated that a person may only be held in incommunicado detention under exceptional circumstances; and, even then, the State must guarantee detainees' minimum and non-derogable rights and uphold their right to question the lawfulness of the detention and to effective defence during detention.[109] In several cases, the Court relied on the definition of torture in article 1 of the Convention against Torture to establish that torture was inflicted.[110]

70. The Inter-American Court of Human Rights has also held that State authorities must not classify or withhold information about human rights violations from judicial or administrative authorities on grounds of public interest, official secrets or national security.[111] Furthermore, the Court has strongly condemned any participation of State military personnel in investigations and prosecutions of human rights violations; instead, such investigations and prosecutions should be conducted by civilian entities.[112]

71. The Inter-American Court of Human Rights has also established that the State is responsible for the right to humane treatment of any individual under its custody.[113] In that regard, a presumption exists that the State is responsible for the torture, cruel, inhuman or degrading treatment suffered by a person under the custody of State agents if the authorities have not carried out a serious investigation of the facts.[114] Therefore, the burden of proof falls upon the State to provide a satisfactory and convincing explanation of what occurred and disprove the allegations regarding its responsibility.[115]

72. In numerous decisions, the Inter-American Court of Human Rights has acknowledged that certain persons in situations of vulnerability face a greater risk of human rights abuses and torture and thus are entitled to certain protections and effective remedies that take into account their individual circumstances.[116] The Inter-American Commission on Human Rights has noted that independent monitoring, public inspection and access to sites in which individuals are deprived of their liberty are effective in preventing torture.[117]

73. To protect more vulnerable detainees, including persons who have been illegally detained, the Inter-American Court of Human Rights has found that police detention centres must meet certain minimum standards that ensure, among other things, the right to humane treatment and to be treated with respect for their dignity.[118] The Court has also established that States must regulate and supervise both public and private health-care facilities under their jurisdiction in order to protect the life and integrity of all persons within their jurisdiction.[119]

74. The issue of torture and ill-treatment was addressed by the Inter-American Commission on Human Rights in the Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas in 2008 and in an extensive report on the human rights of persons deprived of their liberty in the Americas in 2011. Among other safeguards, the Principles guarantee all persons deprived of their liberty the right to lodge complaints about acts of torture, whether individuals do so on their own behalf or on behalf of others.[120]

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107 Inter-American Court of Human Rights, *Miguel Castro-Castro Prison v. Peru*, para. 279.

108 Inter-American Court of Human Rights, *Godínez-Cruz v. Honduras*, Judgment, 20 January 1989, para. 164. See also Inter-American Commission on Human Rights, *Luis Lizardo Cabrera v. Dominican Republic*, Case 10.832, Report No. 35/96, 19 February 1998, paras. 86–87.

109 Inter-American Court of Human Rights, *Suárez-Rosero v. Ecuador*, Judgment, 12 November 1997, para. 51.

110 Inter-American Court of Human Rights, *Maritza Urrutia v. Guatemala*, Judgment, 27 November 2003, para. 90.

111 Inter-American Court of Human Rights, *Gomes Lund et al. ("Guerrilha do Araguaia") v. Brazil*, Judgment, 24 November 2010, para. 202.

112 Inter-American Court of Human Rights, *Fernández Ortega et al. v. Mexico*, Judgment, 30 August 2010, paras. 172 and 176.

113 Inter-American Court of Human Rights, *Baldeón-García v. Peru*, Judgment, 6 April 2006, para. 120; *Ximenes-Lopes v. Brazil*, Judgment, 4 July 2006, para. 138; and *López Álvarez v. Honduras*, Judgment, 1 February 2006, paras. 104–106.

114 Inter-American Court of Human Rights, *Miguel Castro-Castro Prison v. Peru*, para. 273.

115 Inter-American Court of Human Rights, *Juan Humberto Sánchez v. Honduras*, Judgment, 7 June 2003, para. 111; and *Baldeón-García v. Peru*, para. 120.

116 See, for example, Inter-American Court of Human Rights, *Ximenes Lopes v. Brazil*, Judgment, 4 July 2006, para. 103; *Baldeón-García v. Peru*, para. 119; and *Furlan and family v. Argentina*, Judgment, 31 August 2012, paras. 284–288.

117 Inter-American Commission on Human Rights, *Truth, Justice and Reparation: Colombia Country Report* (2013), para. 1121.

118 Inter-American Court of Human Rights, *Baldeón-García v. Peru*, para. 119; *Ximenes-Lopes v. Brazil*, paras. 125–130; *Furlan and family v. Argentina*, paras. 131–132; and *Bulacio v. Argentina*, Judgment, 8 September 2003, para. 132.

119 Inter-American Court of Human Rights, *Ximenes Lopes v. Brazil*, para. 141.

120 Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas, principle V.

75. The Inter-American Court of Human Rights has also recognized the negative psychological effects that solitary confinement can have on mothers separated from their children and acknowledged that States should provide special care to detained pregnant women and ensure that mothers can visit their children.[121]

76. In 1996, the Inter-American Commission on Human Rights became the first international adjudicatory body to recognize rape as torture, stating that rape is a method of psychological torture that often has as an objective the humiliation of the victim as well as the victim's family and community.[122] Since then, the Commission and the Inter-American Court of Human Rights have developed extensive case law clarifying the obligations of States to exercise due diligence in preventing, investigating and punishing instances of gender-based violence,[123] and torture and ill-treatment more generally.[124] The Court has developed important standards on the collection of evidence in cases of sexual violence,[125] the evidentiary value of victims' statements[126] and the need to consider that discrepancies in those statements should not be considered per se as denoting the falsehood of the testimony.[127] Furthermore, the Court has held States responsible for sexual violence as a form of torture committed by non-State actors when the authorities failed to prevent and investigate the crime.[128]

77. In 1994, the Organization of American States adopted the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (Convention of Belém do Pará).[129] The Convention of Belém do Pará establishes that women have the right to live a life free of violence and obliges States parties to take appropriate measures to amend or repeal existing laws and regulations and modify legal or customary practices that perpetuate and tolerate violence against women.

78. Article 1 of the Convention of Belém do Pará defines violence against women as "any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere". Article 2 recognizes that violence may occur within the family or domestic unit, as well as within other interpersonal relationships. Article 6 recognizes that women have the right to be valued and educated free of behavioural and social stereotypes and practices based on inferiority or subordination and article 7 requires States to refrain from committing or practising violence against women and to exercise due diligence to prevent, investigate and impose penalties for acts of violence against women.

79. Also in 1994, the Organization of American States adopted the Inter-American Convention on Forced Disappearance of Persons, which provides additional safeguards that help guarantee the investigation and punishment of acts of forced disappearance.[130]

80. In 2004, the Inter-American Commission on Human Rights established the mandate of the Special Rapporteur on the rights of persons deprived of liberty in the Americas. The Special Rapporteur conducts fact-finding visits to member States of the Organization of American States, monitors the treatment of persons deprived of their liberty and conditions of detention, publishes country and thematic reports, and issues recommendations to improve the situation of persons deprived of their liberty and urgent actions where necessary.[131]

(b) Council of Europe – European Court of Human Rights

81. Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights) states that: "No one shall be subjected to torture or to inhuman or

121 Inter-American Court of Human Rights, *Miguel Castro-Castro Prison v. Peru*, para. 330.
122 Inter-American Commission on Human Rights, *Raquel Martí de Mejía v. Peru*, Case 10.970, Report No. 5/96, 1 March 1996.
123 Inter-American Court of Human Rights, *Azul Rojas Marín v. Peru*, Judgment, 12 March 2020 (concerning torture committed with a discriminatory intent based on the gender identity of the victim), paras. 178–205 (in Spanish only; official summary available in English); *Fernández Ortega et al. v. Mexico*, para. 193; *Cabrera García and Montiel Flores v. Mexico*, Judgment, 26 November 2010, paras. 213–215; *J. v. Peru*, Judgment, 27 November 2013, para. 344; *López Soto et al. v. Venezuela*, Judgment, 26 September 2018, paras. 273–287; and *Miguel Castro-Castro Prison v. Peru*, para. 378.
124 Inter-American Court of Human Rights, *Espinoza Gonzáles v. Peru*, Judgment, 20 November 2014, para. 237–240; and *J. v. Peru*, para. 341–343.
125 Inter-American Court of Human Rights, *González et al ("Cotton Field") v. Mexico*; and *Velásquez Paiz et al. v. Guatemala*, Judgment, 19 November 2015.
126 Inter-American Court of Human Rights, *Fernández Ortega et al. v. Mexico*, para. 100.
127 Inter-American Court of Human Rights, *Espinoza Gonzáles v. Peru*, para. 149.
128 Inter-American Court of Human Rights, *López Soto et al . v. Venezuela*.
129 The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Convention of Belém do Pará") (9 June 1994) entered into force on 5 March 1995.
130 The Inter-American Convention on Forced Disappearance of Persons (Belém do Pará, 6 September 1994) entered into force on 28 March 1996.
131 See www.oas.org/en/iachr/jsForm/?File=/en/IACHR/r/DPPL/mandato.asp.

degrading treatment or punishment." All victims have direct access to the European Court of Human Rights.

82. In its jurisprudence, the European Court of Human Rights has held that the guarantee enshrined in article 3, which is an essential element of the rule of law, occupies a prominent place in the system of protection of the European Convention on Human Rights, as it is underlined by the fact that no derogation from it is permissible under article 15 in time of war or other public emergency.[132] To fall within the scope of article 3, the Court has said that "ill-treatment must attain a minimum level of severity", which is determined by assessing all of the circumstances of the case (e.g. duration of treatment, physical or mental effects, and the sex, age and health of the victim).[133] The Court also stated that, in the absence of physical or mental injury or suffering, acts involving humiliation, the diminishing of human dignity, including unnecessary physical force by law enforcement officers, or that arouses in victims fear or anguish or inferiority capable of breaking their moral and physical resistance may be characterized as degrading and can fall within the prohibitions established in article 3.[134]

83. The European Court of Human Rights highlighted the importance of article 3 and addressed the distinction between conduct that constitutes inhuman or degrading treatment and torture in *Aksoy v. Turkey*, where the applicant had been subjected to reverse suspension, beatings, electric shocks to the genitals, exacerbated by having water thrown on him, and verbal abuse; the Court stated that the conduct in the case was "of such a serious and cruel nature that it can only be described as torture".[135] The Court has also held that to constitute torture under article 3, a deliberate act of inhuman treatment must cause "serious and cruel suffering".[136]

84. In *Gäfgen v. Germany*, the European Court of Human Rights held that "to threaten an individual with torture may constitute at least inhuman treatment" and violate article 3.[137] The Court later found that severity is a key distinguishing factor between torture and inhuman or degrading treatment or punishment, as are purpose and intention – thus bringing the understanding of what torture is close to that of the definition contained in the Convention against Torture, which has been cited by the Court.[138] However, the Court did not classify these elements as exhaustive.[139]

85. The European Court of Human Rights also recognized that rape can amount to torture under article 3 of the Convention. In *Aydin v. Turkey*, the Court held that "the accumulation of acts of physical and mental violence inflicted on the applicant and the especially cruel act of rape to which she was subjected amounted to torture in breach of article 3 of the Convention".[140]

86. In its decisions, the European Court of Human Rights has also drawn on the definition of torture used in the Convention against Torture to arrive at a finding of torture. In *Selmouni v. France*, the Court established both that the pain and suffering inflicted on the applicant were severe and that its purpose was to extract a "confession", thus firmly establishing that courts must consider both the severity and the purpose of the inflicted suffering when determining whether an act constitutes torture.[141] The Court later clarified that, although purpose was a factor, "the absence of any such purpose cannot conclusively rule out the finding of a violation of Article 3".[142] Additionally, the Court asserted that, when considering whether a form of treatment was "degrading" within the meaning of article 3, the Court would have regard to whether its purpose was "to humiliate and debase the person concerned"; however, it again stated that an absence of purpose did not rule out a finding of a violation of article 3.[143]

132 European Court of Human Rights, Öcalan v. Turkey, application No. 46221/99, Judgment, 12 May 2005, paras. 179–183.
133 European Court of Human Rights, *Bouyid v. Belgium*, application No. 23380/09, Judgment, 28 September 2015, para. 86.
134 Ibid., paras. 87–88.
135 European Court of Human Rights, *Aksoy v. Turkey*, application No. 21987/93, Judgment, 18 December 1996, paras. 60–64, at para. 64.
136 European Court of Human Rights, *Ireland v. United Kingdom*, application No. 5310/71, Judgment, 18 January 1978, para. 167.
137 European Court of Human Rights, *Gäfgen v. Germany*, application No. 22978/05, Judgment, 1 June 2010 (rectified on 3 June 2010), para. 91.
138 European Court of Human Rights, *Cestaro v. Italy*, application No. 6884/11, Judgment, 7 April 2015, paras. 172–176.
139 European Court of Human Rights, *Bouyid v. Belgium*, paras. 100–102.
140 European Court of Human Rights, *Aydin v. Turkey*, application No. 23178/94, Judgment, 25 September 1997, para. 86.
141 European Court of Human Rights, *Selmouni v. France*, application No. 25803/94, Judgment, 28 July 1999, paras. 97–105. The Court also applied the "living instrument" concept in *Selmouni*, which led it to conclude that what might not have been considered torture in 1979 when the case of *Ireland v. United Kingdom* was decided was definitely considered to be torture in 1999 at the time *Selmouni* was decided.
142 European Court of Human Rights, *V. v. United Kingdom*, application No. 24888/94, Judgment, 16 December 1999, para. 71.
143 European Court of Human Rights, *Kalashnikov v. Russia*, application No. 47095/99, Judgment, 15 July 2002, para. 95. See also European Court of Human Rights, *Peers v. Greece*, application No. 28524/95, Judgment, 19 April 2001, para. 74.

87. The European Court of Human Rights has established that the failure to conduct an effective investigation can give rise to a violation of the prohibition against torture or ill-treatment under article 3 in cases regarding domestic violence,[144] violence committed against lesbian, gay, bisexual and transgender persons,[145] sterilization of Roma women,[146] police brutality[147] and enforced disappearance.[148] Furthermore, the Court has concluded that "an 'effective remedy' entails, in addition to the payment of compensation where appropriate, … effective access for the complainant to the investigatory procedure".[149]

88. Additionally, the European Court of Human Rights has found violations of the Convention with regard to the exclusionary rule[150] and has reiterated the absolute, non-derogable nature of article 3 in cases related to alleged acts of terrorism, stating that applicants suspected of or charged with terrorist-related activities have a right to be free from torture and inhuman or degrading treatment while in custody.[151] In *El-Masri v. the former Yugoslav Republic of Macedonia*, the Court held that a secret rendition and subsequent secret detention by the former Yugoslav Republic of Macedonia was unlawful and a violation of article 3.[152] The Court has also consistently held that States have an obligation not to extradite or expel persons, including alleged terrorists, to countries where they face a real risk of being subjected to torture or ill-treatment (see also para. 112 et seq. below).[153]

89. In its jurisprudence, the European Court of Human Rights has also determined that interference with reproductive health rights can amount to ill-treatment[154] and that a lack of appropriate medical supervision for inmates with suicidal tendencies or other psychosocial disabilities might lead to a violation of the prohibition against torture and ill-treatment in article 3.[155] Medical procedures considered to be of therapeutic necessity (e.g. force-feeding aimed at saving life) cannot in principle be deemed inhuman or degrading; medical necessity must be established, procedural guarantees must be followed and the medical procedure must be administered in a way that minimizes suffering.[156] If these safeguards are not respected, a breach of article 3 may still occur.

90. Deplorable living conditions in detention centres in cases of expulsion, extradition and migration may also amount to a violation of article 3. The European Court of Human Rights has held that exposing minors to poor conditions in detention centres amounts to a violation of article 3 and has made no distinction in these cases based on whether the minor in question was accompanied[157] or unaccompanied.[158] In both cases, the Court found the determining factor to be

144 European Court of Human Rights, *Opuz v. Turkey*, application No. 33401/02, Judgment, 9 June 2009, para. 176; *Eremia v. Republic of Moldova*, application No. 3564/11, Judgment, 28 May 2013, para. 67; *M.G. v. Turkey*, application No. 646/10, Judgment, 22 March 2016, para. 107 (official version available in French); *Talpis v. Italy*, application No. 41237/14, Judgment, 2 March 2017 (rectified on 21 March 2017), paras. 129–131; and *Bălşan v. Romania*, application No. 49645/09, Judgment, 23 May 2017, paras. 71 and 89.

145 European Court of Human Rights, *Identoba and Others v. Georgia*, application No. 73235/12, Judgment, 12 May 2015, para. 71; and *M.C. and A.C. v. Romania*, application No. 12060/12, Judgment, 12 April 2016, paras. 124–125.

146 European Court of Human Rights, *V.C. v. Slovakia*, application No. 18968/07, Judgment, 8 November 2011, paras. 109 and 120; and *I.G. and Others. v. Slovakia*, application No. 15966/04, Judgment, 13 November 2012, paras. 124, 126 and 134.

147 European Court of Human Rights, *Jasar v. the former Yugoslav Republic of Macedonia*, application No. 69908/01, Judgment, 15 February 2007, para. 60; *Petropoulou-Tsakiris v. Greece*, application No. 44803/04, Judgment, 6 December 2007, paras. 55 and 66; and *Adam v. Slovakia*, application No. 68066/12, Judgment, 26 July 2016, para. 82.

148 European Court of Human Rights, *Er and Others. v. Turkey*, application No. 23016/04, Judgment, 31 July 2012, paras. 92–97.

149 European Court of Human Rights, *Aksoy v. Turkey*, para. 98.

150 European Court of Human Rights, *El Haski v. Belgium*, application No. 649/08, Judgment, 25 September 2012, paras. 86 and 99. See also European Court of Human Rights, *Othman (Abu Qatada) v. United Kingdom*, application No. 8139/09, Judgment, 17 January 2012, paras. 267, 273 and 276, in which the Court affirmed that establishing a "real risk" that evidence had been obtained by torture was sufficient for the evidence to be excluded because of the special difficulties in proving allegations of torture.

151 European Court of Human Rights, *Martínez Sala and Others v. Spain*, application No. 58438/00, Judgment, 2 November 2004, paras. 118 and 120 (official version available in French); and *Öcalan v. Turkey*, paras. 179 and 192–196.

152 European Court of Human Rights, *El-Masri v. the former Yugoslav Republic of Macedonia*, application No. 39630/09, Judgment, 13 December 2012, paras. 215–223.

153 European Court of Human Rights, *Chahal v. United Kingdom*, application No. 22414/93, Judgment, 15 November 1996, paras. 73–74; *Cruz Varas and Others v. Sweden*, application No. 15576/89, Judgment, 20 March 1991, paras. 69–70; and *H.R. v. France*, application No. 64780/09, 22 September 2011, paras. 49–65 (official version available in French).

154 European Court of Human Rights, *R.R. v. Poland*, application No. 27617/04, Judgment, 26 May 2011, paras. 148–162.

155 European Court of Human Rights, *Rivière v. France*, application No. 33834/03, Judgment, 11 July 2006, paras. 59–77 (official version available in French); *Renolde v. France*, application No. 5608/05, Judgment, 16 October 2008, paras. 119–130; *Güveç v. Turkey*, application No. 70337/01, Judgment, 20 January 2009, paras. 82–99; and *Ketreb v. France*, application No. 38447/09, Judgment, 19 July 2012, paras. 108–116 (official version available in French).

156 European Court of Human Rights, *Nevmerzhitsky v. Ukraine*, application No. 54825/00, Judgment, 5 April 2005, paras. 93–99; and *Ciorap v. Moldova*, application No. 12066/02, Judgment, 19 June 2007, paras. 76–89.

157 European Court of Human Rights, *Popov v. France*, application Nos. 39472/07 and 39474/07, Judgment, 19 January 2012, paras. 91–103; *Mahmundi and Others. v. Greece*, application No. 14902/10, Judgment, 31 July 2012, paras. 61–76 (official version available in French); *A.B. and Others v. France*, application No. 11593/12, Judgment, 12 July 2016, paras. 107–115; and *S.F. and Others. v. Bulgaria*, application No. 8138/16, Judgment, 7 December 2017, paras. 84–93.

158 European Court of Human Rights, *Mohamad v. Greece*, application No. 70586/11, Judgment, 11 December 2014, paras. 69–76 (official version available in French).

that the conditions in the detention centres caused the minors feelings of fear, anguish and inferiority.

(c) Council of Europe: European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

91. The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment established the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

92. The European Committee for the Prevention of Torture carries out unannounced visits to places of deprivation of liberty located in the member States of the Council of Europe. Committee members may talk to persons deprived of their liberty in private, visit any or all persons they choose to in such places and see all premises without restrictions.

93. The European Committee for the Prevention of Torture has developed criteria for the treatment of persons held in custody, which constitute general standards.[159] These standards deal not only with material conditions but also with procedural safeguards, including the right of persons deprived of their liberty to inform immediately a third party (family member) of the arrest, to have immediate access to a lawyer and to have access to a physician, including, if they so wish, a physician of their own choosing.

94. The European Committee for the Prevention of Torture has also repeatedly stressed that one of the most effective means of preventing ill-treatment by law enforcement officials is the diligent examination by competent authorities of all complaints of torture and ill-treatment and, where appropriate, the imposition of suitable penalties.

(d) African Union: African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights

95. Unlike the European and Inter-American systems, the African system does not have a convention specifically dedicated to torture or its prevention.

The question of torture is addressed primarily in article 5 of the African Charter on Human and Peoples' Rights, which states that:

> Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of human exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

96. The African Commission on Human and Peoples' Rights is mandated by article 30 of the African Charter to promote human and peoples' rights and ensure their protection in Africa. A victim or an NGO can make a complaint to the Commission regarding acts of torture as defined in article 5 of the African Charter.[160]

97. In 2017, the African Commission on Human and Peoples' Rights adopted general comment No. 4 on the right to redress for victims of torture and other cruel, inhuman or degrading punishment or treatment (article 5). In the general comment, the Commission provides authoritative interpretation on the scope and content of the right to redress for victims of torture or ill-treatment in specific contexts and defines reparation as including restitution, compensation, rehabilitation and satisfaction, which includes the right to the truth and to guarantees of non-repetition.[161] It also identifies concrete and practical steps States need to take to provide redress to victims of torture or ill-treatment in various specific contexts, including to victims of sexual and gender-based violence, to individuals tortured during armed conflict, to victims of torture in transitional justice settings and, notably, in cases of collective harm. The Commission notes that, although the violations of torture and ill-treatment are essentially perpetrated against individuals, these violations may nevertheless have an impact on groups, especially those that are structurally disadvantaged.[162]

98. The African Commission on Human and Peoples' Rights has interpreted the distinction between torture, including both physical and mental abuses, and ill-treatment.[163] For example, the failure, without justification, to notify family members

159 Council of Europe, "Police custody" (Strasbourg, 1992). Available at https://rm.coe.int/16806cea2f.

160 For example, in November 2017, a complaint was submitted to the Commission by victims regarding the failure of Chad to implement the 2015 reparation award granted by a Chadian court. See African Commission on Human and Peoples' Rights, *Clement Abaïfouta and 6,999 others v. Republic of Chad,* Case No. 691/18.

161 African Commission on Human and Peoples' Rights, general comment No. 4 (2017), para. 10.

162 Ibid., paras. 50–51.

163 African Commission on Human and Peoples' Rights, *Gabriel Shumba v. Zimbabwe,* communication 288/04, Decision, 2004, paras. 143–145.

of the date and time of a detainee's execution was held by the Commission to be a case of ill-treatment and a violation of article 5.[164]

99. The African Commission on Human and Peoples' Rights has also found State parties responsible for the torture of a person within their jurisdiction when there was clear evidence detailing the torture produced either by the complainant or another credible party, such as an international organization.[165] If the Commission finds that the evidence fails to prove that an act of torture has occurred, it can still find the State party in violation of article 5 for its failure to investigate.[166]

100. The African Commission on Human and Peoples' Rights has also found article 5 violations based on poor prison conditions, including excessive solitary confinement, overcrowding, lack of access to adequate medical care, shackling and extremely poor quality food.[167]

101. Other instruments also address torture and ill-treatment within the African context, including the Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa (Luanda Guidelines) (2014), the Guidelines on Combating Sexual Violence and its Consequences in Africa (2017) and the Principles and Guidelines on Human and Peoples' Rights while Countering Terrorism in Africa (2015). The African Commission on Human and Peoples' Rights has also adopted a number of resolutions and documents related to torture and ill-treatment, most notably the Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa (Robben Island Guidelines) in 2002, which address torture on the African continent and help enforce the African Charter's absolute prohibition of torture and ill-treatment.

102. The African Commission on Human and Peoples' Rights has also created special mechanisms for particular thematic issues, along lines similar to the special procedures of the Human Rights Council.

103. The Committee for the Prevention of Torture in Africa, formerly known as the Follow-up Committee on the Robben Island Guidelines, provides advice to States and the African Commission on measures required to implement article 5 of the African Charter and the Robben Island Guidelines. Since its establishment, members of the Committee have carried out a number of training and awareness-raising activities in various countries and have carried out visits to a number of States.[168]

104. The African Commission on Human and Peoples' Rights has also established the Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa; the Special Rapporteur on the Rights of Women in Africa; and the Working Group on the Death Penalty and Extra-Judicial, Summary or Arbitrary Killings and Enforced Disappearances in Africa. These mechanisms have created avenues for victims of torture and NGOs to send information directly to Special Rapporteurs.

105. The African Court of Human and Peoples' Rights has rendered relevant jurisprudence, including finding that "incommunicado detention constitutes in itself a gross violation of human rights that can lead to other violations such as torture [and] ill-treatment".[169]

106. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), in force since 2005, includes a comprehensive catalogue of rights of women in Africa. Among others, it includes the prohibition of "all forms of exploitation, cruel, inhuman or degrading punishment and treatment".[170]

107. The African Charter on the Rights and Welfare of the Child outlines a broad range of rights for children in Africa, including a provision protecting children from abuse and torture (art. 16).[171] In its

164 African Commission on Human and Peoples' Rights, *Spilg and Mack and Ditshwanelo (on behalf of Lehlohonolo Bernard Kobedi) v. Botswana*, communication 277/2003, Decision, 16 December 2011, para. 177.

165 African Commission on Human and Peoples' Rights, *Gabriel Shumba v. Zimbabwe*, paras. 111, 113 and 121.

166 Ibid., para. 136.

167 African Commission on Human and Peoples' Rights, *Krishna Achuthan (on behalf of Aleke Banda), Amnesty International (on behalf of Orton and Vera Chirwa) and Amnesty International (on behalf of Orton and Vera Chirwa) v. Malawi*, communication 64/92-68/92-78/92_8AR (1995), Decision, 27 April 1994, paras. 4 and 7.

168 Since 2007, the Committee has organized various seminars for law enforcement officials in Nigeria, Liberia, Benin and Cameroon. It organized regional conferences on the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Dakar and one on the national preventive mechanism in Senegal. See www.achpr.org/sessions/intersession?id=152.

169 African Court on Human and Peoples' Rights, *African Commission on Human and Peoples' Rights v. Libya*, application No. 002/2013, Judgment, 3 June 2016, paras. 84–85.

170 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo, 11 July 2003), art. 4 (1).

171 African Charter on the Rights and Welfare of Children (Addis Ababa, 11 July 1990), art. 16.

jurisprudence, the Committee of Experts on the Rights and Welfare of the Child, which monitors implementation of the Charter, has found States responsible for violating article 16 on the basis of their failure to protect children from beatings by non-State actors when such beatings are used as a physical punishment and intended to cause pain or discomfort, in some cases rising to the level of torture.[172]

(e) Additional regional courts, institutions and instruments

108. *Economic Community of West African States*. The judicial organ of the Economic Community of West African States is the Community Court of Justice, created pursuant to articles 6 and 15 of the revised treaty of the Community in 2005. The Court is competent to examine cases involving alleged human rights violations and has a mandate to investigate and adjudicate allegations of torture, find States responsible and award damages to victims.[173]

109. *East African Court of Justice*. The East African Court of Justice was established in November 2001 pursuant to article 9 of the Treaty for the Establishment of the East African Community. The Court is mandated to resolve disputes between member States of the Community. Complainants may bring suits against State parties for violating their right to freedom from torture and ill-treatment protected under article 7 (2) of the Treaty.[174]

110. *Association of Southeast Asian Nations (ASEAN) Human Rights Declaration and the ASEAN Intergovernmental Commission on Human Rights*. The ASEAN Human Rights Declaration provides that: "No person shall be subject to torture or to cruel, inhuman or degrading treatment or punishment."[175]

111. *Arab Charter on Human Rights*. The Arab Charter on Human Rights was adopted at a summit of the League of Arab States in 2004; it entered into force in 2008.[176] Article 8 of the Charter explicitly prohibits torture and cruel, degrading, humiliating, or inhuman treatment, but not punishment. Article 8 (2) provides for the punishment of acts of torture and ill-treatment, with no statutes of limitations, guaranteeing redress, rehabilitation and compensation for victims. However, the Charter allows the imposition of capital punishment, including on persons under 18 years of age when such punishment is "stipulated in the laws in force at the time of the commission of the crime".[177] Imposing capital punishment on persons under 18 at the time of commission of the offence is in clear violation of international human rights law.[178]

B. International refugee law and non-refoulement

112. The principle of non-refoulement, derived from article 33 of the Convention relating to the Status of Refugees, is not only an important component of refugee law, but of international human rights law, particularly with regard to torture and ill-treatment. The principle of non-refoulement is codified in international conventions[179] and considered as part of the prohibition of torture and ill-treatment[180] according to the well-established case law of the Human Rights Committee[181] and the European Court of Human Rights.[182] The Convention relating to the Status of Refugees defines non-refoulement as the principle prohibiting contracting States from expelling or returning (*refouler*) refugees in any manner whatsoever to the frontiers of territories where their lives or freedom would be threatened on account of their race, religion, nationality, membership

172 African Committee of Experts on the Rights and Welfare of the Child, *Centre for Human Rights (University of Pretoria) and La Rencontre africaine pour la défense des droits de l'homme (Senegal) v. Senegal*, Decision, 15 April 2014, paras. 62–68.

173 Community Court of Justice, *Federation of African Journalists and Others v. the Gambia*, ECW/CCJ/JUD/04/18, Judgment, 13 March 2018, paras. 60–62; and *Adamu and Seven Others v. Federal Republic of Nigeria*, ECW/CCJ/JUD/33/19, Judgment, 9 December 2019, pp. 56–57 (finding that the Court is competent to hear the applicants' claims of a violation of article 5).

174 East African Court of Justice, *Plaxeda Rugumba v. Secretary General of the East African Community and the Attorney General of Rwanda*, Reference No. 8 of 2010, Judgment, 1 December 2011 (using article 7 (2) of the Treaty (good governance) to bring a complaint against the State for conditions of incommunicado detention).

175 ASEAN Human Rights Declaration (Phnom Penh, 19 November 2012), general principle 14.

176 Arab Charter on Human Rights (Tunis, 22 May 2004).

177 Ibid., art. 7 (1).

178 See explicit prohibitions in the Convention on the Rights of the Child, art. 37 (a), and the International Covenant on Civil and Political Rights, art. 6 (5).

179 Convention against Torture, art. 3; and Convention relating to the Status of Refugees, art. 33.

180 International Covenant on Civil and Political Rights, art. 7; and European Convention on Human Rights, art. 3.

181 Human Rights Committee, *Kindler v. Canada* (CCPR/C/48/D/470/1991), para. 13.2; and Human Rights Committee, general comment No. 20 (1992), para. 9.

182 European Court of Human Rights, *Jabari v. Turkey*, application No. 40035/98, Judgment, 11 July 2000, para. 38.

of a particular social group or political opinion.[183] It is also a rule of customary international law.[184]

113. The protection against refoulement under the Convention relating to the Status of Refugees applies to any person who meets its definition of a refugee, as well as to persons who have not yet had their status determined, such as asylum seekers.[185] Article 1 of the Convention defines a refugee as an individual with a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, [who] is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country". Torture has been recognized as an instance of persecution.[186] As the Committee against Torture has stated, the prohibition of refoulement of persons to where there are substantial grounds for believing that they would be in danger of being subjected to torture, as prescribed in article 3 of the Convention against Torture, is absolute.[187]

114. However, the applications of the principle of non-refoulement found in the Convention against Torture and the Convention relating to the Status of Refugees differ in scope. Whereas the Convention relating to the Status of Refugees prohibits returning persons to the countries from which they fled, the Convention against Torture's application explicitly includes instances of forcible transfer, expulsion, deportation, removal or extradition to any country where there are substantial grounds for believing that a person faces a foreseeable, real and personal risk of torture or ill-treatment.[188] In addition, the United Nations High Commissioner for Refugees contemplates that non-refoulement under the Convention relating to the Status of Refugees applies not only to return to a refugee's country of origin, but also to any other place where a person has reason to fear persecution.[189] The Convention against Torture, by contrast, is broader and does not require that a person be at risk of persecution on one of the grounds discussed in the Convention relating to the Status of Refugees; rather, that person must be at risk of torture or ill-treatment.

115. States have a duty to ensure that all forms of forcible transfer of a person, including expulsion, forcible return and extradition, are determined on an individual, case-by-case basis and in a manner that is impartial, independent and in accordance with procedural safeguards.[190] The risk of torture should be evaluated, among other things, in light of the general human rights situation in the person's country of origin.[191] This includes the sending of aliens to a State that will send them to a third State where they risk being tortured, so-called indirect or chain refoulement. The sending State may not rely on diplomatic assurances by a receiving State that an individual person would not be tortured upon return as a loophole to undermine the principle of non-refoulement.[192] When determining whether a risk of torture exists, States should take into account human rights situations that may constitute an indication of a risk of torture as well as ill-treatment not amounting to torture. Additionally, States should not adopt dissuasive measures or policies designed to compel persons to return to their country of origin despite the risk of torture, such as detaining them in poor conditions for indefinite periods or refusing to process their asylum claims etc.[193] Human rights bodies have affirmed and elaborated on the principle of non-refoulement in their decisions.[194] The Human Rights Committee has asserted that States may not extradite, deport, expel or remove individuals from their territory if there are substantial grounds to believe that such individuals would be at a real and personal

183 Convention relating to the Status of Refugees, art. 33 (1).

184 See, for example, Office of the United Nations High Commissioner for Refugees (UNHCR), "The principle of non-refoulement as a norm of customary international law: response to the questions posed to UNHCR by the Federal Constitutional Court of the Federal Republic of Germany in cases 2 BvR 1938/93, 2 BvR 1953/93, 2 BvR 1954/93" (Geneva, 1994); and "Advisory opinion on the extraterritorial application of non-refoulement obligations under the 1951 Convention relating to the Status of Refugees and its 1967 Protocol" (Geneva, 2007), paras. 14–16.

185 UNHCR, "Advisory opinion", para. 6.

186 Committee against Torture, general comment No. 4 (2017), para. 29 (c).

187 Ibid., para. 9.

188 Ibid., para. 11.

189 UNHCR, "Advisory opinion", para. 7.

190 Committee against Torture, general comment No. 4 (2017), para. 13.

191 Human Rights Committee, *X v. Denmark* (CCPR/C/110/D/2007/2010), para. 9.2; and *X v. Sweden* (CCPR/C/103/D/1833/2008), para. 5.18.

192 Committee against Torture, general comment No. 4 (2017), para. 20. See also Committee against Torture, *Agiza v. Sweden* (CAT/C/34/D/233/2003), para. 13.4.

193 Committee against Torture, general comment No. 4 (2017), paras. 14 and 18.

194 CAT/C/CAN/CO/7, para. 25 (a); CAT/C/NLD/CO/7, para. 11; and Committee against Torture, *F.B. v. Netherlands* (CAT/C/56/D/613/2014) (finding a violation of the principle of non-refoulement under article 3 after the State party sought to expel a foreign national who would be forced to undergo female genital mutilation upon her return).

risk of torture or ill-treatment under article 7 of the International Covenant on Civil and Political Rights.[195]

116. The Inter-American Court of Human Rights found that deportation of members of a family to their country of origin, with the knowledge that they were able to have protection as refugees in a third country, is incompatible with the right to seek and to be granted asylum and with the principle of non-refoulement.[196] The European Court of Human Rights established that, where a seriously ill person, if removed, "would face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy", this would raise issues of ill-treatment.[197] Additionally, the Court found that the collective or individual expulsion of asylum seekers to countries with known procedural shortcomings in their asylum systems amounted to a violation of article 3 of the European Convention on Human Rights.[198]

C. International humanitarian law

117. The international treaties and customary law rules governing armed conflict are also known as international humanitarian law, the laws of war or the law of armed conflict; and they unequivocally prohibit torture and ill-treatment in all situations of armed conflict.[199] The four Geneva Conventions of 12 August 1949 establish rules for the conduct of armed conflict and, especially, for the treatment of persons who do not, or who no longer, take part in hostilities, including the wounded, the captured and civilians. All four conventions prohibit the infliction of torture and ill-treatment, and the prohibition against torture extends extraterritorially for the purpose of protecting individuals in armed conflict wherever it occurs, regardless of whether an armed conflict is acknowledged or declared by the belligerents.

118. The Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), and the Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), expand the protection and scope of the Geneva Conventions. All four Geneva Conventions and both Protocols Additional thereto adopted in 1977 identify torture or inhuman treatment and wilfully causing great suffering or serious injury to body or health as violations and grave breaches of the Geneva Conventions or war crimes.

119. When committed in an international armed conflict, torture and some forms of ill-treatment also constitute war crimes under customary international humanitarian law. In *Prosecutor v. Duško Tadić*, the International Tribunal for the Former Yugoslavia found that war crimes could be committed whether the armed conflict was international or non-international.[200] The international criminal tribunals and others have stated that all parties to any armed conflict – whether international or "not of an international character" and whether fighting on behalf of a State or on behalf of a non-State armed group – are bound by the absolute prohibition of torture and ill-treatment.[201]

120. Article 3, common to all four Geneva Conventions (common article 3), applies to armed conflicts "not of an international character", the term not being further clarified, and core obligations must be respected by all parties in all armed conflicts; this is generally understood to mean that, no matter what the nature of an armed conflict, certain basic rules of humanity cannot be abrogated.[202] The prohibition of torture and ill-treatment is one of these and is common to international humanitarian law and human rights law. Common article 3 states:

> the following acts are and shall remain prohibited at any time and in any place whatsoever … (a) violence to life and person, in particular murder

195 Human Rights Committee, general comment No. 20 (1992), para. 9. See also Human Rights Committee, *Hashi and S.A.A. v. Denmark* (CCPR/C/120/D/2470/2014), para. 9.3.

196 Inter-American Court of Human Rights, *Pacheco Tineo Family v. Plurinational State of Bolivia*, Judgment, 25 November 2013, para. 199.

197 European Court of Human Rights, *Paposhvili v Belgium*, application No. 41738/10, Judgment, 13 December 2016, para. 183.

198 European Court of Human Rights, *Sharifi and Others v. Italy and Greece*, application No. 16643/09, Judgment, 21 October 2014, paras. 240–243 (official version available in French); and *M.S.S. v. Belgium and Greece*, application No. 30696/09, Judgment, 21 January 2011, paras. 192 and 344–361.

199 For additional information on the rules of customary international humanitarian law, see International Committee of the Red Cross, Customary IHL Database. Available at https://ihl-databases.icrc.org/customary-ihl/eng/docs/home.

200 International Tribunal for the Former Yugoslavia, *Prosecutor v. Duško Tadić*, Case No. IT-94-1, Decision, 2 October 1995, para. 94.

201 A/HRC/34/54, paras. 44–48.

202 Jelena Pejic, "The protective scope of common article 3: more than meets the eye", *International Review of the Red Cross*, vol. 93, No. 881 (March 2011), pp. 214–216.

> of all kinds, mutilation, cruel treatment and torture; ... (c) outrages upon personal dignity, in particular humiliating and degrading treatment.

121. A former Special Rapporteur on torture, Sir Nigel Rodley, stated that: "The prohibition of torture or ill-treatment could hardly be formulated in more absolute terms. In the words of the official commentary on the text by the International Committee of the Red Cross (ICRC), 'no possible loophole is left; there can be no excuse, no attenuating circumstances'."[203]

122. A further link between international humanitarian law and human rights law is found in the preamble to Protocol II Additional to the Geneva Conventions of 1949. It states that: "international instruments relating to human rights offer a basic protection to the human person".[204] According to the commentary by ICRC to the Protocols Additional to the Geneva Conventions of 1949, the term "international instruments relating to human rights" means in particular the International Covenant on Civil and Political Rights and the Convention against Torture.[205] Although international humanitarian law and international human rights law are two distinct legal systems, each with its own foundations and mechanisms, they apply concurrently in time of armed conflict.[206]

D. International criminal justice

123. The Rome Statute of the International Criminal Court, adopted on 17 July 1998, established a permanent international criminal court to try individuals responsible for genocide, crimes against humanity and war crimes, later adding the crime of aggression to the list. The International Criminal Court has jurisdiction over cases alleging torture as a war crime, in particular when the torture is committed as part of a plan or policy or large-scale commission of such crimes, or as part of the crime of genocide or as a crime against humanity, in the latter case when the torture is committed knowingly as part of a widespread or systematic attack on any civilian population. Torture as a crime against humanity is defined in the Rome Statute, within that context, as the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused.[207]

124. Torture is not only an international crime subject to universal jurisdiction, but has been included in the statutes of numerous international courts and tribunals, including the International Criminal Court,[208] the International Tribunal for the Former Yugoslavia,[209] the International Criminal Tribunal for Rwanda[210] and the Special Court for Sierra Leone.[211]

125. Torture was prosecuted as a war crime at both the International Tribunal for the Former Yugoslavia and at the International Criminal Tribunal for Rwanda. The International Criminal Tribunal for Rwanda played an influential role in international criminal law, by finding, among other things, that rape could be prosecuted as torture and as an act of genocide. As the first United Nations-created war crimes court, the International Tribunal for the Former Yugoslavia set many precedents and affected the prosecution of torture, particularly in relation to armed conflicts.

126. The definition of torture as a war crime used by the International Tribunal for the Former Yugoslavia and the International Criminal Tribunal for Rwanda diverges from the one applicable under human rights law on account of the specificities of international humanitarian law, which make it clear that it is confined to the context of armed conflict. First, there is no need for the involvement of a public official.[212] This difference has been justified on the basis of the need to take "into consideration the specificities of [international humanitarian law]".[213] Another divergence applies specifically to the Rome Statute,

203 Nigel Rodley and Matt Pollard, *The Treatment of Prisoners under International Law*, 3rd ed. (Oxford, Oxford University Press, 2009), p. 60.
204 Protocol II Additional to the Geneva Conventions of 1949, second preambular paragraph.
205 ICRC, *Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949* (1987), para. 4428.
206 Ibid., para. 4429.
207 Rome Statute of the International Criminal Court, art. 7 (2) (e).
208 Ibid.
209 Updated Statute of the International Tribunal for the Former Yugoslavia (2009), arts. 2 (b) and 5 (f).
210 Statute of the International Criminal Tribunal for Rwanda (updated in 2002), arts. 3 (f) and 4 (a).
211 Statute of the Special Court for Sierra Leone (2002), arts. 2 (f) and 3 (a).
212 International Tribunal for the Former Yugoslavia, *Prosecutor v. Dragoljub Kunarac et al.*, Case Nos. IT-96-23-T and IT-96-23/1-T, Judgment, 22 February 2001, paras. 495–496; and International Criminal Tribunal for Rwanda, *Prosecutor v. Laurent Semanza*, Case No. ICTR-97-20-T, Judgment, 15 May 2003, paras. 342–343.
213 International Tribunal for the Former Yugoslavia, *Prosecutor v. Dragoljub Kunarac et al.*, para. 471.

in which the underlying offence of torture as a crime against humanity does not require a specific purpose.[214] However, it does require that the perpetrator knew that the conduct was part of, or intended the conduct to be, "part of a widespread or systematic attack directed against any civilian population"[215] and be committed "pursuant to or in furtherance of a State or organizational policy to commit such attack",[216] both of which indicate purpose.

127. The International Tribunal for the Former Yugoslavia outlined the prohibition of torture in armed conflict in *Prosecutor v. Anto Furundžija*. The Court found that it did not need to determine whether the provisions had passed into customary law in their entirety, because "a general prohibition against torture has evolved in customary international law",[217] and emphasized that, depending upon the circumstances of the particular case, torture may be prosecuted as a category of serious violations of humanitarian law, grave breaches of the Geneva Conventions, crimes against humanity or genocide.[218] Moreover, "under international humanitarian law, in addition to individual criminal responsibility [for acts of torture], State responsibility may ensue as a result of State officials engaging in torture or failing to prevent torture or to punish torturers."[219] The Court also found that the prohibition of torture during armed conflict is reinforced by international human rights instruments, and that the prohibition of torture has become a peremptory norm of international law, covers potential breaches and imposes obligations towards everyone.[220]

128. Rape and sexual violence in armed conflict has also been addressed. In *Prosecutor v. Jean-Paul Akayesu*, the Trial Chamber of the International Criminal Tribunal for Rwanda found that rape could constitute torture. According to the Trial Chamber:

> Like torture, rape is used for such purposes as intimidation, degradation, humiliation, discrimination, punishment, control or destruction of a person. Like torture, rape is a violation of personal dignity, and rape in fact constitutes torture when 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.[221]

129. The Appeals Chamber of the International Tribunal for the Former Yugoslavia affirmed that rape could constitute torture[222] and the International Criminal Court found that rape and other forms of sexual violence were used as a weapon of war.[223]

130. The International Criminal Tribunal for Rwanda has also found that torture can be one of genocide's "underlying offences" because it constitutes an act that "caus[es] serious bodily or mental harm to members of the group".[224] Additionally, the International Tribunal for the Former Yugoslavia found that permanent injury was not required for an act to constitute torture, that causing mental suffering could qualify as torture and that "the prohibited purpose need be neither the sole nor the main purpose of inflicting the severe pain or suffering".[225] The International Tribunal for the Former Yugoslavia did not have a uniform answer about whether or not public officials needed to play a role in acts of torture,[226] and the International Criminal Tribunal for Rwanda decided that there was no public official requirement when acts of torture constituted crimes against humanity.[227]

214 Rome Statute, art. 7 (1) (f).
215 Ibid., art. 7 (1).
216 Ibid., art. 7 (2) (a).
217 International Tribunal for the Former Yugoslavia, *Prosecutor v. Anto Furundžija*, Case No. IT-95-17/1-T, Judgment, 10 December 1998, para. 137.
218 Ibid., para. 141.
219 Ibid., para. 142.
220 Ibid., paras. 144 and 147–152.
221 International Criminal Tribunal for Rwanda, *Prosecutor v. Jean-Paul Akayesu*, Case No. ICTR-96-4-T, Judgment, 2 September 1998, para. 597 (see also para. 687).
222 International Tribunal for the Former Yugoslavia, *Prosecutor v. Dragoljub Kunarac et al.*, Case Nos. IT-96-23 and IT-96-23/1-A, Judgment, 12 June 2002, paras. 149–151.
223 International Criminal Court, *Prosecutor v. Jean-Pierre Bemba Gombo*, Case No. ICC-01/05-01/08, Judgment, 21 March 2016, paras. 98–112. The Appeals Chamber of the International Criminal Court overturned the ruling in *Bemba* in 2018.
224 Human Rights Watch, *Genocide, War Crimes, and Crimes Against Humanity: Topical Digests of the Case Law of the International Criminal Tribunal for Rwanda and the International Criminal Tribunal for the Former Yugoslavia* (New York, 2004), pp. 12 and 21–22. See also International Criminal Tribunal for Rwanda, *Prosecutor v. Jean-Paul Akayesu*, para. 504; and *Prosecutor v. Georges Anderson Nderubumwe Rutaganda*, Case No. ICTR-96-3-T, Judgment, 6 December 1999, para. 51.
225 International Tribunal for the Former Yugoslavia, *Prosecutor v. Miroslav Kvočka et al.*, Case No. IT-98-30/1-T, Judgment, 2 November 2001, para. 153; see also paras. 148–149.
226 International Tribunal for the Former Yugoslavia, *Prosecutor v. Dragoljub Kunarac et al.*, Judgment, 12 June 2002, para. 148; *Prosecutor v. Milorad Krnojelac*, Case No. IT-97-25-T, Judgment, 15 March 2002, para. 187; *Prosecutor v. Anto Furundžija*, para. 162; and *Prosecutor v. Zdravko Mucić et al.*, Judgment, 16 November 1998, paras. 494–496.
227 International Criminal Tribunal for Rwanda, *Prosecutor v. Laurent Semanza*, paras. 342–343.

131. All professions work within ethical codes, which provide a statement of the shared values and acknowledged duties of professionals and set standards with which they are expected to comply. Ethical standards are established primarily in two ways: by international instruments drawn up by bodies such as the United Nations and by codes of conduct drafted by the professions themselves, through their representative associations nationally or internationally. The fundamental tenets are generally the same and focus on obligations owed by the professional to individual clients or patients, to society at large and to colleagues in order to promote the interests of clients and patients, to maintain the integrity of the profession and to ensure that the power and authority invested in members of the profession are not abused. These obligations reflect and complement the rights to which all people are entitled under international instruments. While this chapter specifically addresses the ethics of legal and health professionals, others who work with alleged victims and survivors of torture or ill-treatment should be aware of their professional obligations and, where they may be lacking, consider relevant ethical obligations presented in this chapter.

A. Relevant ethics of legal professionals

1. Principles common to all codes of legal professional ethics

132. Legal professionals "play a critical role in upholding human rights, including the absolute and non-derogable right of freedom from torture and other cruel, inhuman or degrading treatment or punishment".[228] Ethical obligations of judges, prosecutors and lawyers are articulated by the standards and ethical codes developed by the United Nations,[229] and by international,[230] regional and national associations of legal professionals.[231] These ethical obligations underlie the rights to a fair trial and the due process of law, including an impartial, independent, competent judiciary.[232]

(a) Duty to conduct themselves professionally and independently

133. Legal professionals must perform their functions without any restrictions, inducements, pressures, intimidation, improper influences or interferences, direct or indirect, or for any reason, or unjustified exposure to civil, penal or other liability.[233] Legal professionals should also observe professional conduct at all times. They should maintain the highest standards of integrity, propriety and the appearance of honour, dignity, competence and diligence.[234]

(b) Duty to ensure equal treatment to all persons

134. Judges and prosecutors have a duty to ensure equal treatment to all persons without discrimination or prejudice.[235] In this regard, when dealing with victims of torture and other cruel, inhuman or degrading treatment or punishment, they "should strive to minimize re-victimization or trauma".[236] Lawyers must also avoid all types of discrimination

228 Human Rights Council resolution 35/12, thirteenth preambular paragraph.

229 For United Nations ethical obligations for judges, see Basic Principles on the Independence of the Judiciary; Bangalore Principles of Judicial Conduct; United Nations Office on Drugs and Crime, *Commentary on the Bangalore Principles of Judicial Conduct* (Vienna, 2007); and Judicial Integrity Group, "Measures for the effective implementation of the Bangalore Principles of Judicial Conduct (the implementation measures)" (Lusaka, 2010). For prosecutors, see Guidelines on the Role of Prosecutors, adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders (1990) (A/CONF.144/28/Rev.1). For lawyers, see Basic Principles on the Role of Lawyers, adopted at the same Congress.

230 For international ethical obligations for judges, see International Association of Judicial Independence and World Peace; Bologna and Milan Global Code of Judicial Ethics (2015); and International Commission of Jurists, *Judicial Accountability: A Practitioners' Guide* (Geneva, 2016). For prosecutors, see Standards of Professional Responsibility and Statement of the Essential Duties and Rights of Prosecutors, adopted by the International Association of Prosecutors (1999); and United Nations Office on Drugs and Crime, *The Status and Role of Prosecutors: A United Nations Office on Drugs and Crime and International Association of Prosecutors Guide* (New York, 2014). For lawyers, see International Principles on Conduct for the Legal Profession, adopted by the International Bar Association (2011) .

231 See www.icj.org/icj-launches-new-practitioners-guide-on-judicial-accountability. See also American Bar Association, *Model Code of Judicial Conduct*, revised edition (2020); and Council of Europe, "European Guidelines on Ethics and Conduct for Public Prosecutors: 'the Budapest Guidelines'" (Strasbourg, 2005).

232 International Covenant on Civil and Political Rights, art. 14; and Human Rights Committee, general comment No. 32 (2007).

233 For judges' duty to conduct themselves professionally and independently, see Basic Principles on the Independence of the Judiciary, art. 2; Bangalore Principles of Judicial Conduct, value 2; American Bar Association, Model Code of Judicial Conduct, canon 1; and Bologna and Milan Global Code of Judicial Ethics, principle 3.5. For prosecutors, see Guidelines on the Role of Prosecutors, para. 4; International Association of Prosecutors, Standards of Professional Responsibility, para. 2; and Istanbul Protocol, paras. 49 and 74. For lawyers, see Basic Principles on the Role of Lawyers, principle 16. See also the preamble to Human Rights Council resolution 35/12, in which the Council recalled that: "An independent and impartial judiciary, an independent legal profession, an objective and impartial prosecution able to perform its functions accordingly and the integrity of the judicial system are prerequisites for the protection of human rights and the application of the rule of law and for ensuring fair trials and the administration of justice without any discrimination."

234 For judges, see Bangalore Principles of Judicial Conduct, values 3, 4 and 6; and Bologna and Milan Global Code of Judicial Ethics, principles 5.1 and 5.2. For prosecutors, see Guidelines on the Role of Prosecutors, para. 3; and International Association of Prosecutors, Standards of Professional Responsibility, para. 1. For lawyers, see International Principles on Conduct for the Legal Profession, principle 2.

235 For judges' duty to ensure equal treatment to all persons, see Bangalore Principles of Judicial Conduct, value 5; and Bologna and Milan Global Code of Judicial Ethics, principle 5.3. For prosecutors, see Guidelines on the Role of Prosecutors, para. 13 (a).

236 International Commission of Jurists, *Principles on the Role of Judges and Lawyers in Relation to Refugees and Migrants* (Geneva, 2017), p. 22, commentary to principle 13. See also Conor Foley, *Protecting Brazilians From Torture: A Manual for Judges, Prosecutors, Public Defenders and Lawyers*, 2nd ed. (London, International Bar Association, 2013), p. 181.

and can be required by judges in proceedings before a court "to refrain from manifesting bias or prejudice, or engaging in harassment".[237]

2. Principles guiding the conduct of judges

(a) Duty to promote and protect human rights

135. As the ultimate arbiters of justice, judges play a special role in the protection of human rights. Judges have an ethical duty to ensure that human rights are protected. Judges can be responsible for human rights violations when "exercising or failing to exercise their authority in ways that seek to conceal violations perpetrated by military, para-military, or law enforcement agents".[238]

(b) Duty to decide matters impartially in accordance with the law

136. Principle 6 of the Basic Principles on the Independence of the Judiciary states that: "The principle of the independence of the judiciary entitles and requires the judiciary to ensure that judicial proceedings are conducted fairly and that the rights of the parties are respected." In addition, the Bologna and Milan Global Code of Judicial Ethics calls for the strict independence of the judiciary from the legislative and executive branches of government and "that in the decision-making process, judges should be independent and be able to act without any restriction, improper influence, inducements, pressures, threats or interferences, direct or indirect, from any quarter or for any reason".[239] The Code also recognizes the importance of a competent, independent and impartial judiciary in the protection of human rights. Thus, in order to protect individuals from torture and ill-treatment, judges should have sufficient knowledge of the Istanbul Protocol and its Principles and ensure that they are applied by relevant parties in judicial proceedings.

(c) Judges' role in the prevention of and protection against torture

137. In order to protect individuals from torture and ill-treatment, judges "may demand that a suspect be brought before them at the earliest opportunity and check that he or she is being properly treated. Where they have discretion, they may interpret the balance of proof, with respect to allegations of torture and the admissibility of evidence obtained through it, in ways that discourage law enforcement officers, and those in charge of places of detention, from carrying out, or permitting others to carry out, torture and other forms of ill-treatment."[240] A former Special Rapporteur on torture, Sir Nigel Rodley, specified that "when there is prima facie evidence that a defendant has confessed under torture and if his/her allegations are consistent with other evidence, such as forensic evidence, the trial must be suspended by the judge".[241] Furthermore, "if a confession [obtained by means of torture or under duress] is the only evidence against a defendant, the judge should decide that there is no basis for conviction".[242]

3. Principles guiding the conduct of prosecutors

(a) Duty to investigate and prosecute torture and other cruel, inhuman or degrading treatment or punishment

138. Prosecutors have an ethical obligation to investigate and prosecute torture or other cruel, inhuman or degrading treatment or punishment committed by public officials. Article 15 of the Guidelines on the Role of Prosecutors states: "Prosecutors shall give due attention to the prosecution of crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law and, where authorized by law or consistent with local practice, the investigation of such offences."[243] Prosecutors should "take all complaints of ill-treatment seriously"[244] and carry out investigations actively (see para. 253 below) and expeditiously.[245]

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237 American Bar Association, Model Code of Judicial Conduct, rule 2.3 (C).

238 International Commission of Jurists, *Judicial Accountability: A Practitioners' Guide*, p. 9.

239 Bologna and Milano Global Code of Judicial Ethics, para. 4.4 (footnote omitted). The provisions of this Code were articulated to clarify previous international judicial codes and are intended to apply to all judges.

240 Conor Foley, *Combating Torture: A Manual for Judges and Prosecutors* (Colchester, University of Essex, 2003), p. 2.

241 E/CN.4/2001/66/Add.2, para. 102.

242 Ibid.

243 Guidelines on the Role of Prosecutors, para. 15; and United Nations Office on Drugs and Crime, *The Status and Role of Prosecutors*.

244 Foley, *Protecting Brazilians From Torture*, p. 29.

245 Guidelines on the Role of Prosecutors, paras. 11–12; International Association of Prosecutors, Standards of Professional Responsibility, para. 4.2; and Foley, *Protecting Brazilians From Torture*, p. 181.

In exercising their duty to effectively investigate allegations of torture or ill-treatment, prosecutors should have adequate knowledge of and apply the Istanbul Protocol and its Principles in their investigation and documentation practices.[246]

(b) Duty to refuse evidence obtained through torture or ill-treatment: the exclusionary rule

139. Paragraph 16 of the Guidelines on the Role of Prosecutors states:

> When prosecutors come into possession of evidence against suspects that they know or believe on reasonable grounds was obtained through recourse to unlawful methods, which constitute a grave violation of the suspect's human rights, especially involving torture or cruel, inhuman or degrading treatment or punishment, or other abuses of human rights, they shall refuse to use such evidence against anyone other than those who used such methods, or inform the Court accordingly, and shall take all necessary steps to ensure that those responsible for using such methods are brought to justice.

In order to avoid conflicts of interest, the investigation regarding allegations that the evidence was obtained unlawfully should be carried out by a prosecutor other than the one in charge of the initial criminal investigation.[247] International standards state that: "in the institution of criminal proceedings, they will proceed only when a case is well-founded upon evidence reasonably believed to be reliable and admissible, and will not continue with a prosecution in the absence of such evidence."[248] In the absence of other inculpatory material, prosecutors must not solely rely on a confession for prosecution. Prosecutors must "examine proposed evidence to ascertain if it has been lawfully or constitutionally obtained".[249] This examination must be done "according to the gravity of unlawfulness or impropriety and the standards described in their own State's rules of evidence".[250]

(c) Duty of impartiality and objectivity

140. While it is the duty of the State to "ensure that prosecutors are able to perform their professional functions without intimidation, hindrance, harassment, improper interference or unjustified exposure to civil, penal or other liability," prosecutors have a duty to conduct their investigations impartially (Guidelines on the Role of Prosecutors, para. 4) and "perform their duties fairly, consistently and expeditiously, and respect and protect human dignity and uphold human rights" (ibid., para. 12). Prosecutors must strive to be, and to be seen to be, objective and impartial.[251]

(d) Duty to ensure that State authorities respect the right to be free from torture and other cruel, inhuman or degrading treatment or punishment

141. Prosecutors shall ensure that State authorities respect the right to be free from torture and other cruel, inhuman, degrading treatment or punishment. They should give precise instructions against the use of illegal or improper methods to obtain evidence to other investigators and staff under their charge and supervise their conduct; regularly conduct visits to places of detention and police stations; and require that confessions are conducted in the presence of a judge or magistrate.[252] Prosecutors have a special obligation to take all necessary steps to bring to justice those who are suspected of having committed human rights violations such as torture and ill-treatment. Their work is key both to the remedying of past human rights violations and to the prevention of future violations.[253]

4. Principles guiding the conduct of lawyers

(a) Duty to promote and protect human rights

142. Principle 14 of the Basic Principles on the Role of Lawyers provides that: "Lawyers, in protecting the rights of their clients and in promoting the cause of justice, shall seek to uphold human rights and fundamental freedoms recognized by national and international law and shall at all times act

246 "The State party should: (a) ensure that the Istanbul Protocol is made an essential part of the training for all medical professionals and other public officials involved in work with persons deprived of their liberty" (CAT/C/NOR/CO/8, para. 30).

247 E/CN.4/2001/66/Add.2, para. 102.

248 International Association of Prosecutors, Standards of Professional Responsibility, para. 4.2 (d); and United Nations Office on Drugs and Crime, *The United Nations Convention against Corruption: Implementation Guide and Evaluative Framework for Article 11* (New York, 2015), para. 159.

249 International Association of Prosecutors, Standards of Professional Responsibility, para. 4.3 (e).

250 United Nations Office on Drugs and Crime, *The Status and Role of Prosecutors*, p. 41.

251 International Association of Prosecutors, Standards of Professional Responsibility, paras. 1 (e), 3 (a) and 4.2 (c).

252 This statement is supported by the Convention against Torture, art. 11.

253 OHCHR, *Human Rights in the Administration of Justice: A Manual on Human Rights for Judges, Prosecutors and Lawyers* (New York and Geneva, 2003), Professional Training Series No. 9, p. 369.

freely and diligently in accordance with the law and recognized standards and ethics of the legal profession." Given their professional obligation to uphold fundamental freedoms, such as freedom from torture and ill-treatment, lawyers should have adequate knowledge of and apply the Istanbul Protocol and its Principles to ensure effective investigation and documentation practices.

(b) Duty to treat their clients' interests as paramount

143. According to principle 13 of the Basic Principles on the Role of Lawyers, the duties of lawyers include: "(a) Advising clients as to their legal rights and obligations, and as to the working of the legal system in so far as it is relevant to the legal rights and obligations of the clients; (b) Assisting clients in every appropriate way, and taking legal action to protect their interests; (c) Assisting clients before courts, tribunals or administrative authorities, where appropriate." In addition, principle 15 states: "Lawyers shall always loyally respect the interests of their clients." In 2011, the International Bar Association developed the International Principles on Conduct for the Legal Profession as a means of placing the interests of their clients above their own and striving to respect the rule of law. These Principles include, among others: maintaining professional independence; honesty, integrity and fairness in interactions with clients, the court and colleagues; maintaining client confidentiality; and treating a client's interests as paramount.[254] Lawyers have a primary duty to their clients and should give their clients "unbiased advice and representation … including as to the likelihood of success of the client's case" and treat their "interests as paramount".[255] The explanatory note to principle 1 recalls that: "The fact that lawyers are paid by a third party must not affect their independence and professional judgement in rendering their services to the client." However, lawyers' duties towards their clients are "subject always to there being no conflict with the lawyer's duties to the court and the interests of justice, to observe the law, and to maintain ethical standards".[256] Principle 5 establishes that: "Lawyers must not engage in, or assist their client with, conduct that is intended to mislead or adversely affect the interest of justice, or wilfully breach the law."[257]

(c) Duty of confidentiality

144. A lawyer shall always maintain confidentiality "regarding the affairs of present or former clients, unless otherwise allowed or required by law and/or applicable rules of professional conduct".[258] In addition, principle 22 of the Basic Principles on the Role of Lawyers states that "all communications and consultations between lawyers and their clients within their professional relationship are confidential". Nevertheless, lawyers "cannot invoke confidentiality/professional secrecy in circumstances where the lawyer acts as an accomplice to a crime".[259]

B. Ethical obligations of health professionals

145. There are clear links between concepts of human rights and the well-established principles of health-care ethics. The ethical obligations of health professionals are articulated in United Nations documents in the same way as they are for the legal profession. They are also embodied in statements issued by international organizations representing health professionals, such as the World Medical Association (WMA), the World Psychiatric Association (WPA) and the International Council of Nurses (ICN).[260] National medical associations and nursing organizations also issue codes of ethics, which their members are expected to follow. The central tenet of all health professional ethics, however articulated, is always the fundamental duty to respect human dignity and act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. In some countries, specific medical ethical principles, such as that of doctor-patient confidentiality, are incorporated into national law. In some situations, national law may also be in conflict with the ethical obligations of health professionals. All health professionals are morally bound by the ethical standards set by their professional bodies and may be judged guilty

254 International Principles on Conduct for the Legal Profession, principles 1, 2, 4 and 5.
255 Ibid., principles 1 and 5; and Basic Principles on the Role of Lawyers, principles 13 and 15.
256 International Principles on Conduct for the Legal Profession, principle 5.
257 Ibid., p. 25, explanatory note to principle 5.
258 Ibid., principle 4.
259 International Principles on Conduct for the Legal Profession, p. 22, explanatory note to principle 4.
260 There are also a number of regional groupings, such as the Commonwealth Medical Association and the Federation of Islamic Medical Associations that issue important statements on medical ethics and human rights for their members.

of professional misconduct if they deviate from professional standards without reasonable justification.

146. It is important to note that the ethical obligations of health professionals apply to all encounters with individuals wherein professional knowledge and/or skills are applied for some purpose. Conducting a clinical evaluation of alleged or suspected cases of torture, whether in medico-legal, law enforcement, military, primary health-care or other settings, is a procedure based on professional knowledge and skills that entails potential benefits and risks to the individual. The term "patient"[261] is commonly used to refer to individuals who are the subject of some health professional intervention and, therefore, includes alleged victims of torture or ill-treatment. Whether health professionals refer to alleged victims of torture or ill-treatment as "patients" or not, the ethical obligations of health professionals apply to all clinical evaluations. The core ethical obligations that are discussed in this chapter – beneficence, non-maleficence, confidentiality and respect for patient autonomy – apply equally in times of armed conflict and other emergencies and in times of peace, and military personnel have the same ethical obligations as civilian health professionals.[262]

1. United Nations statements relevant to health professionals

147. The United Nations has specifically addressed the ethical obligations of doctors and other health professionals in the 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.[263] The Principles of Medical Ethics impose on health personnel a duty to provide medical care for all detainees and protect their physical and mental health, in accordance with the principles of non-discrimination and equal medical treatment (principle 1). They also specify the circumstances that constitute a violation of medical ethics and invoke the responsibility of health personnel, including: to engage, actively or passively, in acts of torture or ill-treatment (principle 2); to be involved in a professional relationship with detainees separate from the sole purpose of evaluating, protecting or improving their physical and mental health (principle 3); to apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments (principle 4 (a)); to certify the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health (such as prolonged solitary confinement) or to participate in the infliction of any such treatment or punishment that is not in accordance with the relevant international instruments (principle 4 (b)); and to participate in any procedure for restraining prisoners or detainees unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of prisoners or detainees themselves, of their fellow prisoners or detainees, or of their guardians, and presents no hazard to their physical or mental health (principle 5). The Principles of Medical Ethics also recall the non-derogable nature of the above-mentioned principles under any circumstance (principle 6).

148. Health professionals, like all other persons working in prison systems, must observe the Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), which require that medical, including psychiatric, services must be available to all prisoners without discrimination and that all sick prisoners or those requesting treatment be seen daily. The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) complement the Nelson Mandela Rules and articulate specific ethical duties to protect women deprived of their liberty.[264] These requirements reinforce the ethical obligations of physicians and other health-care professionals, discussed below, to treat and act in the best interests of their patients. Rule 32 (1) of the Nelson Mandela Rules states that "the relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community". This includes the "duty of protecting prisoner's physical and mental

261 "Patient" is defined not only as "an individual awaiting or under medical care and treatment", but also as "the recipient of any of various personal services" and "one that is acted upon". The word "patient" derives from the Latin "*pati*", which means to suffer.

262 WMA and others, ethical principles of health care in times of armed conflict and other emergencies (adopted in 2015). See also WMA regulations in times of armed conflict and other situations of violence (adopted in 1956 and last revised in 2012).

263 General Assembly resolution 37/194, annex.

264 Bangkok Rules, rules 10 and 12–18.

health";[265] "adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship";[266] "confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others";[267] and the "absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment".[268] Health professionals are also prohibited from having any role in the imposition of disciplinary sanctions or other restrictive measures.[269] This includes solitary confinement (22 hours or more a day without meaningful human contact), prolonged solitary confinement (15 consecutive days), placement of a prisoner in a dark or constantly lit cell, corporal punishment or the reduction of a prisoner's diet or drinking water and collective punishment.[270] Furthermore, rule 34 of the Nelson Mandela Rules requires health-care professionals who "become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment" to "document and report such cases to the competent medical, administrative or judicial authority".

149. Regarding women who are deprived of their liberty, rule 10 of the Bangkok Rules states that "all women are entitled to treatment and care equivalent to that of community standards for their gender specific health-care needs" and the right to medical confidentiality.[271] In addition, rule 6 (5) of the Bangkok Rules establishes the duty of health personnel to document "any signs of ill-treatment or torture" in health screening examinations.

150. Proper procedural safeguards should be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm. The relevant procedural safeguards concerning the risks of harm specifically in the context of clinical evaluations of torture or ill-treatment are discussed in paragraphs 312 to 315 below. Regional human rights bodies, such as the European Committee for the Prevention of Torture, also require health professionals working in places of detention to document and report medical evidence of torture or ill-treatment.[272]

151. "Participation in torture" 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 or providing medical treatment immediately before, during or after torture on the instructions of those likely to be responsible for it; providing professional knowledge or individuals' personal health information to torturers; and intentionally neglecting evidence and falsifying reports, such as autopsy reports and death certificates.[273] In a situation in which an intervention after torture is essential to preserve the life of an individual, such an emergency intervention may be performed. In addition, health-care personnel are required to report the adverse effects of disciplinary sanctions or other restrictive measures and advise the director to terminate involuntary separation in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner. The Principles of Medical Ethics also prohibit any professional relationship with prisoners or detainees that is not solely to evaluate, protect or improve their physical and mental health. Thus, assessing a detainee's health in order to facilitate punishment or torture is clearly unethical.

152. The duty of health professionals not to participate, actively or passively, in torture and ill-treatment practices and to document and report such practices extends to a wide range of abuses that have been recognized as torture or ill-treatment by the Special Rapporteur on torture and the Committee against Torture.[274] These include, but are not limited to, abusive practices related to gender discrimination, including those under the guise of medical treatment or testing, such as virginity testing, anal examinations to "detect homosexuality", rape, female genital mutilation, forced marriage, child marriage, honour

265 Nelson Mandela Rules, rule 32 (1) (a).
266 Ibid., rule 32 (1) (b).
267 Ibid., rule 32 (1) (c).
268 Ibid., rule 32 (1) (d).
269 Ibid., rule 46 (1).
270 Ibid., rule 43 (1) (a)–(e).
271 Bangkok Rules, rules 8 and 11. See also rules 12–18 thereof, which elaborate duties on the specific gender-based physical and mental health-care needs of women.
272 European Committee for the Prevention of Torture, *23rd General Report of the CPT (1 August 2012–31 July 2013)* (Strasbourg, Council of Europe, 2013), paras. 71–84
273 Health professionals must, however, bear in mind the duty of confidentiality owed to patients and the obligation to obtain informed consent for disclosure of information, particularly when individuals may be put at risk by such disclosure (see paras. 165–171 above).
274 A/HRC/31/57; A/HRC/7/3, paras. 25–26; and OHCHR, "Gender-based crimes through the lens of torture International Women's Day", press release, 8 March 2016.

killing, widow-burning, trafficking in persons, female genital mutilation, conversion therapies to change sexual orientation, non-consensual gender reassignment surgeries, forced or coerced pregnancy testing, forced or coercive sterilization, medical determinations of gender without consent, and unnecessary surgery and treatment on intersex children without their consent. The Special Rapporteur has also recognized certain forms of abuses in health-care settings that may be tantamount to torture or ill-treatment including: force-feeding hunger strikers,[275] the denial of pain relief,[276] compulsory detention for medical reasons, such as compulsory drug detention and "rehabilitation", non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshocks and mind-altering drugs, such as neuroleptics, the use of restraint and solitary confinement for both long- and short-term application.[277]

153. Health professionals who participate in the monitoring of places of detention, notably as part of national mechanisms for the prevention of torture,[278] have a particular role in addressing health issues related to torture and ill-treatment; in assessing the health system in detention, for example through an analysis of medical files and records and discussions with the health-care staff in places of detention; and in evaluating the impact of general conditions of detention (hygiene, nutrition, access to showers, overcrowding etc.) on the health of the detained population. This medical expertise enhances the quality of monitoring that is conducted by the visiting mechanisms. In this perspective, health professionals may provide a substantial contribution to the application of norms and standards – especially on the provision of, and access to, health care and on ethical practices for those working in places of detention – and recommendations to the State authorities addressing health issues in detention that may amount to torture and/or ill-treatment.[279]

2. Statements from international professional bodies

154. Many statements from international professional bodies focus on principles relevant to the protection of human rights and represent an international medical consensus on these issues. WMA declarations define the ethical duties to which all doctors are held. The guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment (Declaration of Tokyo), adopted by the World Medical Assembly,[280] reiterate the prohibition of any form of medical participation or medical presence in torture or ill-treatment. This prohibition is reinforced by the aforementioned Principles of Medical Ethics that specifically refer to the Declaration of Tokyo. Doctors are explicitly prohibited from providing information or any medical instrument or substance that would facilitate ill-treatment. The same rule is specifically applied to psychiatry in the WPA Declaration of Hawaii,[281] which prohibits the misuse of psychiatric skills to violate the human rights of any individual or group, and its Declaration of Madrid on ethical standards for psychiatric practice.[282] The International Conference on Islamic Medicine made a similar point in its Declaration of Kuwait,[283] which bans doctors from allowing their special knowledge to be used "to harm, destroy or inflict damage on the body, mind or spirit, whatever the military or political reason". Similar provisions are made for nurses in the position statement on nurses' role in the care of detainees and prisoners.[284]

155. Health professionals also have a duty to support colleagues who denounce human rights violations related to torture. Failure to do so risks not only an infringement of patient rights and a contravention of the declarations listed above, but also brings the health professions into disrepute. This is elaborated by other WMA policies supplementing the Declaration of Tokyo. For example, the WMA Recommendation on the Development of a Monitoring and Reporting

275 OHCHR, "Force-feeding is cruel and inhuman – UN experts urge Israel not to make it legal", press release, 25 June 2014.
276 The WMA resolution on the access to adequate pain treatment (2011, revised 2020) highlights the problem of the vast majority of the world population having no access to or inadequate pain treatment. The resolution urges health professionals and Governments to ensure adequate pain treatment for all and to establish effective monitoring and compliance mechanisms.
277 A/HRC/22/53, para. 89 (b).
278 Pursuant to the Optional Protocol to the Convention against Torture.
279 The Association for the Prevention of Torture, "Visiting places of detention: what role for physicians and other health professionals?" (Geneva, 2008), pp. 6–7.
280 Adopted in 1975 and revised in 2005, 2006 and 2016.
281 Adopted in 1977 and updated in 1983.
282 Approved by the WPA General Assembly in 1996 and revised in 1999, 2002, 2005 and 2011.
283 Adopted in 1981, otherwise known as the Islamic code of medical ethics.
284 Adopted by ICN in 1998 and revised in 2006 and 2011.

Mechanism to Permit Audit of Adherence of States to the Declaration of Tokyo recommends support for doctors and national medical associations in their efforts to report violations of patients' health rights and physicians' professional ethics in custodial settings. WMA reviews cases of alleged violations of the Declaration of Tokyo and facilitates investigations by national medical associations of such allegations, including possible referral to the Special Rapporteur on torture.[285] The WMA Declaration of Hamburg concerning support for medical doctors refusing to participate in, or to condone, the use of torture and other cruel, inhuman or degrading treatment[286] reaffirms the responsibility of individuals and organized medical groups worldwide to encourage doctors to resist torture or any pressure to act contrary to ethical principles. It calls upon individual doctors to speak out against torture and ill-treatment and urges national and international medical organizations to support doctors who resist such pressure. The WMA resolution on the responsibility of physicians in the documentation and denunciation of acts of torture or cruel or inhuman or degrading treatment establishes the duty of physicians to document and denounce acts of torture and ill-treatment and provides that a failure to do so constitutes complicity in such abuse.[287] This duty applies to all physicians – governmental and non-governmental – wherever they encounter alleged victims of torture in medico-legal and any other contexts. Other health professionals have the same ethical obligation to identify, document and report torture.[288] The duty of doctors to document and report torture and ill-treatment consequently supports an ethical exception to professional confidentiality, allowing physicians to report abuses under limited circumstances. WPA and ICN have also established similar duties for psychiatrists and nurses to report torture and ill-treatment.[289]

156. WMA has also established the ethical obligation of doctors not to engage in other abusive practices that constitute cruel and degrading treatment and possibly torture, including prolonged solitary confinement,[290] forced body searches,[291] force-feeding competent individuals, such as hunger strikers,[292] forced anal examination to substantiate same-sex activity[293] and female genital mutilation surgery[294]

157. In addition, when health professionals are in situations in which State or military law or government policies support detention and/or interrogation practices that systematically violate international law and medical ethics, the health professional must refuse to participate and report the situation to international authorities. Health professionals who disregard their ethical obligations may become complicit in torture and ill-treatment practices in many ways.[295]

3. National codes of health professional ethics

158. Ethical principles are also articulated through national codes. These largely reflect the same core values as mentioned above, since medical ethics are the expression of common values among health professionals. In virtually all cultures and codes, the same basic presumptions occur about duties to avoid harm, help the sick and protect the vulnerable and to not discriminate among patients on any basis other than the urgency of their medical needs. Identical values are present in the codes for the nursing profession. A challenging aspect of ethical principles is that they do not, however, provide definitive rules for every dilemma but require some interpretation. When weighing ethical dilemmas, it is vital that health professionals bear in mind the fundamental moral obligations expressed in their shared professional values and

285 Adopted in 2011.
286 Adopted in 1997 and revised in 2017.
287 Adopted in 2003 and revised in 2007, 2008 and 2020.
288 For example, nurses who are aware of abuse and maltreatment should take appropriate action to safeguard the rights of detainees and prisoners. See ICN, "Nurses' role in the care of detainees and prisoners".
289 WPA, Consensus Guidelines for Independent Medical Examinations (March 2015); and ICN, "Nurses' role in the care of detainees and prisoners".
290 WMA statement on solitary confinement, adopted in 2014 and revised in 2019.
291 WMA statement on body searches of prisoners, adopted in 1993 and revised in 2005 and 2016.
292 WMA Declaration of Malta on hunger strikers, adopted in 1991 and revised in 1992, 2006 and 2017.
293 WMA resolution on prohibition of forced anal examinations to substantiate same sex-sexual activity, adopted in 2017.
294 WMA statement on female genital mutilation, adopted in 1993 and revised in 2005 and 2016.
295 David H. Hoffman and others, *Independent Review Relating to APA Ethics Guidelines, National Security Interrogations, and Torture* (Chicago, Sidley Austin, 2015). The American Psychological Association (APA), the largest association of psychologists in the world, banned the presence of psychologists in national security interrogations, see American Psychological Association, Council of Representatives, resolution to amend the 2006 and 2013 Council resolutions to clarify the roles of psychologists related to interrogation and detainee welfare in national security settings, to further implement the 2008 petition resolution, and to safeguard against acts of torture and cruel, inhuman, or degrading treatment or punishment in all settings, adopted in 2015.

that they implement them in a manner that reflects the basic duty to avoid harm to their patients.[296]

C. Application of ethical principles in clinical evaluations of torture and ill-treatment

159. The codes of conduct of health professional share a number of core principles. The ethical principles most relevant to clinical evaluations of alleged or suspected cases of torture or ill-treatment are to act in the best interests of patients (beneficence), "do no harm" (non-maleficence), respect the decisions of patients (autonomy) and maintain the confidentiality of information shared in encounters with health professionals. In recent years, WMA and the Nelson Mandela Rules have established the ethical obligation for doctors and other medical personnel to document and report acts of torture and ill-treatment under certain circumstances. While these ethical principles may be mutually reinforcing and supportive of a clinical evaluation of alleged torture or ill-treatment, they may conflict and thus present a challenge for health professionals. The present section reviews the application of core ethical principles in clinical evaluations of cases in which torture or ill-treatment is alleged or suspected.

1. Beneficence and non-maleficence

160. The duty of doctors to act in the best interests of the patient and not to harm them has been recognized for centuries in a number of codes, including the Charaka Samhita, a Hindu code dating from the first century A.D., the Declaration of Kuwait, the Prayer of Maimonides and the Hippocratic Oath. The WMA Declaration of Geneva[297] is a modern restatement of the Hippocratic values reflecting four foundational principles – beneficence, non-maleficence, confidentiality and respect for patient autonomy. It is a promise by which doctors undertake to make the health of their patients their primary consideration and vow to devote themselves to the service of humanity with conscience and dignity. These foundational ethical principles are also recognized by WPA and ICN and apply to psychiatrists and nurses.[298]

161. In cases of alleged torture or ill-treatment, the best interests of the patient or alleged victim are often consistent with the purpose of the clinical evaluation, namely the effective documentation of torture and ill-treatment, which may corroborate an individual's allegations of abuse.

162. The ethical obligation of beneficence is reflected in many WMA declarations, which make clear that doctors must always do what is best for the patient, including persons accused or convicted of crimes. This duty of beneficence is also expressed through the notion of professional independence, requiring doctors to adhere to good and accepted medical practices despite any pressure that might be applied. The WMA International Code of Medical Ethics emphasizes doctors' duty to provide care in full professional and moral independence, with compassion and respect for human dignity.[299] It also contains the duty to refuse to use medical knowledge to violate human rights, even under threat. WMA standing policy, such as the Declaration of Tokyo or the Declaration of Seoul on professional autonomy and clinical independence,[300] is unambiguous that doctors must insist on being free to act in patients' interests, regardless of other considerations, including the instructions of employers, prison authorities or security forces. Similar principles are prescribed for nurses in the ICN Code of Ethics for Nurses.

163. Another way in which the duties of physicians is expressed by WMA is through its recognition of patient rights. Its Declaration of Lisbon on the rights of the patient[301] recognizes that every person is entitled, without discrimination, to appropriate health care and reiterates that doctors must always act in a patient's best interest. According to the Declaration, this includes efforts by doctors and other persons or bodies involved in the provision of health care to uphold patients' rights, including autonomy and justice. The Declaration states in its preamble: "Whenever legislation, government action or any other administration or institution denies patients

296 This is recognized by WMA in the regular (minimum every 10 years) review of its policies to ensure that they remain sufficiently detailed and clear to guide physicians' decision-making. Updates clarify language and seek to address matters that were not covered by earlier drafts.
297 Adopted in 1948 and revised in 1968, 1983, 1994, 2005, 2006 and 2017.
298 WPA, Declaration of Hawaii (1983) and Declaration of Madrid; and ICN, ICN Code of Ethics for Nurses (adopted in 1953 and last revised in 2012).
299 Adopted in 1949 and revised in 1968, 1983 and 2006.
300 Adopted in 2008 and revised in 2018.
301 Adopted in 1981, revised in 1995, 2005 and 2015.

these rights, physicians should pursue appropriate means to assure or to restore them." Individuals are entitled to appropriate health care, regardless of factors such as their race, colour, national, ethnic or social origin, language, age, sex, gender, sexual orientation and gender identity, immigration status, political or other opinion, religion, descent, birth, disability, health status, individual merit, etc. People accused or convicted of crimes have an equal moral entitlement to appropriate medical and nursing care. The Declaration emphasizes that the only acceptable criterion for discriminating among patients is the relative urgency of their medical needs.

164. When working with children and young people it is important to remember that: "Organisations have a duty of care to children with whom they work, are in contact with, or who are affected by their work and operations."[302] The principle of safeguarding children includes ensuring that children are protected from harm and are not exposed to risk of harm and that any such risk is reported and addressed immediately.

2. Informed consent

165. The most fundamental principle of medical ethics is patient autonomy. Autonomy recognizes that patients themselves are the best judges of their own interests. This requires health professionals to adhere to an adult patient's decisions rather than to the views of any person in authority about what would be best for that individual. This is equally true in the context of clinical evaluations of alleged torture or ill-treatment that may result in reprisals and the infliction of severe physical and/or mental harm. In cases in which the patient is unconscious or where significant efforts have been made and it is not possible to obtain an individual's free and informed consent or to ascertain their will and preferences, including through the provision of support and accommodations, the standard of "best interpretation of the will and preference" should be applied as a last resort.

166. Organizations of health professionals, such as WMA, WPA and ICN, the Bangkok Rules and the Nelson Mandela Rules require that doctors and nurses respect the autonomous decisions of their patients and obtain voluntary and informed consent from patients prior to any examination or procedure. This means that individuals need to know and understand the implications of agreeing and the consequences of refusing, as well as any reasonable alternatives. Before examining patients, health professionals must, therefore, explain frankly and in an accessible manner the purpose of the examination and treatment. Consent obtained under duress or as a result of conveying false or partial information to the patient is invalid, and doctors knowingly acting on it are in breach of medical ethics. In addition, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health observed that guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services.[303]

167. Torture and ill-treatment, by definition, are crimes committed by or with the consent or acquiescence of State officials. State officials often attempt to conceal these crimes by threatening victims with additional torture and ill-treatment if they reveal any information of abuse to anyone, including evaluating clinicians. In the context of medico-legal evaluations of alleged torture and ill-treatment, informed consent is imperative. Informed consent requires disclosure of all material information – including the purpose of the evaluation – potential risks and benefits, the nature of the evaluation – including the possibility of taking photographs – limits on confidentiality – such as any mandatory reporting requirements of the clinician – how information gathered in the evaluations will be used and stored and who will have access to the information.

168. Consent should be confirmed once again at the end of the interview after the disclosure of specific information by the alleged victim and before the clinical assessment. Informed consent requires that the patients and alleged victims understand the information provided, with the most important information being thoroughly discussed, which may require translation or interpretation, and provide consent voluntarily. The information provided by the clinician should be accessible and comprehensible, meaning that, where needed, information should be available in accessible means, modes and formats of communication, and reasonable accommodation should be provided, such as supported decision-making. As discussed below in paragraph 273, informed consent should be sought at the outset

302 Keeping Children Safe, *The International Child Safeguarding Standards ... and How to Implement Them* (2014/2020), p. 10.
303 A/64/272, para. 18.

of all clinical evaluations of alleged or suspected torture or ill-treatment and fully documented.

169. Adult patients are always assumed to be competent to make decisions for themselves. Health professionals have an obligation to recognize and respect the legal capacity of all adults, including persons with disabilities and persons whose mental capacity has been impaired, and this encompasses respect for the individual's free and informed consent. Efforts should be taken by health professionals to communicate in a manner that is accessible and understandable for the individual. This may entail making information available in accessible formats, providing sign language interpretation or through the provision of supported decision-making. In situations in which significant efforts have been made and it is not possible to obtain the individual's free and informed consent, health professionals should not resort to substituting the individual's decision based on a determination of "best interests", but should take as a last resort the standard of "best interpretation of the will and preferences".[304] This standard implies ascertaining what the individual would have wanted instead of deciding on the basis of their best interests. The process should include consideration of the previously manifested preferences, values, attitudes, narratives and actions, inclusive of verbal and non-verbal communication, of the individual concerned.[305]

170. Those who are minors at the time of decision-making may be able to consent as consent has no specific age at which it becomes valid. Children's ability to consent develops as they learn to make increasingly complex and serious decisions and as such may relate to experience rather than to age. Therefore, children should be informed as fully as possible about the assessment and related procedures in a way that they can understand, ensuring accessible information and communication and adjusting the communication to their age and development. In many cases, given the complexity of understanding for a medico-legal evaluation, informing the parents and seeking their consent will be required or recommended, however, parental consent will not be valid if it is given against the child's best interests.[306] Furthermore, the age under which parents/legal guardians must be informed about any participation or procedure involving the child in their care varies among countries.[307] Therefore, there is a need to be informed about the local legal obligations in terms of informed consent by children and to choose processes that are in the best interests of the child. It is important to remember that informed consent does not absolve heath-care professionals from the duty to safeguard children and their best interests. This duty requires health-care professionals to ensure that any potential immediate and long-term risk to a child as a result of an assessment is identified and considered before seeking consent and carrying out such an assessment.[308] Children who are not yet developmentally able to understand their situation and alternatives should be given the opportunity to assent to treatment or to otherwise express their wishes, as part of their basic right to be heard.

171. The autonomy of individuals who refuse to provide consent for an evaluation should be respected and under no circumstances should they be forced to comply with an evaluation. In some cases, clinical examinations should be presumed to be conducted forcibly and without informed consent when they are based on profound discrimination and criminalization and in situations in which victims understand that State officials have the power to compel them to undergo an examination and non-compliance is likely to result in adverse legal outcomes, ill-treatment or reprisal. Forced hymen examinations to detect virginity and forced anal examination of individuals to detect same-sex activity are examples of such clinical examinations – they have no clinical value, represent forms of sexual assault and constitute ill-treatment and may amount to torture depending on the individual circumstances.[309]

304 Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014), para. 21.
305 A/HRC/37/56, para. 31.
306 Royal College of Paediatrics and Child Health: Ethics Advisory Committee, "Guidelines for the ethical conduct of medical research involving children", *Archives of Disease in Childhood*, vol. 82 (2000), pp. 177–182.
307 Pirkko Lepola and others, "Informed consent for paediatric clinical trials in Europe", *Archives of Disease in Childhood*, vol. 101 (2016), pp. 1017–1025.
308 Royal College of Paediatrics and Child Health, "Guidelines for the ethical conduct of medical research involving children".
309 Independent Forensic Expert Group, "Statement on virginity testing", *Torture Journal*, vol. 25, No. 1 (2015), pp. 62–68; and "Statement on anal examinations in cases of alleged homosexuality", *Torture Journal*, vol. 26, No. 2 (2016), pp. 85–91.

3. Confidentiality

172. Ethical codes, from the Hippocratic Oath to modern times, include the duty of confidentiality as a fundamental principle. Confidentiality also features prominently in WMA declarations, such as the Declaration of Lisbon, as well as the Nelson Mandela Rules. In some jurisdictions, the obligation of confidentiality is seen as so important that it is incorporated into national law. The duty of confidentiality is not absolute and may be ethically breached in exceptional circumstances in which failure to do so will foreseeably give rise to serious harm to the patient or others. Generally, however, the duty of confidentiality covering identifiable personal health information can be overridden only with the informed authorization of the patient.[310] Non-identifiable information can be used for other purposes and should be used preferably in all situations in which disclosure of the patient's identity is non-essential. This may be the case, for example, in the collection of data about patterns of torture or ill-treatment, although special care is required in securing such data. Dilemmas arise when health professionals are pressured or required by law to disclose identifiable information that would be likely to put patients at risk of harm. In such cases, the fundamental ethical obligations are to respect the autonomy and privacy of the patient and avoid harm. This supersedes other considerations. Health professionals should make clear to the court or the authority requesting information that they are bound by professional duties of confidentiality despite potential legal liability. Health professionals responding in this way are entitled to the support of their professional association and colleagues. In addition, during periods of armed conflict, international humanitarian law gives specific protection to doctor-patient confidentiality, requiring that doctors do not denounce people who are sick or wounded.[311] Health professionals cannot be compelled to disclose information about their patients in such situations, particularly in situations of armed conflict.

D. Health professionals with conflicting obligations

173. Health professionals might have conflicting responsibilities due to their circumstances of employment and/or have conflicting ethical obligations related to the setting of their encounter with the patient. In the case of health professionals employed in State institutions, particularly those working with the police, military, other security services or in the prison system, the interests of their employer and their non-medical colleagues may be in conflict with the best interests of the detainee/patient. Whatever the circumstances of their employment, all health professionals have a fundamental duty to act in the best interests of the people who they examine and treat. They cannot be obliged by contractual or other considerations to breach their core ethical obligations or compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly. In addition, health professionals may have conflicting ethical obligations, in that they owe a primary duty to the patient to promote that person's best interests and a general duty to society to ensure that justice is done and violations of human rights prevented. In such circumstances, the primary ethical obligation of health professionals is to act in the best interests of their patients. In situations in which institutional pressure is brought to bear on a health professional, they should ensure that they have mechanisms to resist such pressure, report it to their professional body and escalate their concerns about the health of their patients if their recommendations are not followed.[312]

1. Principles guiding health professionals with conflicting obligations

174. In all cases in which health professionals are acting for another party, they have an obligation to ensure that this is understood by the patient. Health professionals must identify themselves to patients and explain the purpose of any examination or treatment. Even when health professionals are appointed and paid

310 Except for common public health requirements, such as the reporting by name of individuals, for example, with infectious diseases, drug addiction or mental disorders, and acts of violence such as homicide, domestic violence, sexual assault and child and elder abuse.

311 Protocol I (art. 16) and Protocol II (art. 10) Additional to the Geneva Conventions of 1949.

312 Faculty of Forensic and Legal Medicine of the Royal College of Physicians, *Quality Standards for Healthcare Professionals Working with Victims of Torture in Detention* (London, 2019, reviewed 2022).

by a third party, they retain a clear duty to respect their core ethical obligations. They must refuse to comply with any procedures that may harm patients or leave them physically or psychologically vulnerable to harm. They must ensure that their contractual terms allow them professional independence to make clinical judgments. Health professionals must ensure that any person in custody has access to any medical examination and treatment needed. In situations in which the detainee is a minor or a vulnerable adult, doctors have additional duties to act as an advocate. Health professionals retain a general duty of confidentiality so that information should not be disclosed without the patient's knowledge. They must ensure that their medical records are kept confidential. Health professionals have a duty to monitor and speak out when services in which they are involved are unethical, abusive, inadequate or pose a potential threat to patients' health. In such cases, they have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult. They should report the matter to appropriate authorities or international agencies who can investigate, but without exposing patients, their families or themselves to any foreseeable serious risk of harm. Health professionals and professional associations should support colleagues who take such action on the basis of reasonable evidence.

2. Dilemmas arising from conflicting obligations

175. Dilemmas may occur when ethics and law are in contradiction. Circumstances can arise in situations in which the ethical duties of health professionals oblige them not to obey a particular law, such as a legal obligation to reveal confidential medical information about a patient or participate in harmful practices. There is consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or a regulation rather than compromise basic ethical precepts or expose patients to harm.

176. In some cases, two ethical obligations may be in conflict. International codes and ethical principles require the reporting of information concerning torture or ill-treatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have conflicting responsibilities: to the patient and to society at large, which has an interest in preventing torture and ill-treatment and ensuring perpetrators of abuse are brought to justice.

177. As previously stated, rule 32 (1) (c) of the Nelson Mandela Rules requires the confidentiality of medical information "unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others". In addition, rule 34 states that any signs of torture or ill-treatment should be reported to the "competent medical, administrative or judicial authority" and that: "Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm." Rule 71 requires prison directors to report torture and ill-treatment to a "competent authority that is independent of the prison administration and mandated to conduct prompt, impartial and effective investigations into the circumstances and causes of such cases". It has been noted that the exception to confidentiality in rule 32 (1) (c) should be understood narrowly and not as applying to the whole medical file. Rather, it requires an assessment of which specific pieces of information need to be communicated and at what level on a "need to know basis".[313] WMA has provided guidance to physicians on the circumstances in which breaches in confidentiality may be considered, for example when harm is believed to be imminent, serious (and irreversible), unavoidable except by unauthorized disclosure, and greater than the harm likely to result from disclosure. In determining the proportionality of these respective harms, the physician needs to assess and compare the seriousness of the harms and the likelihood of their occurrence. In cases of doubt, WMA recommends that physicians seek expert advice. It also recommends that disclosure should contain only the information necessary to prevent the anticipated harm and should be directed only to those who need the information in order to prevent the harm, that the physician inform the patient of the disclosure of information, explain the reason for the disclosure and seek the patient's cooperation if possible. Reasonable steps

313 Penal Reform International and the Human Rights Centre at the University of Essex, *Essex Paper 3: Initial Guidance on the Interpretation and Implementation of the UN Nelson Mandela Rules* (London, 2017).

should be taken to minimize the harm and offence to the patient that may arise from the disclosure. It is recommended that physicians should inform their patients that confidentiality might be breached for their own protection and that of any potential victim. The patient's cooperation should be enlisted if possible.

178. In applying this guidance to the context of clinical evaluations of alleged or suspected cases of torture or ill-treatment, health professionals need to balance the duty of not harming the alleged victim and that of preventing potential harm to others who may otherwise be subjected to unchecked torture practices. Before health professionals consider the possibility of breaching confidentiality without the alleged victim's consent, the health professional should reasonably believe that:

(a) Severe or life-threatening harm to others is reasonably certain to occur imminently (not only foreseeable and probable) if the health professional does not take action;

(b) Disclosure of information will prevent the reasonably certain and imminent serious or life-threatening harm to others;

(c) The risk of reprisals to alleged victims is deemed to be low by both the clinician and the alleged victim;

(d) There is sufficient clinical evidence, such as observed injuries and/or psychological distress, to warrant a suspicion of torture or ill-treatment;

(e) Information can be provided to an independent body that will conduct a prompt, impartial and effective investigation into the circumstances.

179. Health professionals should seek all opportunities to ensure the alleged victim's safety and that they will not be tortured again. Given these considerations, the circumstances under which health professionals may breach the duty of confidentiality are limited. For example, clinicians who observe evidence of patterns of abuse may report anonymous information to an independent body if they can do so without triggering reprisals against the torture victim. Clinicians working in prisons, places of detention, forensic institutions, and national (e.g. national human rights institutions and national preventive mechanisms) and international monitoring bodies may be in a position to observe evidence of patterns of abuse and report anonymous information, thereby preventing potential harm to others. A clinician who examines an alleged victim who fears reprisals and refuses to consent to a clinical evaluation, however, should not breach the primary ethical duties of "do no harm" and respect for autonomy over the obligation to document and report.

180. The clinician's capacity to respect autonomy and confidentiality establishes a foundation for trust that is essential in conducting an effective evaluation of physical and psychological evidence of torture and ill-treatment. While the ethical obligations of clinicians are the same in all encounters with patients and alleged victims, an individual's ability to exercise free choice about the disclosure of information may depend on the circumstances of the evaluation. For example, in therapeutic settings and medico-legal evaluations conducted by independent, non-governmental clinicians at the request of the alleged victim, there are generally no mandatory reporting requirements. In such circumstances, individuals typically view clinical evaluations of torture and ill-treatment to be in their best interests and the clinician's capacity to respect autonomy and confidentiality establishes a foundation for trust and, consequently, the disclosure of information. Documenting and reporting torture and ill-treatment in such encounters is entirely appropriate as long as informed consent is provided.

181. Although health professionals in State institutions have the same ethical obligations as other health professionals, in some State institutions, the conditions of their evaluations may make it difficult to establish trust with patients and alleged victims. State employees, particularly forensic experts and those working with the police, military or other security services or in the prison system, often have mandatory reporting requirements. In such settings, individuals may have limited power and choice in the evaluation and may not wish to speak openly about the alleged abuse for fear of reprisals against them or family members. The health professionals in these circumstances should, nevertheless, comply with their ethical obligations and do their best to facilitate trust and rapport with the patient/detainee. As stated in paragraphs 166–167 above, before beginning any evaluation, the clinician must identify themselves, inform the individual of the purpose and content of the evaluation and disclose any mandatory reporting requirements. Regulations may not permit the patient to refuse examination, but the patient has the option of choosing whether to cooperate with the evaluation and/or to disclose the cause of any injury. In such cases, the clinician must respect the patient's decision,

including the decision not to cooperate with the evaluation. Clinicians should not examine individuals for the court without the consent of the individual regardless of the law. Forensic doctors may not falsify their reports but must provide impartial evidence, including making clear in their reports any evidence of maltreatment.[314] If the detainee does not give consent for the evaluation (or any part of the evaluation) or its documentation, the clinician should document the reason for the lack of consent (see also para. 273).

182. As stated above, health professionals must also bear in mind that reporting abuse to the authorities in whose jurisdiction it is alleged to have occurred may well entail risk of harm for the patient or for others, including the whistle-blower. Health professionals must not knowingly place individuals in danger of reprisal. They are not exempt from taking action but should use discretion and must consider reporting the information to a responsible body outside the immediate jurisdiction or, in situations in which this would not entail foreseeable risks to health professionals and patients, report it in a non-identifiable manner. Clearly, if the latter solution is taken, health professionals must take into account the likelihood of pressure being brought on them to disclose identifying data or the possibility of having their medical records forcibly seized. While there are no easy solutions, health professionals should be guided by the basic injunction to avoid harm above all other considerations and seek advice, where possible, from national or international health professional bodies.

314 Vincent Iacopino and others, "Physician complicity in misrepresentation and omission of evidence of torture in postdetention medical examinations in Turkey", *Journal of the American Medical Association*, vol. 276, No. 5 (1996), pp. 396–402.

183. The Convention against Torture envisages three main pillars in the fight against torture: the obligation of States to ensure justice and to prevent and redress all acts of torture. The obligation to investigate is central to the realization of all three main pillars.[315] The Special Rapporteur on torture specified that:

> The obligation to investigate acts of torture is initiated by the existence of reasonable grounds. Evidence of torture that rises to the level of "proof" in criminal proceedings (that is, beyond a reasonable doubt) should not be necessary to establish State recognition and responsibility for torture or to trigger the obligations that do not involve assigning individual guilt and punishment, such as the implementation of public policies for prevention and administrative or civil remedies, including rehabilitation. This is important because States often claim that torture and their corresponding obligations to address it do not exist because torture has never been "proven" in court.[316]

184. States are required under international law to investigate reported incidents of torture promptly, impartially and effectively.[317] In situations in which evidence warrants it, a State within whose jurisdiction a person alleged to have committed or participated in torture is present must submit the case to its own competent authorities for the purpose of investigation and prosecution under national or local criminal laws unless it extradites the alleged perpetrator to another State that has competent jurisdiction.[318] The fundamental principles of any viable investigation into incidents of torture are competence, impartiality, independence, adequate resources, promptness, effectiveness, thoroughness, sensitivity to gender, age, disability and similarly recognized characteristics, victim involvement and public scrutiny. These elements can be adapted to any legal system and should guide all investigations of alleged torture.

185. Investigations may take the form of a criminal investigation into specific acts of torture, particularly as defined in article 1 of the Convention against Torture or torture as an element of war crimes, crimes against humanity or genocide, or other forms of cruel, inhuman or degrading treatment or punishment (ill-treatment).[319] Investigation of such acts may also come within the mandate of national human rights institutions, fact-finding missions or commissions of inquiry, which exercise important investigative functions.[320] Evidence of torture is relevant, and often of critical importance, in a range of legal proceedings, for example: civil and public law inquiries, claims concerning reparation for torture, applications for asylum and non-refoulement, national, regional and international human rights complaints procedures, and criminal proceedings, including the exclusion of evidence obtained as a result of torture. Irrespective of the legal context in which it takes place, in order to combat impunity any investigation or other procedure to establish the facts of, and responsibility for, torture or ill-treatment should be carried out in conformity with the standards set out in this manual.

186. Under the Convention against Torture, States must take legislative, institutional, administrative, budgetary and other measures to ensure that an adequate framework for prompt, impartial, independent, effective and gender- and child-sensitive investigations is in place.[321] The Special Rapporteur on torture has recommended adopting and implementing the manual "as an investigative tool and standard".[322] States are required to make torture a specific offence under national law, which is subject to proportionate penalties that reflect the gravity of the crime;[323] establish jurisdiction over the offence of torture, including by providing for the exercise of the principle of universal jurisdiction;[324] and remove legal barriers, such as amnesties, immunities, statutes of limitation or other such procedural restrictions,[325] including pardons or other measures resulting in impunity.[326] States must guarantee the rights of victims and

315 A/69/387, para. 21.
316 Ibid., para. 25.
317 Convention against Torture, arts. 12–13. See also A/69/387, paras. 22–28.
318 Convention against Torture, arts. 5–8.
319 See, inter alia, Rome Statute, arts. 8 (2) (a) (ii) and (c) (i), 7 (1) (f) and 6 (b).
320 OHCHR, *Commissions of Inquiry and Fact-Finding Missions on International Human Rights and Humanitarian Law: Guidance and Practice* (New York and Geneva, 2015).
321 Convention against Torture, art. 2; and Committee against Torture, general comment No. 2 (2007), para. 2.
322 A/69/387, para. 67.
323 Committee against Torture, general comment No. 2 (2007), paras. 8–11.
324 A/HRC/4/33, paras. 41–47.
325 Committee against Torture, general comment No. 2 (2007), para. 5; and general comment No. 3 (2012), para. 38.
326 Inter-American Court of Human Rights, *Barrios Altos v. Peru* (see footnote 102); and *Barrios Altos and La Cantuta v. Peru* (see footnote 103). See also Committee against Torture, *Urra Gurridi v. Spain* (CAT/C/34/D/212/2002), para. 6.7.

witnesses at all stages of the investigation, including the right to lodge complaints, to participate in proceedings, to be protected from threats and harassment,[327] to have their right to privacy respected, as well as the right to an effective remedy and to reparation. Reparation must be victim-oriented, gender-sensitive, adequate, effective, prompt and comprehensive, tailored to the particular needs of the victim(s) and proportionate to the gravity of the harm suffered.[328]

187. In situations in which investigative procedures are inadequate because of a lack of resources or expertise, the appearance of bias, the apparent existence of a pattern of abuse or other substantial reasons, States should pursue investigations through an independent body or mechanism, such as a commission of inquiry or similar procedure. Members of that body must be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any institution, agency or person that may be the subject of the inquiry. Investigative bodies, such as commissions of inquiry, should be provided with adequate financial and human resources.[329]

188. International law recognizes the important role in investigations of actors other than criminal justice investigatory bodies, including independent bodies at the national, regional and international level, and non-State actors, such as human rights defenders who document torture, prompt and monitor investigations, and represent victims of torture.[330] States should respect the exercise of legitimate functions by these actors.[331] Any mandated or non-mandated actor who investigates torture or ill-treatment, or whose role has a bearing on the investigation of torture or ill-treatment, should adhere to the standards set out in this manual.

189. Section A describes the broad purpose of an investigation into torture or ill-treatment. Section B sets out basic principles concerning the effective investigation and documentation of torture and ill-treatment. Section C suggests procedures for conducting an investigation into alleged torture or ill-treatment, first considering the decision regarding the appropriate investigative authority, then offering guidelines regarding the collection of testimony from the reported victim and other witnesses and other evidence. Section D provides guidelines for establishing a special independent commission of inquiry. These guidelines are based on the experiences of practitioners and the practice of several countries that have established independent commissions to investigate alleged human rights abuses, including extrajudicial killings, torture and disappearances. Section E describes the role of prosecutors, judges and other actors in the investigation of torture or ill-treatment. Section F sets forth basic principles on the use of evidence of torture or ill-treatment in other legal procedures.

A. Purposes of an investigation into torture or ill-treatment

190. The broad purpose of the investigation is to establish the facts relating to alleged incidents of torture or ill-treatment, with a view to identifying those responsible for the incidents and facilitating their prosecution, or for use in the context of other procedures designed to obtain redress or protection for victims. The issues addressed here may also be relevant for other types of investigations of torture or ill-treatment. To fulfil this purpose, those carrying out the investigation must, at a minimum, seek to (a) obtain statements from the victims of alleged torture; (b) recover and preserve evidence, including medical evidence, related to the alleged torture or ill-treatment to aid in any potential prosecution of those responsible; (c) identify possible witnesses and perpetrators and obtain statements from them concerning the alleged torture or ill-treatment; and (d) determine how, when and where the alleged incidents of torture or ill-treatment occurred as well as any pattern or practice within which it took place, including identifying particular locations and perpetrators, methods used and the role of corruption, and other contextual factors, such as gender, sexual orientation, gender identity, disability, race, ethnicity, nationality, age and socioeconomic status of the victim(s).

327 Committee against Torture, general comment No. 3 (2012), paras. 29–36.

328 Ibid., paras. 6–18; Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law; and African Commission on Human and Peoples' Rights, general comment No. 4.

329 A/HRC/19/61, para. 58.

330 A/69/387, para. 54.

331 Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (General Assembly resolution 53/144, annex), inter alia, art. 9; and updated set of principles for the protection and promotion of human rights through action to combat impunity, principle 19.

B. Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

191. The following principles are based on international legal standards as discussed in chapter I and examples of good practice, and represent a consensus among individuals and organizations having expertise in the investigation of torture and ill-treatment. The purposes of effective investigation and documentation of torture and ill-treatment include the following (see annex I):

(a) Clarification of the facts and establishment and acknowledgement of individual and State responsibility for victims and their families;

(b) Identification of measures needed to prevent recurrence;

(c) Facilitation of prosecution or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.[332]

1. Elements of the crime of torture

192. Facts to be determined in an investigation depend on the elements of the crime (or other legal context) being investigated, as recognized in the jurisdiction or before the tribunal in question. For torture, as defined in article 1 of the Convention against Torture, these elements consist of the intentional infliction of severe pain or suffering, whether physical or mental, the relevant purpose, and the level of involvement of persons acting in an official capacity. The elements of cruel, inhuman or degrading treatment or punishment consist of the multiple forms of ill-treatment that have been identified in international instruments, jurisprudence and relevant practice.[333] Torture or ill-treatment committed as elements of international crimes require additional elements to be proven, such as nexus to an armed conflict for torture as a war crime, or being part of a widespread or systematic attack against any civilian population for torture as a crime against humanity.[334] Gender-based crimes committed against men, women, boys, girls or transgender or intersex persons, racially, ethnically or politically motivated crimes and crimes abusing vulnerability, such as of children or persons with disabilities, may warrant special consideration. They may constitute concurrent crimes of torture and rape, or torture and other relevant offences related to the specific form of abuse respectively.[335] The investigation of such crimes requires establishing the relevant facts, patterns and causes of the crime, particularly discrimination, also with a view to preventing recurrence, including adequate measures of protection.

2. Prompt, independent and effective investigations

193. States should establish, preferably on a statutory basis, mechanisms with full investigatory powers that are institutionally and functionally independent, such as independent police complaints commissions or ombudspersons, to ensure impartiality.[336] Investigative bodies should reflect the diversity of the communities that they serve.[337] States must ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be carried out wherever there is reasonable ground to believe that an act of torture or ill-treatment has been committed. A prompt investigation is essential in order to ensure the protection of the victim and to avoid the risk that any traces of torture or ill-treatment might disappear.[338] Investigations need to be commenced without any delay, taking place within hours or, at the most, a few days after the suspicion of torture

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332 Adequate reparation includes restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition, as set out in the Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law. See also Committee against Torture, general comment No. 3 (2012).

333 A/HRC/13/39, para. 60.

334 See, for example, International Criminal Court, Elements of Crimes (2010), arts. 7 (1) (f), 8 (2) (a) (ii)-1 and 8 (2) (c) (i)-4.

335 A/HRC/31/57, inter alia, paras. 51–53.

336 Council of Europe, "Opinion of the Commissioner for Human Rights concerning independent and effective determination of complaints against the police", CommDH(2009)4, 12 March 2009.

337 Investigative bodies should focus on incorporating anti-bias measures into their recruitment, training, education and evaluation of investigators. See Michael H. Tulloch, *Report of the Independent Police Oversight Review* (Ontario, 2017), sects. 4.100, para. 9, and 4.730; and Committee on the Elimination of Racial Discrimination, general recommendation 31 (2005) para. 1 (b).

338 Committee against Torture, *Blanco Abad v. Spain* (CAT/C/20/D/59/1996), para. 8.2.

or ill-treatment has arisen, and to be conducted expeditiously throughout.[339] The lack of a prompt or expeditious investigation does not provide a justification for lack of action due to the passage of time, as torture and ill-treatment ought not to be subject to any statutes of limitation.[340] Investigations must be carried out in an impartial manner, taking into account potential conflicts of interest, hierarchical relationships with potential suspects and the specific conduct of the investigators.[341] An impartial investigation must be thorough and include several essential investigatory steps, including a forensic medical investigation.[342] The investigators, who should be independent of the suspected perpetrators and the agency that they serve, must be competent and impartial. They must have access to or be empowered to commission investigations by impartial medical or other experts. The methods used to carry out these investigations must meet the highest professional standards. The investigation should be conducted transparently and the victims, their lawyers and the judicial authority should have access to the findings. Authorities should systematically collect and regularly publish disaggregated data on the number, content and outcome of complaints and investigations relating to torture or ill-treatment.[343] An independent review body should be tasked with reviewing the handling of specific complaints and investigations relating to torture or ill-treatment upon request and with examining, and annually reporting on, the effectiveness of relevant complaints procedures and investigations.[344]

3. Adequate resources, capacity and competence

194. The investigative authority should have the power and obligation to obtain all the information necessary for the inquiry.[345] The persons conducting the investigation must have at their disposal all the necessary budgetary and technical resources for effective investigation. The investigative body must also have the authority to oblige all those acting in an official capacity who were allegedly involved in torture or ill-treatment to appear and testify. The same applies to any witness. To this end, the investigative authority is entitled to issue summonses to witnesses, including any officials allegedly involved and to demand the production of evidence.

4. Protection measures

195. Alleged victims of torture or ill-treatment, witnesses and those conducting the investigation and their families must be protected from violence, threats of violence or any other form of intimidation or reprisals that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment should be removed from any position of control or power, whether direct or indirect, over complainants, witnesses or their families, as well as those conducting the investigation.[346] In addition, States should take the steps necessary to protect the victims and/or witnesses, such as moving them into a safe location (e.g. witness protection and safe houses).

5. Rights of victims in the context of investigations

196. Alleged victims of torture or ill-treatment have the right to complain about such treatment and to have such complaints promptly and impartially examined and the right to an effective remedy.[347] States must ensure that the right to complain can be exercised effectively. This includes the right: (a) to be informed about available remedies and complaints procedures;[348] (b) to have access to a lawyer, to a physician (upon being taken into custody and regularly during detention), to family members[349] and to diplomatic and consular representatives (for

339 Convention against Torture, arts. 12–13; and Inter-American Convention to Prevent and Punish Torture, art. 8. See also A/69/387, paras. 24 and 68 (a).
340 European Court of Human Rights, *Cestaro v. Italy* (see footnote 138), para. 208. See also, for example, CCPR/C/JOR/CO/5, para. 17 (a); and CAT/C/THA/CO/1, para. 9 (c).
341 Nelson Mandela Rules, rule 57 (3).
342 See, for example, A/68/295.
343 Erik Svandize, *Effective Investigation of Ill-Treatment: Guidelines on European Standards*, 2nd ed. (Council of Europe, 2014), pp. 15 and 65; and Committee against Torture, general comment No. 2 (2007), para. 23. See also CAT/C/57/4, paras. 59 and 75.
344 Svandize, *Effective Investigation of Ill-Treatment*, pp. 42 and 58; and Council of Europe, "Opinion of the Commissioner for Human Rights", paras. 80–87.
345 Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.
346 Nelson Mandela Rules, rule 71 (3).
347 Committee against Torture, general comment No. 3 (2012), paras. 25 and 33–34.
348 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 13; and Nelson Mandela Rules, rule 54 (b).
349 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principles 15–19 and 24–25; Nelson Mandela Rules, rules 58–61; and European Committee for the Prevention of Torture, "12th general report on the CPT's activities covering the period 1 January to 31 December 2001", CPT/Inf(2002)15, para. 40. See, on health-care services in detention, Nelson Mandela Rules, rules 24–35; and Svandize, *Effective Investigations of Ill-Treatment*, pp. 25–30.

foreign nationals[350] and for refugees and stateless persons);[351] (c) to lodge complaints in a timely and confidential manner;[352] and (d) to have access to external judicial and monitoring bodies.[353] "Complaints about torture should be recorded in writing, and a forensic medical examination (including, if appropriate, by a forensic psychiatrist) should be immediately ordered."[354] It is also in the public interest that any person is able to raise allegations of torture or ill-treatment, or report torture or ill-treatment, without the risk that such persons and their relatives and legal representatives and human rights defenders are exposed to adverse consequences as a result of making and pursuing a complaint.[355]

197. Alleged victims of torture or ill-treatment and their legal representatives must be informed of, and have access to, any hearing, as well as to all information relevant to the investigation, and must be entitled to present other evidence. Moreover, they must be able to challenge investigative measures, or the lack thereof, before an independent body and, where necessary, be provided with legal aid.[356] Authorities must ensure the rights of victims to security, privacy and physical and mental integrity, and take measures to minimize the risk of traumatization throughout the course of investigations and other relevant legal proceedings.[357] In cases of investigating sexual violence or abuse of children or other vulnerable persons, the authorities should pursue an approach that fully takes into consideration the characteristics of victims and the impact of the particular form of torture.

6. Independent commission of inquiry

198. In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States must ensure that investigations are carried out through an independent commission of inquiry or similar procedure. Members of such a commission should be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any suspected perpetrators and the institutions or agencies that they may serve. The commission must have the authority to obtain all information necessary to the inquiry and should conduct the inquiry as provided for under these principles.[358] A written report, made within a reasonable time, must include the scope of the inquiry, procedures and methods used to evaluate evidence as well as the conclusions and recommendations based on findings of fact and on applicable law. The publication of findings should be in accordance with the victims' best interests. Therefore, it should take into account the duty of confidentiality in examinations and the risk for the victims' integrity as a result of the findings being made public. It must also describe in detail specific events that were found to have occurred and the evidence upon which such findings were based and list the names of witnesses who testified with the exception of those whose identities have been withheld for their own protection. The State must, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate the steps to be taken in response (see paras. 238–251 below).

7. Medical expert's report

199. Medical experts involved in the investigation of torture or ill-treatment should behave at all times in conformity with the highest ethical standards and, in particular, must obtain informed consent before any examination is carried out. The examination must conform to established standards of medical practice. In particular, examinations must be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials. The medical expert should promptly prepare

350 Nelson Mandela Rules, rule 62 (1); Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 16 (2); and Vienna Convention on Consular Relations, art. 36 (1).

351 Nelson Mandela Rules, rule 62 (2).

352 Ibid., rules 56–57; Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 33 (1)–(3); and Svandize, *Effective Investigations of Ill-Treatment,* pp. 35–37.

353 Nelson Mandela Rules, rule 56 (3); and Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principles 29 and 33 (4). See also Inter-American Commission on Human Rights, *Report on the Human Rights of Persons Deprived of Liberty in the Americas* (2011), para. 254.

354 A/62/221, para. 53 (a). See also Committee against Torture, general comment No. 3 (2012), para. 25.

355 A/69/387, para. 55.

356 Svandize, *Effective Investigation of Ill-Treatment,* p. 58, para. 4.5.1.

357 Committee against Torture, general comment No. 3 (2012), para. 21; and Sara Ferro Ribeiro and Danaé van der Straten Ponthoz, *International Protocol on the Documentation and Investigation of Sexual Violence in Conflict – Best Practice on the Documentation of Sexual Violence as a Crime or Violation of International Law,* 2nd ed. (London, 2017), p. 239, which lists the following strategies to mitigate retraumatization: (a) ensuring physical and emotional safety before, during and after interview; (b) promoting trustworthiness; (c) choice; (d) collaboration and participation; and (e) empowerment.

358 Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.

an accurate written report. This report should include at least the following (see annex I):

(a) *The circumstances of the interview.* The name of the subject and name and affiliation of those present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic or house); any appropriate circumstances at the time of the examination (e.g. the nature of any restrictions on arrival or during the examination, the presence of security forces during the examination, the demeanour of those accompanying the prisoner and any threatening statements to the examiner); and any other relevant factors;

(b) *The background.* A detailed record of the subject's account of events as given during the interview, including alleged methods of torture or ill-treatment, the time at which torture or ill-treatment was alleged to have occurred and all complaints of physical and psychological symptoms;

(c) *A physical and psychological examination.* A record of all physical and psychological findings upon clinical examination, including appropriate diagnostic tests, body diagrams to record the location and nature of all injuries and, where possible, colour photographs of all injuries;

(d) *An opinion.* An interpretation as to the probable relationship of physical and psychological findings to possible torture or ill-treatment. A recommendation concerning any necessary medical and/or psychological treatment or further examination(s) should also be given;

(e) *A record of authorship*. The report should clearly identify those carrying out the examination and their authority and should be signed.

200. Reports should be confidential and communicated to the subjects or their nominated representative. Reports should be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that reports are delivered securely to these persons. Reports should not be made available to any other persons, except with the consent of the subjects or when authorized by a court empowered to enforce the transfer. For general considerations about written reports following allegations of torture, see chapter IV. Chapters V and VI describe in detail the physical and psychological assessments, respectively.

C. Procedures involved in an investigation of torture or ill-treatment

1. Determination of the appropriate investigative body

201. States must ensure that any investigation of torture is carried out by an independent and impartial body, which has no institutional links to the alleged perpetrator(s) and is free from bias.[359] In cases in which persons acting in an official capacity are suspected of being involved in torture, including possible orders for the use of torture by ministers, ministerial aides, officers acting with the knowledge of ministers, senior officers in State ministries, senior military leaders or others in similar positions of authority, or tolerance of torture by such individuals, an objective and impartial investigation may not be possible unless a specially constituted independent body is established (such as a commission of inquiry). A specially constituted independent investigative body may also be necessary in situations in which the public interest would be served by it, particularly where investigations by regular investigative agencies are in question because of a lack of capacity, expertise or impartiality or for other reasons, including the importance of the matter, the apparent existence of a pattern of abuse, complaints from the person or other substantial reasons.

202. States must consider the following factors when deciding to establish a specially constituted independent body or mechanism, such as a commission of inquiry. First, persons subject to an inquiry should be guaranteed the minimum procedural safeguards recognized in international law at all stages of the investigation. Second, investigators should have the support of adequate technical and administrative personnel, as well as access to objective, impartial legal advice to ensure that the investigation will produce admissible evidence for criminal or other legal proceedings. Third, investigators should receive the full scope of the State's

359 Nelson Mandela Rules, rule 71; Committee against Torture, general comment No. 3 (2012), para. 23; and CAT/C/DEU/CO/5, para. 19.

resources and powers. Finally, investigators should have the power to seek help from the international community of experts in law and medicine.

203. States are required to "ensure that the fundamental principles of investigation … are … officially recognized among relevant departments and personnel, including prosecutors, defence attorneys, judges, law enforcement, prison and military personnel, forensic and health professionals and those responsible for detainee health care".[360] States must provide training, and adequate guidance and instructions, on international standards concerning the investigation of torture or ill-treatment, as set out in this manual, and on good practice to any persons involved in relevant investigations and other legal proceedings.[361] Such measures should include a focus on specific considerations applicable in cases of investigating sexual violence or abuse of children or other vulnerable persons, such as the need for a gender- and child-sensitive approach.

2. Planning and preparing an investigation

204. Investigating bodies must carefully plan and prepare their investigations into torture or ill-treatment. Essential planning considerations include, in particular: (a) conducting thorough and dynamic risk and threat assessments; (b) selecting, training and vetting members of the investigating team (including investigators, possible interpreters, intermediaries, analysts and support staff); (c) preparing a written investigation plan; (d) mapping support services to which the victim can be referred as needed; (e) considering what evidence to collect and how to safely record, store, transport, organize and analyse such evidence as appropriate; (f) putting in place codes of conduct and standard operating procedures, including appropriate self-care procedures to minimize the risk of secondary trauma for members of the investigating team; (g) selecting an interview location that is safe, private, neutral and comfortable; and (h) putting in place protective measures for victims and witnesses.

205. Considering that there may be multiple (national and international) actors with varying mandates relating to the investigation of torture or ill-treatment, investigators need to be mindful, from the earliest stages and throughout any investigation, of the need for co-ordination. Investigators should be equipped with knowledge and skills on the use of consolidating statements. Investigators and other actors should seek to avoid taking additional or duplicative statements from victims and witnesses in instances in which they have already been interviewed, particularly to avoid the risk of retraumatization and of undermining trust in the work and effectiveness of justice procedures. This includes adopting a team approach involving legal investigators and medical examiners who also want and need to take a detailed history of events.

3. Conducting an investigation

206. Investigating bodies must conduct, as promptly and expeditiously as possible, the full range of generally recognized investigative measures with a view to establishing a record that is as comprehensive and accurate as possible in the circumstances of the particular case. Such investigative steps include gathering: (a) testimonial evidence (i.e. interviewing the alleged victims, witnesses and the alleged perpetrator(s));[362] (b) physical evidence, including forensic evidence; (c) digital evidence; and (d) documentary evidence, both in relation to specific acts of torture or ill-treatment and relevant elements of the crime, where appropriate, and broader patterns of torture and ill-treatment.

(a) Interviewing alleged victims and other witnesses

207. Because of the nature of torture cases and the trauma individuals suffer as a result, often including a devastating sense of powerlessness, it is particularly important to show sensitivity to the alleged torture victim and other witnesses by putting in place measures and procedures that reduce the risk of further traumatization or retraumatization.[363] The State must protect alleged victims of torture and witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Investigators must inform witnesses about the consequences of their involvement

360 A/69/387, para. 66.

361 Committee against Torture, general comment No. 3 (2012), para. 35; and Inter-American Court of Human Rights, *Espinoza Gonzáles v Peru*, paras. 323–327.

362 For guidance on effective interviewing and implementation of safeguards during questioning, see the Principles on Effective Interviewing for Investigations and Information Gathering (2021). Available at www.apt.ch/sites/default/files/publications/apt_PoEI_EN_08.pdf.

363 Committee against Torture, general comment No. 3 (2012), para. 21. Regarding the need for "methodological training in order to prevent re-traumatization of victims of torture or ill-treatment", see general comment No. 3 (2012), para. 35.

in the investigation and about any subsequent developments in the case that may affect them.

(i) Informed consent and other protection for the alleged victims

208. From the outset, alleged victims should be informed, wherever possible, of the nature of the proceedings, why their evidence is being sought, and if and how evidence offered by them may be used. Investigators should explain to the alleged victims which portions of the investigation will be public information and which portions will be confidential and establish a mechanism for making these determinations. Every effort should be made to accommodate the schedule and wishes of the alleged victims. Alleged victims should be regularly informed of the progress of the investigation, particularly following interviews and examinations. The alleged victims should also be notified of all key hearings in the investigation and prosecution of the case. The investigators should inform the alleged victims of the arrest of the suspected perpetrators. Alleged victims of torture or ill-treatment should be given contact information for advocacy and treatment groups that might be of assistance to them. Investigators should work with such groups within their jurisdiction to ensure that there is a mutual exchange of information and training concerning torture and ill-treatment.

209. Seeking informed consent from children involves their parents or legal guardians, but also consideration of possible independent consent from the child in addition to that of responsible adults. It requires consideration of safeguarding the child's best interests (see para. 170 and annex II below).

(ii) Selection of the investigator

210. The authorities investigating the case must identify a person primarily responsible for interviewing the alleged victims. While the alleged victims may need to discuss their case with both legal and medical professionals, the investigating team should make every effort to minimize unnecessary repetition of such persons' accounts of events. In selecting a person as the primary investigator with responsibility for the alleged victims, special consideration should be given to the alleged victims' preference for a person of the same gender, the same cultural background or the ability to communicate in their native language. The primary investigator should have prior training or experience in documenting torture and in working with victims of trauma, including torture. Where appropriate, the primary investigator should also have specific expertise in dealing with child victims of torture or ill-treatment, or victims of sexual torture. Children who may have been traumatized by torture should not be isolated from positive and supportive adult contact. The quality of evidence may be compromised if children are interviewed by those without appropriate skills so only investigators who possess sufficient experience in interviewing children, or expertise in working with them, should be involved in interviewing child victims of torture or ill-treatment. Interviews that are not properly conducted may retraumatize victims, place them at additional risk, affect the quality and reliability of the information provided and distort victims' memory of the events.[364] At the same time, while being careful to ensure that children are interviewed by professionals with appropriate skills, children must not be isolated because of fear of contaminating evidence from those who must continue to have ordinary and caring contact with them. Child well-being and best interests must be paramount at all times. Information and guidance about torture, and interviewing torture victims, is available from sources, including this manual, several professional and training publications, training courses and professional conferences.[365] The investigator should also have access to international expert advice and assistance throughout the investigation.

(iii) Context of the investigation

211. Investigators should carefully consider the context in which they are working, take necessary precautions and provide safeguards accordingly. If interviewing persons who are still imprisoned or in similar situations in which reprisals are possible,

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364 Ferro Ribeiro and van der Straten Ponthoz, *International Protocol on the Documentation and Investigation of Sexual Violence*, p. 161.

365 Materials include Polona Tepina, *The Torture Reporting Handbook: How to Document and Respond to Allegations of Torture within the International System for the Protection of Human Rights*, 2nd ed. (Colchester, Human Rights Centre, University of Essex, 2015), including appendices that list relevant instruments and further information and reading; Svandize, *Effective Investigation of Ill-Treatment*, which has six appendices, including key European documents; Asia Pacific Forum of National Human Rights Institutions, *Undertaking Effective Investigations: A Guide for National Human Rights Institutions* (Sydney, 2013, updated in 2018); Association for the Prevention of Torture, Asia Pacific Forum of National Human Rights Institutions and OHCHR, *Preventing Torture: An Operational Guide for National Human Rights Institutions* (Geneva, 2010); Redress Trust, *Taking Complaints of Torture Seriously: Rights of Victims and Responsibilities of Authorities* (London, 2004); and Foley, *Combating Torture* (see footnote 240). On sexual violence, see African Commission on Human and Peoples' Rights, *Guidelines on Combating Sexual Violence and its Consequences in Africa* (2017); and *Ferro Ribeiro and van der Straten Ponthoz, International Protocol on the Documentation and Investigation of Sexual Violence*. For interviews of child abuse victims, see United States of America, National Institute of Child Health and Human Development, "Revised NICHD Protocol: interview guide" (2014).

the interviewer should use care not to put them in danger. The interviewer must choose a place for a private interview where the witness feels comfortable to talk freely, as much as possible, and make every effort to obtain such conditions.

212. Investigations occur in a variety of political contexts. This results in important differences in the manner in which investigations should be conducted. The investigator must adapt the following guidelines according to the particular situation and purpose of the investigation.

213. Investigations taking place in challenging contexts, such as during armed conflict or in extremely resource-limited contexts, must nevertheless take all reasonable steps to comply with the standards set out in this manual.[366] In situations in which strict compliance with the standards proves impossible, for instance in contexts in which the capacity or resources are not present, States should endeavour to draw on international expertise and support in order to comply with their obligations.

214. The political context may be hostile towards the alleged victim and the examiner, for example, when detainees are interviewed while they are held in prison by their Governments or while they are detained by foreign Governments in order to be deported. In countries where asylum seekers are examined in order to establish evidence of torture or ill-treatment, the reluctance to acknowledge claims of trauma and torture or ill-treatment may be politically motivated. The possibility of further endangering the safety of the detainee is very real and must be taken into account during every part of the investigative process. Even in cases in which persons alleging torture or ill-treatment are not in imminent danger, investigators should use great care in their contact with them. The investigator's choice of language and attitude will greatly affect the alleged victim's ability and willingness to be interviewed. The location of the interview should be as safe and comfortable as possible, including access to toilet facilities and refreshments. Sufficient time should be allotted to interview the alleged victim. Investigators should not expect to get the full account of events during the first interview. Questions of a private nature may be traumatic for the alleged victim. The investigator must be sensitive in tone, phrasing and sequencing of questions, given the traumatic nature of the alleged victim's testimony. The witness must be told of the right to stop the questioning at any time, to take a break if needed or to choose not to respond to any question.

215. Psychological counsellors or those trained in working with torture victims should be accessible, if possible, to the alleged victim, witnesses and members of the investigating team. Retelling the facts of torture or ill-treatment may cause the person to relive the experience or suffer other trauma-related symptoms (see paras. 277–280 below). Hearing details of torture may result in secondary trauma symptoms to interviewers, and they must be encouraged to discuss their reactions with one another, respecting their professional ethical requirements of confidentiality. Wherever possible, this should be with the help of an experienced facilitator. There are two particular risks to be aware of: first, there is a danger that the interviewers may identify with those alleging torture and not be sufficiently challenging of the account of events; and, second, the interviewers may become so used to hearing histories of torture that they diminish in their own minds the experiences of the person being interviewed.

(iv) Safety of witness

216. The victim's testimony is crucial in establishing the occurrence of torture or ill-treatment. Other witnesses play an important role in investigations of torture or ill-treatment, including as eyewitnesses of relevant acts or omissions, or by testifying on the condition of the alleged victim before and after the alleged torture or ill-treatment, on detention conditions, other relevant circumstances, the identities of perpetrators or as expert witnesses. Witnesses may be vulnerable, uncooperative or hostile, and can therefore pose a challenge for the investigating authorities. States need to consider the difficult position in which witnesses typically find themselves when involved in investigations of torture or ill-treatment. The State is responsible for protecting complainants, victims and witnesses, their families and legal representatives, and human rights defenders from violence, threats of violence or any

366 See also European Court of Human Rights, *Mocanu and Others v. Romania*, application Nos. 10865/09, 45886/07 and 32431/08, Judgment, 17 September 2014, para. 319: "Even where the events leading to the duty to investigate occur in a context of generalised violence and investigators are confronted with obstacles and constraints which compel the use of less effective measures of investigation or cause an investigation to be delayed, the fact remains that Articles 2 and 3 [of the European Convention on Human Rights, the right to life and the prohibition of torture, respectively] entail that all reasonable steps must be taken to ensure than an effective and independent investigation is conducted."

other form of intimidation that may arise pursuant to the investigation and specific investigative measures, such as identity parades. Those potentially implicated in torture or ill-treatment should be removed from any position of control or power, whether direct or indirect over complainants, witnesses and their families as well as those conducting investigations. Investigators must give constant consideration to the effect of the investigation on the safety of the person alleging torture or ill-treatment and other witnesses. The rights of witnesses, such as the right to privacy, may only be interfered with to the extent absolutely necessary for the investigation and in conformity with recognized international human rights standards.

217. One technique suggested for providing a measure of safety to interviewees, including persons deprived of their liberty in countries in conflict situations, is to keep a secure record of the identities of people visited so that investigators can follow up on the safety of those individuals during a return visit. Investigators must be allowed to talk to anyone and everyone, freely and in private, and be allowed to repeat a visit to the same person (thus the need for traceable identities of those interviewed) as the need arises. Not all countries accept these conditions and investigators may find it difficult to obtain such guarantees. In cases in which witnesses are likely to be put in danger because of their testimony, the investigator should seek other forms of evidence referred to in this chapter that can be secured without creating such a risk.

218. Persons deprived of their liberty are at higher risk of reprisals as a result of their cooperation with investigators. Persons deprived of their liberty might have different reactions to different situations. In one situation, persons deprived of their liberty may unwittingly put themselves in danger by speaking out too rashly, thinking that they are protected by the very presence of the "outside" investigator. This may not be the case. In other situations, investigators may come up against a "wall of silence", as persons deprived of their liberty may be too intimidated to trust anyone, even when offered talks in private. In the latter situation, it may be necessary to start with "group briefings" (but not group interviews), so as to be able to explain clearly the scope and purpose of the investigation and subsequently offer to have interviews in private with those persons who wish to speak. If the fear of reprisals, justified or not, is too great, it may be necessary to interview all persons deprived of their liberty in a given place of custody, so as not to pinpoint any specific person. In situations in which an investigation leads to prosecution or another public truth-telling forum, the investigator should recommend measures to prevent harm to the alleged victim by such means as expunging names and other information that identifies the person from the public records or offering the person an opportunity to testify through image or voice-altering devices or closed-circuit television. These measures must be consistent with the rights of the accused.

(v) Use of interpreters

219. Interpreters fulfil a critical role in investigations. An interpreter is the gatekeeper and conduit for information flowing both ways between the interviewer and interviewee. The absence of a good interpreter risks jeopardizing the efficacy of the investigation. Working through an interpreter when investigating torture is not easy, even with professionals (see paras. 296–298 below). It will not always be possible to have interpreters on hand for all different languages and dialects and sometimes it may be necessary to use interpreters from the person's family or cultural group. This is not ideal, as persons may not always feel comfortable talking about the torture or ill-treatment experience through people they know. Children should not be expected to interpret for their parents in interviews that relate to torture or ill-treatment. Ideally, the interpreter should be part of the investigating team, professionally trained and vetted, and knowledgeable about torture and ill-treatment issues as well as words and euphemisms used to refer to body parts and sexual acts in order to recognize hints if sexual torture is being disclosed and react appropriately. When interviewing children, only interpreters who have received special training and have prior experience of working with children should be used (see annex II). Interpreters should: (a) speak directly to victims and witnesses; (b) only use direct speech ("can you please describe what happened" not "the investigator is asking what happened"); (c) use active listening techniques (posture, nodding and respectful eye contact); (d) be able to control their emotional responses and show empathy and sensitivity; and (e) not editorialize, that is interpret exactly what is said and nothing more.

(vi) Information to be obtained from the person alleged to have been tortured or ill-treated

220. The investigator should attempt to obtain as much of the following information as

possible through the testimony of the alleged victim (see paras. 360–370 below):

(a) The circumstances leading up to the alleged torture or ill-treatment, including threats, harassment, insults, arrest or abduction and detention;

(b) Approximate dates and times of the alleged torture or ill-treatment, including when the last instance of torture or ill-treatment occurred. Establishing this information may not be easy, as there may be several places and alleged perpetrators (or groups of alleged perpetrators) involved. Separate stories may have to be recorded about the different places. Expect chronologies to be inaccurate and sometimes even confusing; notions of time are often hard to focus on for someone who has been tortured or ill-treated. Separate stories about different places may be useful when trying to get a global picture of the situation. Survivors will often not know exactly to where they were taken, having been blindfolded or semi-conscious. By putting together converging testimonies, it may be possible to "map out" specific places, methods and even perpetrators;

(c) A detailed description of the persons directly or indirectly involved in the alleged arrest, detention and torture or ill-treatment, including the command structure of the place of detention, whether they knew any of them prior to the events relating to the alleged torture or ill-treatment, clothing, scars, birthmarks, tattoos, height, weight (victims may be able to describe the alleged torturers or persons who committed the ill-treatment in relation to their own size), anything unusual about the perpetrator's anatomy, language and accent, names, including nicknames used, and whether the alleged perpetrators were intoxicated at any time;

(d) Details of what the person was told or asked. For example, this may provide relevant information when trying to identify secret or unacknowledged places of detention;

(e) A description – which can be supplemented by sketches – of the place of detention and its layout, or place of alleged torture or ill-treatment if outside of a detention facility, detention cells, interrogation rooms and torture rooms if different, including torture equipment present in the room and/or used (e.g. rods, pipes, hooks, ropes, barbed wire and water tanks);

(f) A description of the conditions of detention (e.g. space, food, hygiene, temperature, light, access to medical treatment, contact with other detainees and visits), the usual routine in the place of detention and the pattern of alleged ill-treatment (e.g. the location and time of day the torture or ill-treatment tended to occur, its duration and other such factors);

(g) A description of the facts of the alleged torture or ill-treatment, including the methods used. This is understandably often difficult, and investigators should not expect to obtain the full account of events during one interview. It is important to obtain precise information, but questions related to intimate humiliation and assault will be traumatic, often extremely so;

(h) Whether the individual was sexually assaulted. Most people will tend to answer a question on alleged sexual assault as meaning actual rape or sodomy. Investigators should be sensitive to the fact that verbal assaults, disrobing, groping, lewd or humiliating acts or blows or electric shocks to the genitals are often not taken by the victim as constituting sexual assault, and that children might not comprehend the concept of sexual assault or identify it. These acts all violate the individual's intimacy and should be considered as being part and parcel of sexual assault. Very often, victims of sexual assault will say nothing or even deny any sexual assault. It is often only on the second or even third visit, if the contact made has been empathic and sensitive to the person's gender, sexual orientation, culture and personality, that more of the sexual assault history will be disclosed (see paras. 274–276 below);

(i) Physical injuries sustained in the course of the alleged torture or ill-treatment as well as other related immediate and long-term physical harm;

(j) Immediate and long-term mental harm suffered, functional limitations and the socioeconomic impact of the alleged torture or ill-treatment on the person and the person's family;

(k) A description of weapons or other physical objects allegedly used. If specifically designed torture equipment was allegedly used, any information about its type, make (manufacturer) and country of origin;

(l) The identity of witnesses to the events involving alleged torture or ill-treatment;

(m) A description of any other relevant evidence, such as any recordings of the alleged torture or ill-treatment or events leading up to it or following it, and the

existence of documents, such as a statement signed under threat of torture or ill-treatment.

(vii) Statement from the person who is alleging torture and other witnesses

221. The officially mandated investigator with the mandate and capacity to keep the records safe should tape-record a detailed statement from the person and have it transcribed. The investigator should use broad open-ended questions (i.e. questions that require a narrative answer) to obtain a broad uninterrupted account and more specific open-ended questions to obtain particular details and clarify the account. The statement or interview notes should be based on answers given in response to "tell, explain and describe" open-ended questions (e.g. "Please tell me how …", "Please explain to me what …" and "Please describe to me …") and "wh" open questions concerning the "what", "who", "when", "where", "how" and "how do you know" of the alleged torture or ill-treatment. "Why" is usually not a productive question type as it can invite an opinion response rather than a fact-based response and may also be stigmatizing or blaming. Investigators should not use leading questions. Non-leading questions do not make assumptions or conclusions and allow the person to offer the most complete and unbiased testimony. Examples of non-leading questions are "What happened to you?" and "Where did this happen?" rather than "Were you tortured in prison?". The latter question assumes that what happened to the witness was torture and limits the location of the actions to a prison. Avoid asking questions with lists, as this can force the individual into giving inaccurate answers if what actually happened does not exactly match one of the options. Allow persons to tell their own account of events without interrupting them to first obtain a free recall account, but assist by asking questions that increase in specificity. Encourage persons to use all their senses in describing what happened to them. Ask what they smelled, heard and felt. This is important, for instance, in situations in which the person may have been blindfolded or experienced the assault in the dark. Similar considerations apply, with appropriate adjustments made, to taking statements from other witnesses, including relatives of alleged victims, co-detainees and officials, in relation to establishing relevant facts relating to the alleged torture or ill-treatment, including prior to, during and following such treatment.

(viii) Statements from alleged perpetrators

222. Investigators should make every possible effort to interview alleged perpetrators. Where necessary, the investigators should use identity parades or other investigative measures to identify the alleged perpetrators. Investigators must provide the alleged perpetrators with legal protections guaranteed under international and national law. This includes safeguards against arbitrary arrest and detention, the presumption of innocence, and the right to a fair trial. Such guarantees do not include amnesties, immunities or other mechanisms that result in the impunity of the perpetrators.

(b) Securing and obtaining physical evidence

223. One of the most important aspects of a thorough and impartial investigation of torture or ill-treatment is the collection and analysis of physical evidence. Physical evidence consists of any physical objects or matter that can provide relevant information to help establish that torture has taken place or provide a link between the torture and its alleged victim or between the torture and its alleged perpetrator(s). It includes: (a) physical material, such as blindfolds, tape, clothes or electric devices; (b) weapons, such as knives, batons or other torture devices; (c) biological/forensic materials, including saliva, blood, vomit, semen and vaginal fluids; (d) electronic/digital items, such as phones or computers; (e) toxicological analysis, showing the presence of drugs, poison or alcohol; (f) traces, such as fibres or hair; (g) impressions, including fingerprints, footprints and marks; and (h) the sites of alleged violations, such as detention centres.

224. Provided the investigators have the legal authority and professional training required to collect and store relevant physical evidence, and the resources to properly and safely store, transport and preserve such evidence, they should gather as much physical evidence as possible to document an incident or pattern of torture or ill-treatment. Investigators who lack the authority, capacity or resources should not collect physical evidence and instead document the evidence by recording notes, drawing sketches and photographing and/or video recording the evidence. Investigators should document the chain of custody involved in recovering and preserving physical evidence in order to use such evidence in future legal proceedings, including potential criminal prosecutions.

225. Most torture and ill-treatment occur in places of detention in which preservation of physical evidence or unrestricted access may be initially difficult or even impossible. Investigators must be given authority by the State to obtain unrestricted access to any place or premises and be able to secure the setting in which torture allegedly took place. Investigative personnel and other investigators should coordinate their efforts in carrying out a thorough investigation of the place in which torture allegedly occurred. Investigators must have unrestricted access to the alleged scene of torture or ill-treatment. Their access must include, but not be limited to, open or closed areas, including buildings, vehicles, offices, prison cells or other premises in which torture or ill-treatment is alleged to have taken place.

226. A site of violation/crime scene, such as a place of detention, may contain useful physical, digital and documentary evidence that can corroborate testimonial evidence provided by the alleged victim or other witnesses. Collaboration with clinical and forensic experts is of vital importance in retrieving and analysing evidence present in sites of violations and ensuring that the chain of custody is properly maintained. Any building or area under investigation must be closed off so as not to lose or risk contamination of any possible evidence. Only appropriately trained investigators and their staff should be allowed to enter an area once it has been designated as under investigation. Examination of the scene for any material evidence should take place.

227. All evidence must be properly collected, handled, packaged, labelled and placed in safekeeping to prevent contamination, tampering or loss of evidence. If the torture or ill-treatment has allegedly taken place recently enough for such evidence to be relevant, any samples found of body fluids (such as blood or semen), hair, fibres and threads should be collected, labelled and properly preserved. Any implements that could be used to inflict torture, whether destined for that purpose or used circumstantially, should be taken and preserved. If recent enough to be relevant, any fingerprints located must be lifted and preserved. A labelled sketch of the premises or place at which torture allegedly took place must be made to scale, showing all relevant details, such as the location of the floors in a building, rooms, entrances, windows, furniture and surrounding terrain. Colour photographs and/or video recordings must also be taken to record the same. A record of the identity of all persons present at the alleged torture scene must be made, including complete names, addresses and telephone numbers or other contact information. If torture is recent enough for it to be relevant, an inventory of the clothing of the person alleging torture, bedding, sheets, blindfolds and other relevant evidence should be taken and tested at a laboratory, if available, for bodily fluids and other physical evidence. Information must be obtained from anyone present on the premises or in the area under investigation to determine whether they witnessed the incidents of alleged torture or ill-treatment. Any relevant papers, records or documents should be saved for evidential use and handwriting analysis.

(c) Medico-legal evidence

228. Medico-legal documentation can take the form of notes, medical charts (including body charts, such as those included in annex III, to show the location of injuries), official medical certificates, computer files, digital mobile files, recordings, photographs, reports or a combination thereof. Collecting medico-legal evidence consists of the collection of: (a) the narrative history of the alleged torture or ill-treatment, medical (physical and psychological) examination and documentation of the findings for the purpose of corroboration and, where feasible, storing and processing of samples; and (b) physical evidence – forensic specimens – from the body of the alleged victim(s) (or other persons involved). Medico-legal evidence should only be collected, processed and analysed by trained health and forensic professionals. Investigators requesting medical services to provide medical records or service provision or patient information should only do so in situations in which they are duly mandated and have the requisite legal powers, while fully considering confidentiality, data protection and informed consent.

229. Investigators should arrange for medical examinations of the alleged victims. The timeliness of such medical examinations is particularly important. A medico-legal examination should be carried out regardless of the length of time since the alleged torture or ill-treatment and be arranged urgently before acute signs fade. The examination should include an assessment of the need for treatment of injuries and illnesses, psychological help, advice and follow-up (see chap. V for a description of the clinical evaluation of physical evidence). Medico-legal examinations should only take place with the informed consent of alleged victims, including with respect to their right to be examined by a practitioner of the gender of their choice, in settings that are private and secure. Ideally, clinical treatment and medico-legal examinations should be provided at

the same time to reduce the number of procedures a victim must undergo. A psychological appraisal of the alleged torture victim is always necessary and may be part of the physical examination or, in situations in which there are no physical signs, may be carried out as a psychological assessment only (see chap. VI for a description of the clinical evaluation of psychological evidence). In situations in which a person is alleged to have died as a result of torture or ill-treatment, or after having been subjected to such abuse, the investigator shall arrange for an autopsy to be carried out in accordance with recognized international standards.[367]

230. The Istanbul Principles indicate that clinicians should provide an "interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment".[368] In their interpretation of findings, clinicians should assess the level of consistency between physical and psychological findings and the allegations of torture or ill-treatment. Additional guidance on the interpretation of physical and psychological evidence of torture and ill-treatment is provided in chapters IV, V and VI (see paras. 379–381, 417–423 and 540–545) and annexes I and IV. If the clinician considers that there are clinical reasons for an inconsistent finding, this should be discussed (see paras. 268, 342–353 and 386 below). The Istanbul Principles also require clinicians to provide a clinical opinion on the overall possibility of torture or ill-treatment. In formulating a clinical opinion on the possibility of torture or ill-treatment, clinicians should consider all relevant clinical evidence, including "physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc.", as stated in annex IV. In addition to providing a conclusion on the possibility of torture or ill-treatment, clinicians should reiterate current symptoms and disabilities and likely effects on social functioning and provide any recommendations for further evaluations and care for the individual.

231. The investigator should ensure that any clinical evaluation is of the highest standard and in accordance with the Istanbul Protocol and its Principles to avoid the need for a second clinical evaluation. In situations in which a clinical evaluation previously carried out or arranged by the investigator was not carried out in accordance with the Istanbul Protocol and its Principles, including on account of concerns that the status of the clinical evaluator as a government employee might have influenced the evaluation, the investigator should arrange for a second clinical evaluation by a competent, independent health professional. The investigator should respect the right of alleged victims of torture or ill-treatment and their family members to request an independent clinical evaluation and report at any time.[369] In situations in which an earlier evaluation was conducted without complying with these standards, a clinical evaluator should approach a possible second examination with additional care and put in place mitigation measures concerning duplication risks, including retraumatization and inconsistencies from second interviews. Clinical evaluations by foreign experts should be allowed with the consent or upon the request of alleged victims or their family members if the alleged victims are not in a position to provide their consent or make such a request.

(d) Digital evidence and digital open source investigations

232. The investigator must seek to secure any probative information that is stored on, received or transmitted by an electronic device. Digital evidence may in particular be acquired when electronic devices, such as computers and mobile phones, are seized and by browsing the Internet for open source information. If digital evidence is retrieved from seized electronic devices, such devices need to be preserved as physical evidence and the digital expert who extracted the data should prepare a report or affidavit that can be used in court. Digital evidence includes: (a) electronic health records; (b) videos recorded by closed-circuit cameras; (c) pictures and videos, for instance of sites of violations and physical injuries, taken with mobile devices, such as digital cameras or smartphones; (d) pictures, videos or other information posted on social media; (e) information stored on computer hard drives and other peripheral equipment, such as memory cards, USB drives and CD-ROMs; (f) emails, texts and instant messages; (g) aerial photos and satellite imagery, for instance of a secret detention centre or other site of violation; (h) location information stored on a cell phone or social media; and (i) metadata,

367 *The Minnesota Protocol on the Investigation of Potentially Unlawful Death: the Revised United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions* (United Nations publication, 2017).

368 General Assembly resolution 55/89, annex, para. 6 (b) (iv).

369 A/69/387, para. 39; and Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 25.

that is information that provides information about a file (e.g. time and location when a digital photograph was taken). The authenticity of the digital evidence is a critical consideration for its use as evidence. Its authenticity should therefore be vetted by using recognized techniques of digital forensics.

233. As set out in the Berkeley Protocol on Digital Open Source Investigations:

> Open source investigations are investigations that rely, in whole or in part, on publicly available information to conduct formal and systematic online inquiries into alleged wrongdoing. Today, large quantities of publicly available information are accessible through the Internet, where a quickly evolving digital landscape has led to new types and sources of information that could assist in the investigation of alleged human rights violations and serious international crimes. The ability to investigate such allegations is of particular value to investigators who cannot physically access crime scenes in a timely manner, which is often the case in international investigations.
>
> Open source information can provide leads, support intelligence outputs and serve as direct evidence in courts of law. However, in order for it to be used in formal investigation processes, including legal investigations, fact-finding missions and commissions of inquiry, investigators must employ consistent methods, which both strengthen the accuracy of their findings and allow judges and other fact-finders to better evaluate the quality of the investigation process itself.[370]

(e) Photography

234. Colour photographs should be taken of the injuries of persons alleging that they have been tortured or ill-treated with the person's consent, of the premises where torture or ill-treatment allegedly occurred (interior and exterior) and of any other physical evidence found there. A measuring tape or some other means of showing scale on the photograph is essential. Photographs must be taken as soon as possible, even with a basic camera or other suitable device, because some physical signs fade rapidly and locations can be interfered with. Instantly developed photos may decay over time. More professional photos are preferred and should be taken as soon as the equipment becomes available. If possible, photographs should be taken using a digital camera, which records the date and time (either on the photo itself or as metadata attached to the photo electronically). If a film camera is used, if possible this should be one with an automatic date and time feature, and the chain of custody of the film, negatives and prints must be fully documented. Additional stringency is required in respect of the storage and use of intimate images. If analogue photographs are taken by someone other than the investigator, their collection and handling should follow principles of evidence collection and chain of custody.

(f) Documentary evidence

235. Documents, both official and non-official, can be the source of extremely relevant information when documenting torture or ill-treatment. Documentary evidence should be collected in particular from detention sites, official buildings, military bases, court records, hospital archives, historical archives or open sources.

236. Official documents include: (a) lists of prisoners and other custody records (e.g. lists of deaths, transfer logs and food delivery logs); (b) medical certificates; (c) police records and investigation files; (d) complaints filed with the police, national human rights institutions, offices of missing persons or others; (e) trial documents and previous case law; (f) military and intelligence reports and other operational documents (duty logs, transport logs, logistics records, reports of activities, military plans and strategies, communication records, written directives and orders); (g) identity and registration documents, including official documents about missing persons and grave registrations; and (h) official archives, such as the minutes of government sessions, command and control documents, internal government memorandums and diplomatic records.

237. Non-official documents include: (a) other health records; (b) reports and records of civil society organizations, including non-governmental human rights organizations; (c) newspaper articles and

370 Human Rights Centre, University of California, Berkeley, School of Law, and OHCHR, *Berkeley Protocol on Digital Open Source Investigations: A Practical Guide on the Effective Use of Digital Open Source Information in Investigating Violations of International Criminal, Human Rights and Humanitarian Law* (New York and Geneva, 2020), p. vii.

journalistic materials, including notes taken by journalists not included in publications; (d) accounts by whistle-blowers/insiders of relevant events, practices and information; (e) diaries and words scratched onto a wall, for instance in a place of detention; and (f) sketches, for instance of sites of violations.

D. Commissions of inquiry

238. Commissions of inquiry fulfil an important role in contributing to the accountability of perpetrators, responding to the needs of victims, identifying institutional responsibility, proposing institutional, legal and personnel reforms and promoting reconciliation.[371] Yet, on its own, a commission of inquiry is "never sufficient to fully satisfy a State's obligations under international law with regard to torture and other forms of ill-treatment" and "care must be taken to ensure that the work of the commission does not inhibit prosecutions in any way".[372]

1. Defining the scope of the inquiry

239. States and organizations establishing commissions of inquiry need to define the scope of the inquiry by including terms of reference in their authorization. Defining the commission's terms of reference can greatly increase its success by giving legitimacy to the proceedings, assisting commission members in reaching a consensus on the scope of the inquiry and providing a measure by which the commission's final report can be judged. Vesting a commission of inquiry with a specific task must be complemented by providing adequate resources to enable the commission to fulfil the task. Recommendations for defining the terms of reference are as follows:

(a) They should be neutrally framed so that they do not suggest a predetermined outcome. To be neutral, terms of reference must not limit investigations in areas that might uncover State responsibility for torture or ill-treatment;

(b) They should state precisely which events and issues are to be investigated and addressed in the commission's final report;

(c) They should provide flexibility in the scope of the inquiry to ensure that thorough investigation by the commission is not hampered by overly restrictive or overly broad terms of reference. The necessary flexibility may be accomplished, for example, by permitting the commission to amend its terms of reference as necessary. It is important, however, for the commission to keep the public informed of any amendments to its mandate.

2. Power of the commission

240. The powers of the commission should be set out by stipulating general principles. The commission specifically needs the following:

(a) Authority to obtain all information necessary to the inquiry, including the authority to compel testimony under legal sanction, to order the production of documents, including State and medical records, and to protect witnesses, families of the victim and other sources;

(b) Authority to issue a public report;

(c) Authority to conduct on-site visits, including at the location where the torture or ill-treatment is suspected to have occurred;

(d) Authority to receive evidence from witnesses and organizations located outside the country.

3. Membership criteria

241. Commission members should be chosen for their background and recognized impartiality, competence and independence as individuals, as defined as follows:

(a) *Impartiality.* Commission members should not be closely associated with any individual, State entity, political party or other organization potentially implicated in the torture or ill-treatment. They should not be too closely connected to an organization or group of which the victim is a member, as this may damage the commission's credibility. This should not, however, be an excuse for blanket exclusions from the commission, for instance, of members of large organizations of which the victim is also a member or of persons associated with organizations dedicated to the treatment and rehabilitation of torture victims;

371 A/HRC/19/61, para. 26.
372 Ibid., paras. 69 and 55. See also updated set of principles for the protection and promotion of human rights through action to combat impunity, principles 6–13.

(b) *Competence.* Commission members must be capable of evaluating and weighing evidence and exercising sound judgment. If possible, commissions of inquiry should include individuals with expertise in law, medicine and other appropriate specialized fields;

(c) *Independence.* Members of the commission should have a reputation in their community for honesty and fairness;

(d) *Representation.* The composition of the commission should be such as to ensure adequate representation of gender and persons with characteristics and experiences relevant in the specific context.

242. The objectivity of the investigation and the commission's findings may, among other things, depend on whether it has three or more members rather than one or two. A single commissioner should in general not conduct investigations into torture or ill-treatment. A single, isolated commissioner will generally be limited in the depth of the investigation that the commissioner can conduct alone. In addition, a single commissioner will have to make controversial and important decisions without debate and will be particularly vulnerable to State and other outside pressure.

4. Commission's staff

243. Commissions of inquiry should have impartial, expert counsel. Where the commission is investigating allegations of State misconduct, it would be advisable to appoint counsel outside the ministry of justice. The chief counsel to the commission should be insulated from political influence, through civil service tenure or as a wholly independent member of the bar. The investigation will often require expert advisers. Technical expertise should be available to the commission in areas such as pathology, forensic science, psychiatry, psychology, gynaecology and paediatrics. To conduct a completely impartial and thorough investigation, the commission would almost always need its own investigators to pursue leads and develop evidence. The credibility of an inquiry would thus be significantly enhanced to the extent that the commission would be able to rely on its own investigators.

5. Protection of witnesses

244. The State shall protect complainants, witnesses, those conducting the investigation and their families from violence, threats of violence or any other form of intimidation (see paras. 204–207 above). If the commission concludes that there is a reasonable fear of persecution, harassment or harm to any witness or prospective witness, the commission may find it advisable to hear the evidence in camera, keep the identity of an informant or witness confidential, use only evidence that will not risk identifying the witness and take other appropriate measures.

6. Proceedings

245. It follows from general principles of criminal procedure that hearings should be conducted in public, unless in camera proceedings are necessary to protect the safety and/or privacy of a witness. In camera proceedings should be recorded and the sealed, unpublished record kept in a known location. Occasionally, complete secrecy may be required to encourage testimony and the commission may want to hear witnesses privately, informally or without recording testimony.

7. Notice of inquiry

246. Wide notice of the establishment of a commission and the subject of the inquiry should be given. The notice should include an invitation to submit relevant information and written statements to the commission and instructions to persons willing to testify. Notice can be disseminated through newspapers, magazines, radio, television, leaflets and posters.

8. Receipt of evidence

247. Commissions of inquiry should have the power to compel testimony and produce documents, as well as the authority to compel testimony from officials allegedly involved in torture or ill-treatment. Practically, this authority may involve the power to impose fines or sentences if government officials or other individuals refuse to comply. Commissions of inquiry should invite persons to testify or submit written statements as a first step in gathering evidence. Written statements may become an important source of evidence if their authors are afraid to testify, cannot travel to proceedings or are otherwise unavailable. Commissions of inquiry should review other proceedings that could provide relevant information.

9. Rights of parties

248. Those alleging that they have been tortured (or suffered ill-treatment) and their legal representatives

should be informed of and have access to any hearing and all information relevant to the investigation and must be entitled to present evidence. This particular emphasis on the role of the alleged victims as parties to the proceedings reflects the especially important role their interests play in the conduct of the investigation. However, all other interested parties should also have an opportunity to be heard. The investigative body must be entitled to issue summonses to witnesses, including the officials allegedly involved, and to demand the production of evidence. All these witnesses should be permitted legal counsel if they are likely to be harmed by the inquiry, for example, when their testimony could expose them to criminal charges or civil liability. Witnesses may not be compelled to testify against themselves. There should be an opportunity for the effective questioning of witnesses by the commission. Parties to the inquiry should be allowed to submit written questions to the commission.

10. Evaluation of evidence

249. The commission must assess all information and evidence it receives to determine reliability and probity. The commission should evaluate oral testimony, taking into account the demeanour and overall credibility of the witness. The commission must be sensitive to social, cultural and gender issues that affect demeanour. Corroboration of evidence from several sources will increase the probative value of such evidence and the reliability of hearsay evidence. The reliability of hearsay evidence must be considered carefully before the commission accepts it as fact. Testimony not tested by cross-examination must also be viewed with caution. In camera testimony preserved in a closed record or not recorded at all is often not subject to cross-examination and, therefore, may be given less weight.

11. Report of the commission

250. The commission should issue a public report within a reasonable period of time, which "should be published widely and in a manner that is accessible to the broadest audience possible".[373] Furthermore, when the commission is not unanimous in its findings, the minority commissioners should file a dissenting opinion. Commission of inquiry reports should contain, at a minimum, the following information:

(a) The scope of the inquiry and terms of reference;

(b) The procedures and methods of evaluating evidence;

(c) A list of all witnesses, including age and gender, who have testified, except for those whose identities are withheld for protection or who have testified in camera, and exhibits received as evidence;

(d) The time and place of each sitting (this might be annexed to the report);

(e) The background of the inquiry, such as relevant social, political and economic conditions;[374]

(f) The specific events that occurred and the evidence upon which such findings are based;

(g) The law upon which the commission relied;

(h) The commission's conclusions based on applicable law and findings of fact;

(i) Recommendations based on the findings of the commission.

251. The State should reply promptly and publicly to the commission's report and, where appropriate, indicate which steps it intends to take in response to the report, particularly with a view to expeditiously and effectively implementing its recommendations.

E. Role of prosecutors, judges, national human rights institutions and other actors in the investigation of torture

252. "Judges, prosecutors and lawyers play a critical role in upholding human rights, including the absolute and non-derogable right of freedom from torture and other cruel, inhuman or degrading treatment or punishment."[375]

373 A/HRC/19/61, para. 77.

374 According to the Special Rapporteur on torture, "beyond a recitation of facts, the report of a commission of inquiry should attempt to provide an accurate picture of the social and political background against which the acts of torture and other international crimes took place. Crucially, the report should identify loopholes in the public and private institutional order that have allowed for the breakdown of legal and procedural protections and led to a culture of impunity for the crimes investigated by the commission" (Ibid., para. 75).

375 Human Rights Council resolution 35/12, thirteenth preambular paragraph. See also Foley, *Combating Torture* (see footnote 240).

1. Prosecutors

253. Prosecutors, in the administration of justice, "shall perform an active role in criminal proceedings, including institution of prosecution and, where authorized by law or consistent with local practice, in the investigation of crime, supervision over the legality of these investigations, supervision of the execution of court decisions and the exercise of other functions as representatives of the public interest".[376] In doing so, "prosecutors shall give due attention to the prosecution of crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law and, where authorized by law or consistent with local practice, the investigation of such offences".[377]

254. As a general principle, "prosecutors shall, in accordance with the law, perform their duties fairly, consistently and expeditiously, and respect and protect human dignity and uphold human rights, thus contributing to ensuring due process and the smooth functioning of the criminal justice system".[378] Prosecutors have a duty to refuse to take into account evidence that they know or believe on reasonable grounds was obtained through recourse to torture or ill-treatment. They must ensure that any information, confession or admission obtained from a person by such means is inadmissible in evidence against that person in any proceeding (the exclusionary rule). However, such evidence, information, confession or admission may be admitted against any person accused of torture as evidence that it was obtained by torture.[379] In such cases, prosecutors must inform the court about the existence of such evidence and should take all necessary steps to ensure that those responsible for using such methods are brought to justice.[380]

255. Prosecutors must be professionally qualified and provided with regular training, adequate resources, independence and protection to ensure that they can exercise their role in the context of investigations into alleged acts of torture or ill-treatment in accordance with this manual. The prosecuting authorities should issue guidelines on the use of this manual and prosecutors should receive regular training on relevant standards, investigation methods and developments.[381] Prosecutors should exercise their discretion in a manner that fully upholds the prohibition of torture throughout any legal proceedings. They should not become complicit in the enabling or commission of acts of torture or ill-treatment or impunity for such acts.

256. Upon receiving a complaint, or otherwise learning of an allegation of torture or ill-treatment, prosecutors should immediately take measures to ensure that a prompt, impartial, effective and gender- and child-sensitive investigation is carried out in accordance with this manual.[382] Prosecutors should take or request expeditious investigative measures to be taken in accordance with this chapter. They should open an investigation to this effect and in situations in which investigations are at any stage found to have been inadequate in light of the standards set out in this manual, the original investigation should be reopened or a fresh investigation commenced. Throughout proceedings, prosecutors should take all possible measures to ensure the protection of victims and witnesses. This includes instituting proceedings against anyone who endangers the physical or psychological integrity of victims or witnesses or others involved in investigations. Prosecutors should seek to establish the responsibility of any officials or other individuals involved in acts of torture or ill-treatment and bring charges for the criminal offence of torture or ill-treatment, or relevant similar offences under national law, in situations in which sufficient evidence is available. In cases in which insufficient evidence is available to bring charges of torture or ill-treatment, prosecutors should consider bringing charges for lesser crimes or recommending disciplinary measures as appropriate. When requesting punishment, particularly a custodial sentence, prosecutors must ensure that it is commensurate with the gravity of the offence, taking into consideration the rights and views of victims of torture or ill-treatment and their families as appropriate.

2. Judges

257. "An independent and impartial judiciary … and the integrity of the judicial system are prerequisites for

376 Guidelines on the Role of Prosecutors, para. 11.
377 Ibid., para. 15.
378 Ibid., para. 12.
379 See, in particular, Convention against Torture, art. 15.
380 Guidelines on the Role of Prosecutors, para. 16.
381 A/69/387, para. 67.
382 CAT/C/54/2, para. 92.

the protection of human rights and the application of the rule of law and for ensuring fair trials and the administration of justice without any discrimination."[383] Judges must be provided with the requisite independence, training, resources and protection that enable them to adequately discharge their multiple functions in the context of investigations and other legal proceedings relating to torture and ill-treatment in accordance with this manual.

258. Judges must be particularly vigilant in exercising an oversight role within the scope of their functions to ensure the physical and psychological integrity and well-being of any persons deprived of their liberty.[384] Judges have the judicial authority to order and ensure that suspects and detainees are not arbitrarily detained, or detained or transferred to places where they could be tortured. In situations in which State authorities or others acting in an official capacity, as well as judges, know or have reasonable grounds to believe that torture or ill-treatment has been, is being or will be committed by State actors or private actors and, where mandated to do so, they fail to investigate, prosecute and punish the actors, the State bears responsibility. Officials who did not take measures to prevent such treatment from taking place should be held responsible for consenting to or acquiescing in such impermissible acts.[385] The Committee against Torture cites the specific example of the case in which a person is to be transferred or sent to the custody of an individual or institution known to have engaged in torture or ill-treatment or not to have implemented adequate safeguards.[386]

259. In situations in which judges suspect that a person has been subjected to torture or ill-treatment, they should use their judicial authority and power to initiate investigations or inform prosecutors to enable them to intervene in the matter. In particular, in situations in which suspects or the accused raise allegations of torture or ill-treatment in the course of legal proceedings or trials, judges must take action to ensure that a prompt, impartial and effective investigation is carried out into such allegations in accordance with this manual.[387] In accordance with article 15 of the Convention against Torture, a judge must not admit any evidence alleged to have been obtained as a result of torture or ill-treatment in situations in which the prosecuting authorities cannot demonstrate that such evidence was not thus obtained, other than as evidence against the person accused of obtaining such evidence. The prohibition on the use of evidence or information alleged to have been obtained as a result of torture (the exclusionary rule) applies to any proceedings, including court and non-court proceedings, such as penal and administrative hearings, and extradition hearings.[388]

260. Judges mandated to direct investigations into cases of torture or ill-treatment must ensure that all relevant investigative measures are taken in accordance with this manual, and direct investigative bodies to take further measures as required. In criminal trials against the alleged perpetrators of torture, judges should hear and weigh all available evidence with a view to establishing to the required standard of proof whether the accused are guilty – while fully considering their right to a fair trial – and, if so, what punishment is appropriate in the particular circumstances. In particular, judges should examine the relevance and reliability of forensic evidence, which has been described as a type of expert evidence, by considering the professional expertise, relevant circumstances and other evidence.[389] As emphasized by the Special Rapporteur on torture:

> The Istanbul Protocol should be used for assessment of allegations of torture and medico-legal reports undertaken in compliance with the standards and principles of the Protocol, including independence and impartiality, [which] present reliable findings on torture. These medico-legal reports therefore should be considered as reliable evidence on the issue of whether torture has or has not been perpetrated.[390]

261. Judges should ensure that the principles and standards set out in this manual are upheld in all legal proceedings, including fundamental and civil rights cases, administrative and civil proceedings, and asylum and non-refoulement cases. Judges of

383 Human Rights Council resolution 35/12, fifth preambular paragraph. See also the Basic Principles on the Independence of the Judiciary.
384 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, principle 4; and CAT/OP/2.
385 Committee against Torture, general comment No. 2 (2007), para. 18.
386 Ibid., para. 19.
387 CAT/C/54/2, para. 92.
388 Committee against Torture, *P.E. v. France* (CAT/C/29/D/193/2001), paras. 3.3, 6.2 and 6.3.
389 A/69/387, para. 49.
390 Ibid., para. 52.

regional and international courts and tribunals and members of human rights treaty bodies should consider questions pertaining to torture or ill-treatment with due reference to the standards and principles set out in this manual. However, the outcome of legal procedures should not be dependent on a prior full investigation of the allegations of torture or ill-treatment. For example, in constitutional, civil or administrative cases in which a victim presents credible allegations of torture or ill-treatment in custody or an individual died in custody, the burden of proof ought to shift and be on the State to provide a plausible explanation of how the harm was caused.[391]

3. National human rights institutions and national preventive mechanisms

262. National institutions that are, in accordance with the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles), vested with the competence to promote and protect human rights should be mandated to investigate all complaints of human rights violations, including torture and ill-treatment.[392] In exercising this mandate, national human rights institutions should discharge their functions in respect of alleged acts, and patterns of torture or ill-treatment, in accordance with the non-coercive investigatory techniques and the standards and principles set out in this manual, particularly in respect of any legal investigations into allegations of torture or ill-treatment that such an institution is mandated to carry out.[393] Monitoring bodies, such as national preventive mechanisms, while not tasked with investigating complaints, should also be provided with training on the manual.[394] Such bodies should be able to receive confidential allegations of torture or ill-treatment and be mandated to identify issues of concern, which must be raised with the authorities concerned, as part of their regular visits.

4. Other actors

263. International law obliges States to investigate allegations of torture or ill-treatment. Actors other than States, such as civil society organizations, play an important independent and complementary role in seeking to achieve the objectives of investigations to combat impunity, secure justice and uphold the rule of law. This role consists in documenting torture or ill-treatment, representing victims, prompting investigations or other inquiries or legal proceedings resulting in investigations, providing evidence and/or expertise to investigative bodies, scrutinizing proceedings and providing legal analysis of the adequacy of investigations. When documenting torture or ill-treatment, for use in legal procedures – such as investigations or judicial or quasi-judicial proceedings – for redress, prevention and accessing services or in asylum or non-refoulement applications, non-State actors should seek documentation that is from a reliable and identifiable source, detailed, internally consistent and collected as soon as possible. Non-State actors should adhere to the principles set forth in this manual, so as not to jeopardize the purpose of an investigation. States are required to respect the role played by such actors and provide effective protection against any threats, harassment or other unwarranted interference.[395]

F. Use of evidence of torture or ill-treatment in other legal procedures

264. The findings of investigations concerning alleged acts of torture or ill-treatment should be taken into consideration in any other relevant legal proceedings. This includes: (a) proceedings relating to the exclusion of confessions or statements made under torture (exclusionary rule) in which the State bears the burden of proof in demonstrating that a person has not been tortured;[396] (b) civil and administrative cases and fundamental rights and human rights cases, particularly to establish liability and identify adequate forms of reparation so as to

391 E/CN.4/2003/68, para. 26 (k). This is in line with the jurisprudence of regional and international courts and human rights treaty bodies, see United Nations Voluntary Fund for Victims of Torture, "Interpretation of torture in the light of the practice and jurisprudence of international bodies" (2011), p. 9.

392 A/56/44, para. 46 (c).

393 Association for the Prevention of Torture, Asia Pacific Forum of National Human Rights Institutions and OHCHR, *Preventing Torture: An Operational Guide for National Human Rights Institutions*, pp. 55–60.

394 See, inter alia, the Optional Protocol to the Convention against Torture. For the relationship between national human rights institutions and national preventive mechanisms, see OHCHR, *Preventing Torture: The Role of National Preventive Mechanisms– A Practical Guide*, Professional Training Series No. 21 (New York and Geneva, 2018), p. 16.

395 General Assembly resolutions 32/31 and 70/161.

396 A/HRC/25/60.

secure the right of victims to an effective remedy and reparation;[397] (c) truth commissions and other procedures established in the context of a transition from repressive regimes and/or conflict;[398] and (d) applications for asylum or non-refoulement.[399] In situations in which no full investigation has been carried out, any evidence submitted in relevant legal proceedings should be obtained by adhering to the Istanbul Protocol and its Principles.

265. Decision makers, particularly in asylum and refoulement cases, must apply the correct standard of proof – of a reasonable likelihood or real risk of being subjected to torture (or other human rights violations amounting to persecution) – and adequately consider available evidence, particularly clinical evidence, in their decision-making. In particular, decision makers must not adopt opinions on clinical matters for which they are not qualified and must not dismiss clinical evidence on the basis of having made a prior negative credibility finding. Clinical evidence of past torture or ill-treatment is typically a strong indicator of a real risk of persecution or torture upon return.[400] The lack of clinical evidence does not establish that a person has not been tortured or that the claim of a person alleging torture lacks credibility.

397 Committee against Torture, general comment No. 3 (2012), inter alia, para. 30: "States parties shall also make readily available to the victims all evidence concerning acts of torture or ill-treatment upon the request of victims, their legal counsel, or judge. A State party's failure to provide evidence and information, such as records of medical evaluations or treatment, can unduly impair victims' ability to lodge complaints and to seek redress, compensation and rehabilitation."

398 A/HRC/24/42.

399 Committee against Torture, general comment No. 4 (2017), para. 18 (e).

400 Ibid., para. 28.

266. When a person who has allegedly been tortured is interviewed, there are a number of issues and practical factors that have to be taken into consideration. These general considerations apply to all clinicians conducting interviews. Clinical evaluations of torture and ill-treatment aid in establishing such facts and by providing critical evidence in medico-legal and other contexts (see chap. VII). They may also serve as useful guidelines for other professionals who conduct interviews with alleged victims, including lawyers, prosecutors, adjudicators, human rights monitors and others. This chapter provides "common ground" guidance on general interview considerations and addresses different interview contexts.

A. Preliminary considerations

1. Purpose of inquiry, examination and documentation

267. The purpose of the investigation is to establish the facts constitutive of the alleged incidents of torture or ill-treatment (see chap. III and annex I), to ensure accountability and redress for these crimes and, ultimately, prevention through deterrence. Clinical evaluations of torture or ill-treatment may provide critical evidence in medico-legal and other contexts (see chap. VII), including:

(a) Clinical evaluations of physical and psychological evidence of alleged torture or ill-treatment in criminal, civil, administrative and other cases, for the purposes of:

(i) Protecting persons from torture and ill-treatment through periodic clinical assessments of possible physical and psychological evidence of torture or ill-treatment during periods of deprivation of liberty, such as in custodial settings and prisons;

(ii) Identifying perpetrators responsible for torture and ill-treatment and bringing them to justice;

(iii) Documenting evidence of torture and ill-treatment in asylum proceedings;

(iv) Documenting and establishing findings of torture and ill-treatment for the purpose of various legal proceedings, including identification of confessions obtained under torture or ill-treatment;

(v) Documenting and establishing domestic, regional and international practices of torture and ill-treatment;

(b) International human rights monitoring and torture prevention visits to places of detention;

(c) Human rights investigations, missions and inquiries;

(d) Accountability of State officials and State investigation and documentation practices, including clinical evaluations by State officials;

(e) Advocacy for torture prevention, accountability and redress;

(f) Primary health-care encounters in which torture or ill-treatment is alleged or suspected;

(g) Implementation of conditions necessary for effective investigation and documentation of torture and ill-treatment (see chap. VIII);

(h) Identifying the therapeutic, rehabilitation and potential reparation needs of torture survivors.

268. The purpose of the medico-legal evaluation of alleged or suspected cases of torture or ill-treatment is to provide a clinical interpretation of the degree to which clinical findings correlate with the alleged victim's contention of abuse, and a clinical opinion on the veracity of such claims, and the possibility of torture, based on all relevant clinical evidence, and to effectively communicate these findings, interpretations and conclusions to the judiciary or other appropriate authorities. In addition, clinical testimony often serves to educate the judiciary, other government officials and the local and international communities about the physical and psychological sequelae of torture. All clinical evaluations of alleged or suspected torture or ill-treatment should be conducted in accordance with the Principles included in annex I. The examiner should be prepared to do the following:

(a) Assess possible injury and abuse, even in the absence of specific allegations by individuals or law enforcement or judicial officials;

(b) Document physical and psychological evidence of injury and abuse;

(c) Correlate the degree of consistency between the evaluation findings and specific allegations of abuse by the alleged victim;

(d) Correlate the degree of consistency between the individual evaluation findings and the torture methods used in a particular region and their common after-effects;

(e) Render a clinical interpretation of the findings of medico-legal evaluations and/or provide expert opinion on the possibility of torture based on all relevant clinical evidence, including "physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc." as stated in annex IV;

(f) Use information obtained in an appropriate manner to enhance fact-finding and further documentation of torture;

(g) Upon judicial or other appropriate legal request, provide an assessment of the reliability of the clinical findings.

2. Essential conditions and interview skills

269. All clinical evaluations of cases in which torture or ill-treatment is alleged or suspected should be conducted with objectivity and impartiality. The evaluation should be based on the clinician's expertise and professional experience. The ethical obligations of beneficence, non-maleficence, confidentiality and respect for autonomy demand uncompromising accuracy and impartiality in order to establish and maintain professional credibility. Clinicians who conduct evaluations of persons deprived of their liberty should have knowledge of the Istanbul Protocol and its Principles and the capacity to effectively evaluate and document the physical and psychological effects of torture and ill-treatment.

270. Clinicians should have knowledge of detention conditions and torture methods used in the particular region where the alleged victim was detained or imprisoned, in situations in which this information is available, and the common after-effects of torture. The clinical report should be factual and carefully worded. Jargon should be avoided. All clinical terminology should be defined so that it is understandable by lay persons. The clinician should not assume that the official requesting a medico-legal evaluation has relayed all the material facts. It is the responsibility of clinicians to discover and report upon any material findings that they consider relevant, even if they may be considered irrelevant or adverse to the patient's case or the case of the party requesting the clinical evaluation.

271. The location of the interview and examination should be as safe, private and comfortable as possible and the interview should be given sufficient time, which may require multiple interviews.

272. Building trust and rapport are essential components of eliciting an accurate account of abuse. Establishing rapport and earning the trust of someone who has endured torture or other ill-treatment requires the interviewer to treat the individual with courtesy and respect through the use of active listening, meticulous communication, courtesy and genuine empathy and honesty. Explaining ahead of time what to expect can give the interviewee a greater sense of control. The clinician should be mindful of the tone, phrasing and sequencing of questions (sensitive questions should be asked only after some degree of rapport has been developed) and should acknowledge the individual's right to take a break if needed or to choose not to respond to any question. Providing the interviewee with a sense of control over the pace of the interview can strengthen rapport.

273. Clinicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the alleged victim's consent (see paras. 165–171). Persons should be examined individually, with privacy. They should be informed, in a manner that is clear and comprehensible, of any limits on the confidentiality of the evaluation, including those that may be imposed by the State judicial authorities. The clinician should make sure that the information given is clearly understood by the interviewees. This includes any mandatory reporting requirements that the clinician may have. Clinicians must ensure that informed consent is based on adequate disclosure and understanding of the potential benefits and adverse consequences of a clinical evaluation, that the individual is mentally competent and that consent is given voluntarily without coercion by others, particularly law enforcement or judicial authorities. The alleged victim has the right to refuse the evaluation. In such circumstances, the clinician should document the reason for the refusal of an evaluation.

3. Disclosure of sexual torture or ill-treatment

274. Disclosure of sexual torture or ill-treatment may be so difficult that a person prefers not to talk about it at all or it may be disclosed only long afterwards during therapy.[401] However, without disclosure of such experiences, documentation will be incomplete and an assessment of resulting health-care needs compromised. It is important that individuals retain control over their disclosures to minimize retraumatization, especially as regards when, how much detail and to whom. A subjective assessment has to be made by the examiner about the extent to which pressing for details is necessary for the effectiveness of the report in court. Clues indicating that a person has suffered sexual violence, but not disclosed it, may be found by exploring gaps in their narrative of events or euphemisms, such as "they did what they wanted". A useful question to ask can be: "Did the officers ever remove their clothes?" Clues in the psychological examination may also raise concerns that sexual violence has occurred but has not been disclosed, such as a history of compulsive washing many times a day, repeated self-harming behaviour and the nature of trigger and avoidance behaviour relating to intrusive recall and flashbacks of traumatic experiences.

275. Avoidance, a feature of post-traumatic stress disorder (PTSD), may also inhibit disclosure. Clinicians need to be mindful of their own responses to a person's disclosures and that they do not themselves also avoid these important issues. Disclosure of sexual violence, even in the relatively safe setting of an evaluation, may be intensely distressing and raise the person's risk of self-harm and suicide. A risk assessment of harm to self and from others must be made. If the disclosure is made for the first time in the context of a medico-legal evaluation, the reasons for not previously making the disclosure should be discussed in the report. Victims may feel that others will judge them to be at fault for having put themselves at risk in some way. They may feel that if they have not been physically injured then they will not be believed or be believed to have consented.

276. Disclosure of sexual violence may be inhibited by many factors, including the shame and fear evoked, the challenge it presents to a person's gender identity and sexual orientation or the fear of "honour violence" from family or the community. There are unique difficulties for men, women and others in disclosing experiences of sexual violence. Gender norms are entrenched in most societies and both the victims' own ideas of their sexual orientation and gender identity and the views of the society in which they live may be inextricably bound up in the impact of the sexual violence experience for them and influence disclosure. Sexual violence against men highlights the victim's vulnerability and powerlessness, challenging and conflicting with their ideas of masculinity. Perceptions of sexuality, procreative ability and gender identity may also be challenged.[402] The response of submission or freezing, the association of male rape with homosexual pleasure and the lack of recognition and services for sexual violence against men may significantly affect disclosure in men.[403] In women, social stigma and concerns about "losing one's honour" and/or being outcast from the family or community are often entrenched in societies and influence disclosure. Sexual violence against homosexual individuals similarly has unique impacts on the victims and distinct challenges regarding disclosure that must be considered and mitigated.

4. Risk of retraumatization of the interviewee

277. Interviewers should be aware that clinical interviews and evaluations, including recounting past experiences of torture and severe trauma, as well as physical and psychological examination and common procedures and ancillary diagnostic testing, such as blood tests, can be profoundly retraumatizing for victims, both during the examination and afterwards. Retraumatization refers to traumatic stress reactions (emotional and/or physical) triggered by exposure to memories or reminders of past traumatic events.[404] During the evaluation, retraumatization can manifest as anxiety about the interview, wanting to avoid discussing particular incidents, minimizing conversation, re-experiencing physical or emotional symptoms, symptoms of hyperarousal or insomnia, numbing of general responsiveness or becoming overwhelmed with memories and emotion. Retraumatized individuals may mobilize strong

401 Crime survey data from the United Kingdom of Great Britain and Northern Ireland show that nearly 31 per cent of the rape victims had never disclosed their experience to anyone and approximately 83 per cent had not reported it to the police. Office for National Statistics, "Sexual offences in England and Wales: year ending March 2017" (London, 2018).

402 UNHCR, "Working with men and boy survivors of sexual and gender-based violence in forced displacement" (Geneva, 2012), p. 4.

403 Clayton M. Bullock and Mace Beckson, "Male victims of sexual assault: phenomenology, psychology, physiology", *Journal of American Academy of Psychiatry and Law*, vol. 39, No. 2 (2011), pp. 197–205.

404 Melanie P. Duckworth and Victoria M. Follette, eds, *Re-traumatization: Assessment, Treatment, and Prevention* (New York, Routledge, 2012), chap. 1.

defences that result in profound withdrawal and affective flattening during examination or interview; alternatively, they may express hostility and anger. Retraumatization presents special difficulties because torture victims may be unable to communicate their trauma history and related sequelae, although it would be beneficial for them to do so. Symptoms of retraumatization may be present during the interview or affect the survivor for days and even weeks after the interview and examination. In addition, those who survive torture and remain in their country may experience intense fear and suspicion about being rearrested and they may feel forced to go into hiding.

278. Interviews, examinations and diagnostic testing may also exacerbate psychological sequelae in torture survivors. The interview can trigger new or worsening symptoms of post-traumatic stress such as: (a) symptoms of physical pain or anxiety; (b) re-experiencing of the traumatic event (e.g. flashbacks); (c) avoiding reminders associated with the trauma; (d) numbing of general responsiveness; (e) insomnia and sleep-related phenomena; and (f) feelings of fear, shame and guilt. Symptoms of depression and anxiety may also worsen during and after the interview and examination. Because exacerbation of these symptoms may worsen suicidal thoughts, clinicians should consider reassessing the risk of self-harm when relevant. Clinicians should also be aware that questions about psychological distress are sometimes considered taboo in many traditional societies and the asking of such questions can be regarded as irreverent or insulting.

279. The torture survivor's personal reactions to the interviewer (and the interpreter, in cases in which one is used) can impact the interview process and, in turn, the outcome of the evaluation. Likewise, the personal reactions of the interviewer towards the interviewee can also affect the process of the interview and the outcome of the evaluation. It is important to examine the barriers to effective communication, including the implicit and explicit bias of the clinician, and the influence that these personal reactions might have on an evaluation. The clinician should maintain awareness of such factors through an ongoing examination of the interview and evaluation process. Consultation and discussion with colleagues familiar with the field of psychological assessment and treatment of torture survivors may be helpful.

280. Examiners can prevent and mitigate retraumatization and psychological sequelae with effective communication, empathy and by allowing individuals control over their narrative account of the alleged events. Applying these and other essential interview skills are of paramount importance in conducting an effective interview and in avoiding retraumatizing a torture survivor. Despite efforts to prevent and mitigate retraumatization, torture survivors are likely to experience some level of distress during a clinical interview. Clinicians, together with the individual, should balance the potential traumatic effects of an interview with the potential benefits of a comprehensive medico-legal evaluation. When the interviewer suspects that retraumatization has occurred, it would be important to acknowledge the concern, mitigate ongoing retraumatization (such as with breaks, breathing exercises and redirection to less emotional topics), offer psychological support and refer the alleged victim to appropriate follow-up care.

5. Gender, sexual orientation and gender identity

281. Both victims and perpetrators of torture or ill-treatment can be of any sexual orientation or gender and, though often discussed together, sex, gender and sexual orientation are each different from one another. Sexual orientation refers to inherent emotional, romantic and/or sexual attraction to other people. Gender identity refers to how individuals perceive themselves and what they call themselves. Individuals who self-identify with any from a wide and varied spectrum of non-heterosexual orientations are often referred to as lesbian, gay, bisexual, transgender and queer persons. Intersex persons are those who are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies. These individuals, as well as those who find themselves in the process of questioning, exploring or beginning to understand their sexual orientation, are all at increased risk of torture and ill-treatment. In cases in which the alleged victims do not conform to the traditional binary notion of gender (including transgender, intersex and gender non-conforming persons), interviewers should acknowledge the stated gender identity of interviewees and use their preferred name and gender pronouns accordingly (see paras. 599–601 below).

282. It is important to differentiate between sexual and gender-based torture and abuse. Sexual torture includes verbal, emotional and physical acts of a sexual nature with the intention of producing physical and psychological suffering. In gender-based torture, the gender identity and/or sexual

orientation of the persons involved play a key role in the abuse. Both sexual and gender-based torture are reliant on the power dynamics involved and can change based on the social, cultural and religious context. Even if no explicit sexual assault is alleged, many forms of torture have sexual or gendered aspects that must be considered in the evaluation.

283. The gender of the clinician may also influence the evaluation process. Ideally, an evaluation team should include clinicians of different genders offering the interviewee the option of being attended by a clinician and, where necessary, an interpreter of the same or another gender. The wishes of the alleged victim for having a clinician of the same or another gender conducting the interview must be respected. Experience has shown, particularly in cases of victims still in custody, that in most situations, the most important factor may be that the interviewer is a clinician to whom the victim can ask honest questions, regardless of gender. When the evaluation team does not have a clinician of the desired gender for an evaluation, the interviewee may still choose to speak to a clinician in order to gain clinical information and advice. These considerations are particularly important in situations of known gender-based violence and sexual torture. In cases in which the clinician and the interviewee are of different genders, and especially during a physical examination, it is essential that a chaperone be offered.

6. Interviewing children

284. There are unique and specialized considerations that must be taken into account when interviewing children. Clinicians who interview children should ideally obtain specialized training on how to conduct paediatric evaluations. Clinicians without specialized expertise are urged to be cautious in evaluating children.

285. Children have the right to have their consent and confidentiality respected. Except in exceptional circumstances, which were discussed in paragraph 170 above, they should not be given medical treatment without their consent or that of a parent or guardian. Particular attention must be given to providing support, such as taking time to build rapport, using clear and age-appropriate language throughout, and providing breaks and opportunities to ask questions.

286. It is important to understand that the features and psychological effects of torture and ill-treatment depend on the child's developmental stage and the social norms of the community in which they have been raised. Younger children may be tortured to cause pain to their parents. Older children may be tortured to suppress political activity. Age-appropriate communication with children is key both at the time of receiving informed consent/assent and when carrying out assessments. Information on procedures needs to be tailored for children and communicated in ways that they can understand. Although they may physically resemble adults, it is increasingly recognized that brain development continues into early adulthood, and interviews with older children, adolescents and young adults should be tailored to their individual cognitive and verbal capacity.

287. Memory and cognition in children are dependent on development as well as the trauma and its frequency and social context. Development of cognitive processes required for adult memory storage – recalling and recounting in a coherent chronological manner – is a gradual process and may be delayed in children who are traumatized. In considering memory and recall of traumatic events, it is important to consider some unique issues among children. While both single and repeated traumas can affect a young person's language, development and memory, repeated trauma may have a more serious effect. Part of a child's memory can form from their family remembering and retelling experiences, which helps to reinforce memory. If a child has been separated from their family at a young age or if the family does not speak of certain experiences, the memories of such experiences may as a result be fragile and sparsely detailed and may be lost altogether as the child grows up. Children who have suffered traumatic experiences and those who have been separated from their caregivers may show particularly uneven development. Such children may be adept in some ways due to having an early responsibility to care for themselves or others despite lacking formal education. Experience of torture or ill-treatment, subsequent mental health conditions and pre-existing developmental difficulties, such as learning difficulties or disabilities, may all influence a child's understanding of events and their ability to recount them.

288. Building rapport with children can be facilitated by taking measures to ensure the environment and tone of the interview is as informal and comfortable as possible. It is helpful to allow children some input into the flow of interviews by letting them know approximately how long the conversations will last and that breaks are available on demand. Children's attention spans can be quite short,

so it may be necessary to take breaks during the interviews or conduct them over multiple sessions.

289. Interviewers should use child-appropriate language and adapt their communication style to match local terminology and cultural norms to help the child feel at ease and engage in the interview process. The interviewer can utilize a "practice narrative" whereby the child is encouraged to talk at depth about a neutral topic. This also enables interviewers to get to know children, their verbal ability and their degree of relational (un)ease. Questions about their age, what they like to do if they have free time and where they currently live can all be good "ice breakers" before transitioning to more sensitive topics. A clinician can slowly lead into trauma-related topics using their own words in response to open-ended questions whenever possible.

290. Emotional reactions among children may vary. Children may become silent for a long period of time, avert their gaze or change the topic altogether when they become overwhelmed by a question. In those cases, it is usually best to follow their lead and switch, at least temporarily, to a less threatening subject. The ability to concentrate and participate in interviews may also be affected by heightened emotionality and limited capacity to regulate their affect, especially in adolescents. Explanations of events that appear shallow or implausible to an adult may be a reflection of a child or adolescent's limited reasoning or more impulsive behaviour.

291. The presence of important attachment figures such as parents or guardians, at least early in the interview process, can provide comfort to an anxious child and also allow the parent or guardian to tacitly endorse the child's cooperation. Particularly when the torture consisted of forced separation from caregivers, clinicians must exercise patience in desensitizing the child to being interviewed alone, which is ultimately desirable. A child may feel uncomfortable in disclosing information about trauma in the presence of a parent due to their concern that the disclosure will distress their parent or add to their guilt, shame or embarrassment. Clinicians must exercise judgment and patience in making children comfortable and support them when being interviewed alone, especially in situations involving sexual violence. Clinicians may need to consider the wishes of children to keep information they disclose confidential from their parents and how to address this ethically.

292. In discussing traumatic events, some techniques may assist the child in describing the events. Drawing a timeline can help a child to sequence events and using well-remembered chronological anchors, for example "Did this happen before or after your tenth birthday?" or "Before or after the school year ended?", can further help to pinpoint events in time with greater specificity. Some children will be able to relax more while moving their entire bodies, for example talking while walking. A child may prefer to draw a picture and then to explain it. While toys may be helpful to allow a range of expression, physically discharge anxiety during the interview and provide comfort, toys should not be used to elicit history as they can blur the line between fantasy and reality. For survivors of torture and other trauma, it is important to note that traumatic play is characteristically very repetitive and long lasting, often with either a disengaged, flat affect or with an overly aroused, anxious affect, either of which can render the child somewhat impervious to interruptions by the clinician. Although non-verbal methods of exploration must be used with caution, they may be a source of information.

293. Children typically provide less information than adults. This is partly because they are less capable of, and less skilled at, generating retrieval cues independently. The use of probing questions is effective with children, especially young children, as they provide a cue within the question (e.g. "You mentioned a man; did the man say something to you?" or "What did the man say?"). However, for reasons outlined above, interviewers should avoid interviewing children solely with probing and closed-ended questions. A better method is to encourage elaboration based on what a child has already said (e.g. "You said [detail]; what happened next?" or "You said [detail]; tell me more about that"). As a child becomes more developmentally mature, they become better at generating their own retrieval cues and are better able to answer open-ended questions. Empowering the child to answer "I do not know" or to defer or refuse to answer questions if they are too painful or difficult not only can increase the accuracy of the information obtained but suggests that a fact-finding agenda will not override the child's well-being.

7. Cultural, religious and social/political awareness

294. Clinicians who conduct evaluations of victims of alleged torture should have the cultural humility and transcultural perspective necessary to understand and effectively document the physical and psychological

effects of the alleged torture or ill-treatment. The clinician should attempt to understand mental suffering in the context of the interviewee's own experience, circumstances, beliefs and cultural norms. Idioms of distress can be culturally specific or language-bound methods to express a feeling or experience. Culture and language can also influence how a specific illness, symptom or experience is conceptualized and described. Awareness and constant learning of idioms of distress and culture-specific conceptualizations of pain and illness are of paramount importance for conducting the interview and formulating the clinical impression and conclusion.

295. Interviewers should also be aware of the sociocultural dynamics of their own identity and how implicit and explicit perceptions of power, ethnicity, nationality, gender, age, sexual orientation and socioeconomic status may impact the interview. In addition, interviewers should make sure to conduct themselves in a manner that does not offend cultural or religious sensibilities. A lack of such awareness risks alienating the individual and/or causing them to feel uneasy, leading to a less effective interview.

8. Use of interpreters

296. For many purposes, it is necessary to use an interpreter to allow the interviewer to understand what is being said. There are some essential considerations for using interpreters that may also apply to any trainees or support persons present during the evaluation. Adequately briefing interpreters prior to the evaluation is essential. Interpreters must be advised that what they hear and interpret in interviews is strictly confidential. They should interpret precisely what the interviewee says and should avoid side conversations with the interviewee during the course of the interview. Interviewers should use caution in relying on interpreters to provide cultural context as that knowledge may be out of date if the interpreters left the country years before, or their knowledge may be biased by their own socioeconomic, ethnic, religious or gender lens.

297. Interviewers should remember to speak directly to the interviewee and maintain eye contact, rather than follow the natural tendency to speak to the interpreter. The interviewer should be mindful of speaking to the interviewee in the second rather than third person just as they would if an interpreter was not present. It is essential for interviewers to observe not only the words but also the accompanying body language, facial expressions, tone of voice and gestures of interviewees if they are to obtain a full and accurate picture. Interviewers should familiarize themselves with torture-related words and terminology in the person's language to demonstrate that they are knowledgeable about the issue.

298. When visiting persons deprived of their liberty, it is best not to use interpreters employed in or by the same facility. It may also be unfair for such interpreters, who may be "debriefed" by the facility authorities after a visit or otherwise put under pressure. It is best to use independent interpreters who are clearly seen as coming from elsewhere. The next best thing to speaking the local language fluently is to work with a trained interpreter with experience, who is sensitive to the issue of torture and to the local culture. As a rule, co-detainees should not be used for interpretation, unless it is an emergency situation and the interviewees have chosen someone they trust. In the case of persons who are not in detention, many of these same rules also apply.

9. Emotional reactions and their potential effects

299. The clinician should explain the interview process and types of questions that will be asked in order to prepare the individual for the difficult emotional reactions that the questions may provoke. The individual should be given an opportunity to request breaks, to interrupt the interview at any time and to leave if needed. An individual who chooses to leave should be offered a later appointment. Clinicians need to be sensitive and empathic in their questioning, while remaining objective in their clinical assessment.

300. Clinicians who conduct clinical and psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in both the interviewee and the interviewer. These emotional reactions are known as transference and countertransference, respectively. Transference refers to the feelings a survivor has towards the clinician that relate to past experiences, but which are misunderstood as directed towards the clinician personally. Mistrust, fear, shame, rage and guilt are among the typical reactions that torture survivors experience, particularly when being asked to recount or remember details of their trauma. In addition, the clinician's emotional response to the torture survivor, known as countertransference, may affect the psychological evaluation. Transference and countertransference are mutually interdependent and interactive.

301. Transference reactions may alter the evaluation by assigning distressing and unwanted memories, thoughts and feelings on the examiner. Furthermore, even though an alleged torture victim may consent to an evaluation with the hope of benefiting from it, the resulting exposure may renew the trauma experience itself or leave the survivor with disturbing memories of the examination and examiner. This may include the following phenomena:

(a) The evaluators' questions may be perceived as forced exposure akin to an interrogation. This may lead the subject to perceive the evaluator as being on the side of the enemy. Simply taking time at the start to explain the purpose of the interview to the interviewee will help alleviate this;

(b) Torture survivors may perceive evaluators as persons in positions of authority, which is often the case, and for that reason may not trust them with certain aspects of the trauma history or may be too trusting in situations in which the interviewers cannot guarantee safety. Every precaution should be taken to ensure that detainees do not put themselves at risk unnecessarily.

302. Countertransference reactions are often unconscious but may interfere with the evaluation process, especially when clinicians are unaware of them. Having feelings when listening to individuals speak of their torture is to be expected. When these feelings are not acknowledged they can interfere with the clinician's effectiveness, but when these feelings are recognized and understood they can provide important information about the psychological state of a torture victim. There is a consensus among professionals that those who regularly conduct this kind of examination should obtain professional support from peers or counsellors who are experienced in this field. Common countertransference reactions include:

(a) Avoidance, withdrawal and defensive indifference;

(b) Disillusionment, helplessness and overidentification with the survivor;

(c) Omnipotence and grandiosity;

(d) Feelings of insecurity about professional skills;

(e) Feelings of guilt about not sharing the torture survivor's experience and pain or frustration about inaction;

(f) Anger and rage towards torturers and persecutors. These reactions are expected, but may undermine the ability to maintain objectivity when they are driven by unrecognized personal experiences and thus become excessive or chronic. When expressed during evaluations, they may be perceived by survivors as disgust or anger directed at them;

(g) Anger or repugnance against the victim may arise as a result of feeling exposed to unaccustomed levels of anxiety.

B. Conducting interviews

1. Clinical qualifications

303. All clinicians who conduct clinical evaluations of alleged or suspected cases of torture or ill-treatment should do so in accordance with the Istanbul Protocol and its Principles. The clinical skills necessary to document physical and psychological evidence of torture and ill-treatment include basic clinical competencies. Conducting evaluations in accordance with the Istanbul Protocol does not require certification as a forensic expert, even though this may be the normative practice in some States and is sometimes used to intentionally exclude the testimony of independent clinicians from court proceedings.

304. Documentation of clinical evidence of torture requires specific knowledge by qualified health practitioners. Knowledge of torture and its physical and psychological consequences can be gained through publications, training courses, professional conferences and experience. In addition, knowledge about regional practices of torture and ill-treatment is important because such information may corroborate an individual's accounts of these regional practices. Experience interviewing and examining individuals for physical and psychological evidence of torture or ill-treatment and documenting findings under the supervision of experienced clinicians is highly recommended.

305. Judges and legal experts should be familiar with relevant criteria to qualify forensic and other clinical expert witnesses in legal proceedings on the basis of their expertise, knowledge, experience and training, rather than on the basis of a particular professional licence or certificate. Qualification to conduct evaluations in accordance with the Istanbul Protocol is not synonymous with certification as a

forensic expert. Forensic expert witnesses are key target trainees regarding the Istanbul Protocol and its Principles and their clinical evaluations should be consistent with these standards. In each legal case, all government forensic expert witnesses and non-governmental forensic and clinical expert witnesses should be prepared to demonstrate their qualifications as experts on documenting torture and ill-treatment. Judges should not presume that official certification is sufficient to qualify a government forensic expert to conduct an evaluation in accordance with the Istanbul Protocol.

306. The Special Rapporteur on torture has recognized the practice of prosecutors and judges excluding non-State experts from judicial proceedings, stating that:

> Courts should neither rule out non-State experts nor award State expert testimony more weight based solely on their "official" status. Regarding required expertise, it must be determined on its merits. In that regard, independence and objectivity are a primary concern. The State will usually have more resources and be in a privileged position to examine victims. Those facts must be considered alongside the degree of independence and impartiality such experts enjoy, as well as the obstacles that non-State experts might face in gaining access to and procuring evidence. The presumption must be that the State has to account for its own action or inaction and its inability to protect the rights of persons under its effective control. It is the State's obligation to rebut allegations, and to show that it has conducted truly effective investigations.[405]

307. The most important clinical qualification in conducting an evaluation of an alleged victim is knowledge of how to apply the Istanbul Protocol and its Principles. If clinicians are asked to list their clinical qualifications in judicial proceedings, they may consider listing additional information such as: (a) clinical education and training; (b) psychological/psychiatric training; (c) experience in documenting evidence of torture and ill-treatment and other forms of violence; (d) completion of relevant training courses and seminars, including those specific to the Istanbul Protocol; (e) supervision and mentoring by experienced clinicians; (f) association with a human rights organization or network or a treatment centre for torture survivors; and (g) regional human rights expertise relevant to medico-legal evaluations. When possible, clinicians conducting clinical evaluations should have knowledge of prison conditions and torture methods used in the region in which torture and ill-treatment were alleged.

308. Many clinicians including primary care physicians, psychiatrists, psychologists, clinical social workers and nurses may acquire the knowledge and skills to diagnose psychiatric conditions. Some physicians may be able to document both physical and psychological evidence of torture or ill-treatment. Clinicians who are not formally trained in psychiatry and/or psychology may acquire knowledge and skills to identify psychological evidence of torture and ill-treatment, such as symptoms of depression, PTSD and anxiety through training or experience.

2. Integration of physical and psychological evaluations

309. Medico-legal evaluations of alleged torture or ill-treatment may require the expertise of more than one clinician, including experts in physical and psychological evidence, as well as subspecialists in medicine, surgery and neuropsychology. In legal cases, it is important to integrate the findings of multiple evaluations into one comprehensive evaluation when possible. It may be advisable for the experts in physical evidence and psychological evidence to conduct one evaluation together. When conducted separately, clinical evaluations should set out, for the clear understanding of legal professionals, that such evaluations represent components of a single clinical evaluation and be considered accordingly. If there are separate clinical evaluations and there is strong supporting evidence in one evaluation and only moderate supporting evidence in the other, the totality of evidence should be considered strongly supportive.

3. Interview settings

310. Clinical evaluations of persons alleging torture or ill-treatment should be conducted at a location that the clinician and interviewee deem most suitable. This is of particular concern in detention settings. In many situations, it is not possible to control the environment of the interview, for example in prisons, and the interviewer and interviewee will have to make the best of less than ideal conditions. Such shortcomings should be clearly documented in the report and requests should be made to the relevant authority to provide

405 A/69/387, para. 53.

appropriate conditions. In some cases, it may be best to insist that the evaluation take place at the facility's medical unit or off-site from the prison or jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if, for example, they are concerned that the medical premises may be under surveillance. However, interviewers should apply and adapt these basic principles on interviewing as much as possible. The best place will be dictated by many factors, but in all cases, interviewers should ensure that interviewees are not forced into accepting a place in which they do not feel comfortable or safe.

311. If possible, the room should have appropriate physical conditions (light, ventilation, size and temperature). There should be access to toilet facilities and refreshment opportunities. The seating arrangement should allow the interviewer and interviewee to be equally comfortable and at an appropriate distance to establish eye contact and see each other's faces clearly. Neither the interviewer nor the interviewee should sit in a position that blocks access to the door. Attention should be paid to arrange the room in a way that it is not reminiscent of official surroundings or the interrogation process.

4. Procedural safeguards with respect to detainees

312. Medico-legal evaluations of detainees should be conducted when requested by official written requests by public prosecutors or other appropriate officials and with the informed consent of the alleged victim. Requests for medico-legal evaluations by law enforcement officials are to be considered invalid unless they are requested on the written order of a public prosecutor or other appropriate official. Detainees themselves or their lawyers or relatives have the right to request a clinical evaluation to assess evidence of torture or ill-treatment. The detainee should be taken to the clinical examination by officials other than soldiers and police since torture or ill-treatment may have occurred in their custody and, therefore, that would place unacceptable coercive pressure on the detainee or the clinician not to document torture or ill-treatment effectively. The officials who supervise the transportation of the detainee should be responsible to the public prosecutor or other appropriate official, but not to other law enforcement officials. The detainee's lawyer should be present during the request for examination and post-examination transport of the detainee. Detainees have the right to obtain a second or alternative clinical evaluation by a qualified clinician of their choice during and after the period of detention.

313. Each detainee must be examined in private. Police or other law enforcement officials should not be present in the examination room. This procedural safeguard may be precluded only when, in the opinion of the examining clinician, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, the security personnel of the health facility, not the police or other law enforcement officials, should be available upon request by the clinician. In such cases, security personnel should remain out of earshot (i.e. be within only visual contact) of the interviewee.

314. The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the clinician's official medico-legal report. Their presence during the examination may be grounds for disregarding a negative medico-legal report. The identity and titles of others who are present in the examination room during the clinical evaluations should be indicated in the report. Official medico-legal evaluations of detainees by State forensic experts should include the use of a standardized medical report form that is consistent with the Istanbul Protocol and its Principles, including annex IV.

315. The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor or other appropriate officials, and/or their legal representative. When detainees or lawyers acting on their behalf request a medico-legal report, the report must be provided. Copies of all medico-legal reports should be retained by the examining clinician. Under no circumstances should a copy of the medico-legal report be transferred to law enforcement officials.[406] It is mandatory that a detainee undergo a thorough medical examination at the time of detention.[407] Access to a lawyer should be provided at the time of the clinical evaluation. An outside presence during examinations may be impossible in most prison situations. In such cases, it should be stipulated that prison doctors working

406 When police officers transport detainees to clinicians for evaluations and demand to receive a copy of the report, the clinician should refuse and, instead, provide a copy to the public prosecutor or other appropriate legal officials. The clinician's reports may be shared with detainees, but the risk of the police accessing a copy should be discussed with them.

407 Nelson Mandela Rules, rule 30; and Bangkok Rules, rule 6.

with prisoners should respect medical ethics and should be capable of carrying out their professional duties independently of any third-party influence. If the medico-legal examination supports allegations of torture or ill-treatment, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee's legal disposition.[408] A national medical association or a commission of inquiry may choose to audit medico-legal reports to ensure that adequate procedural safeguards and documentation standards are adhered to, particularly by clinicians employed by, and conducting an official evaluation on behalf of, the State. Reports should be sent to such an organization, provided issues of independence and confidentiality have been addressed.

5. Official visits to places of detention

316. Visits to persons deprived of their liberty can, in some cases, be notoriously difficult to carry out in an objective and professional way, particularly in countries in which torture is still being practised. A one-time visit, without follow-up to ensure the safety of the interviewees after the visit, may risk the well-being of detainees even further. The notion that some evidence is better than no evidence is not valid when working with persons deprived of their liberty who might be put in danger by giving testimony. Well-meaning interviewers may fall into the trap of visiting a prison or police station and obtaining an incomplete or false picture of reality. They may give an alibi to the perpetrators of torture or ill-treatment, who may exploit the fact that outsiders visited their prison and did not report findings of abuse. There may be value in unannounced visits or freedom to choose which detention setting to visit because authorities may take advantage of prior notice to conceal evidence or silence prisoners.

317. Independent commissions constituted by jurists and clinicians should be given periodic access to visit places of detention and prisons. Monitoring visits, including by human rights investigators, national human rights institutions or national preventative mechanisms, should include qualified legal and clinical experts to ensure that interviews with detainees are consistent with the Istanbul Protocol and its Principles (see chap. VII). Members of national preventative mechanisms should be familiar with the standards and recommendations in the Istanbul Protocol and its Principles and international/regional standards for monitoring places of deprivation of liberty.

318. Interviews with persons who are still in custody, and possibly even in the hands of the perpetrators of torture or ill-treatment, will obviously be very different from interviews in the privacy and security of an outside medical facility. The importance of obtaining the person's trust in such situations cannot be stressed enough. However, it is even more important not to betray that trust, perhaps unwittingly. All precautions should be taken to ensure that detainees do not place themselves in danger. Detainees who allege being tortured or ill-treated should be asked whether they have concerns that the information they provide in the evaluation can be used against them and in which way. For example, they may be too afraid to allow use of their names, fearing reprisals. Interviewers, clinicians and interpreters should not make promises to detainees that they are not able to fulfil.

319. The location of an interview should be considered carefully, out of sight and hearing of security officers, to ensure confidentiality. The possible presence of cameras, microphones and/or one-way mirrors should also be considered, especially if a police interview room is used. Interviews should typically take place with the informed consent of interviewees, in a comfortable room in which they do not feel intimidated. Interviewers should avoid places that may hold memories of traumatic experiences for some detainees or simply be associated with abusive authority.

320. A clear dilemma may arise in cases in which a visiting team finds that widespread and systematic acts of torture and ill-treatment are practised in a given place of deprivation of liberty, but all victims refuse to allow interviewers to use their evaluations out of fear of reprisals. Clinicians must preserve confidentiality and avoid betraying the individuals' trust through unilateral decisions to report the abuses. When confronted with this type of situation, in which a number of detainees may show clear signs of abuse, such as marks on their bodies of whippings, beatings, lacerations, etc., but who all refuse to allow mention of their cases, it is useful to organize a "health inspection" of the whole ward in full view in the courtyard. In that way, the visiting clinical interviewers can directly observe the visible signs of torture on the individuals and make a report on what they have seen without having to state that individuals

408 "Health care for prisoners: implications of 'Kalk's refusal'", *Lancet*, vol. 337, No. 8742 (1991), pp. 647–648.

complained about torture. This first step ensures the individuals' trust for future follow-up visits.

321. Other, less visible forms of torture, psychological or sexual, for example, cannot be dealt with in the same way. In such cases, it may be necessary for interviewers to refrain from comment for one or several visits until the circumstances allow or detainees feel safe enough.

322. Clinicians must perform due diligence at all times even when conducting multiple evaluations in a single day. A person interviewed at 8 p.m. deserves as much attention as one seen at 8 a.m. Interviewers should manage their workloads to ensure sufficient time and energy for each evaluation.

6. Preparation for the interview

323. In advance of the interview, interviewers should familiarize themselves with the case and prepare by identifying potential topic areas to focus on that are important for the report, while also being flexible enough to expect that new topic areas might arise during the interview. For this, it is useful to review appropriate documents/affidavits that the subject's legal counsel may have prepared. Such documents may help the clinician to anticipate the content of the individual's narrative. Also, knowledge of prior testimonies may aid in identifying elements in the history that need clarifying. Despite the utility of legal documents/affidavits, the information contained therein should not be relied upon solely and should be independently verified. All information relevant to a clinical evaluation should be gathered by the clinician.

324. It is critical to understand the many reasons traumatized individuals may miss or be late for appointments and allow for rescheduling whenever possible. Establishing contact just prior to the appointment can help prevent the frustration and inefficiency of missed appointments.

7. Communication barriers

325. The clinician should also try to anticipate and, when possible, address possible barriers to effective communication. Barriers to communication can drastically influence the value and/or process of an interview. Possible barriers to communication include:

(a) Environmental barriers, such as lack of privacy, uncomfortable interview setting or inadequate time for the interview;

(b) Physical barriers, such as pain or other discomfort the individual may be experiencing: for example, physical pain, difficulty sitting for extended periods, fatigue or sensory deficits, such as blindness or deafness;

(c) Psychological barriers, such as fear or anxiety, or mental health disorders, such as depression, PTSD or cognitive deficits;

(d) Sociocultural barriers, such as the gender of the interviewer (this is particularly important with victims of sexual torture or ill-treatment), language issues (including appropriateness and accuracy of the interpreter) and the power imbalance between the examiner and interviewee (including race, culture or social status);

(e) Barriers relating to the interviewer, such as the absence of an interview plan or structure, the use of poor questioning techniques and/or poor interpersonal skills, personal biases or lack of understanding of the cultural or age-dependent needs of the interviewee.

8. Building rapport

326. Building rapport, which in this context means a working relationship between the interviewer and interviewee, is key to conducting an effective interview.[409] Taking time to build trust and rapport will make it easier for interviewees of all ages to talk about difficult topics.

327. Showing respect for the interviewee, being fully engaged in the interview process, open body language, attentiveness and matching the communication style of the interviewee can build rapport. Time should be allowed for some discussion of family and other personal matters to develop a relationship. Individuals should not be forced to talk about any form of torture or ill-treatment unless and until they are comfortable doing so.

328. Empathy is an important component of building rapport, which is particularly important for clinicians

409 Allison Abbe and others, "The role of rapport in investigative interviewing: a review", *Journal of Investigative Psychology and Offender Profiling*, vol. 10, No. 3 (2013), pp. 237–249; and Jonathan P. Vallano and others, "Rapport-building during witness and suspect interviews: a survey of law enforcement", *Applied Cognitive Psychology*, vol. 29, No. 3 (2015), pp. 369–380.

to use when listening to the interviewee disclose information about torture or ill-treatment. Empathy refers to the ability to recognize and understand the emotional experience of an interviewee by considering and acknowledging how the interviewee might be feeling. Empathy can be communicated through active listening, appropriate facial expressions or by verbally acknowledging the interviewee's emotions. In some cases, clinicians may find it helpful to state their clear position against human rights violations, including torture and ill-treatment. Clinicians should acknowledge the distress that they observe in their clinical interviews while maintaining professional boundaries and clinical objectivity.

9. Level of detail in the history

329. In the course of obtaining a narrative account of events and experiences, the clinician should attempt to obtain as much detail as possible that is relevant to conducting the assessment. Extensive and detailed narratives can provide more information from which to asses the correlation between the allegations and the findings; they frequently provide a sense of "being there", which adjudicators often consider useful. However, the inclusion of detailed historical information may be considered irrelevant by some adjudicators.

330. Attempts to obtain a detailed history may elicit accounts of events and experiences of which individuals are less certain. Interviewees should be advised to be forthcoming about uncertainty, for example by saying when they are sure or unsure of something.

331. A high level of detail, or a strong degree of certainty with which a memory is held, are helpful when present, but their absence cannot be taken to indicate that the memory is unreliable. Inconsistencies may arise within the account or between the account and other sources of information and these should be explored during the interview. The evaluating clinician should assess clinical reasons for limitations in recalling and recounting experiences, as discussed in paragraph 342 below.

332. Interviewees should be reminded about the importance of reporting only what they recall and be transparent about when injuries are unrelated to their alleged torture or ill-treatment. The evaluating clinician should acknowledge potential limitations in recalling all events. In addition, a lack of detail should not be considered as an indication of being untruthful as there may be important social, cognitive and contextual reasons for the lack of detail, including: the level of trust and rapport, gender alignment in the interview, age, social class, literacy and level of education, cultural factors, and clinical conditions affecting cognitive processes.

10. Techniques of questioning

333. Several techniques may assist in obtaining information from interviewees.

(a) Types of questions

334. The use of open-ended questions as an interview technique significantly increases both the amount and the accuracy of information provided by the interviewee. Open-ended questions often start with the words "tell", "explain" or "describe" (e.g. "Tell me what happened" and "Describe what you mean when you said …"). Open-ended questions give interviewees the freedom to respond by reporting their history in their own words as they remember it. This style of questioning therefore encourages people to take on the active role of generating and providing information, rather than a passive role of simply answering questions.

335. To clarify open-ended responses or motivate hesitant interviewees, it is appropriate to use focused or probing questions. Focused questions may start with the words "who", "what", "where", "when" and "how".

336. Closed-ended questions might be required to specify things, for example "Did that happen before or after …?" or "Which person did that?". Closed-ended questions (sometimes known as "specific questions" or "option-posing questions") generally elicit shorter answers; therefore, they are not effective as a main interview technique. Caution should be taken in closed-ended questioning as the use of rapid-fire closed-ended questions is known to restrict both the amount and the accuracy of information provided by the interviewee. Furthermore, asking too many questions too quickly might confuse individuals, creating contradictory responses or even reminding them of being interrogated.

337. Leading questions are to be avoided wherever possible, because individuals may answer with what they think the interviewer wants to hear. This is especially important when interviewing for medico-legal purposes in situations in which the testimony may be challenged in court. Children are particularly susceptible to leading questions that suggest a desired response.

(b) Cognitive techniques

338. The quality of the information gained can be improved by some specific techniques to facilitate retrieval. First, in a clinical setting in which time allows it, individuals should be told to describe everything surrounding the time of ill-treatment (e.g. describing the events and process of being taken into detention), even if it does not appear directly relevant to them. This might help discover details or events that could be more important than the individuals realize. Second, as individuals relate these events, other events might be brought to mind. It helps if individuals are encouraged to recall the context in which the events happened, including physical, emotional, and sensory aspects of that event (e.g., "What could you see?", "What could you hear?", "What could you smell?" and "How did you feel?"). Mentally reinstating context in this way typically promotes the recall of additional accurate information and is particularly effective following a long delay.[410] Use of such techniques can, however, trigger flashbacks, so the interviewer should use them cautiously.

339. Communicating certain types of information may be difficult to do verbally or in a linear narrative. Interviewers should therefore consider whether some of the information an individual has to report might be better described or communicated non-verbally. For instance, it may be useful to invite the individual to generate a sketch of a room or building(s) to report important spatial information and help cue memory for details that might otherwise have been forgotten. Similarly, using a timeline can enhance communication of the temporal order of events and actions.

340. The judicious use of silence and pauses can help to foster a safe space for revealing very personal details as well as provide the interviewee with the necessary time to organize their thoughts. Even if there is limited time for the interview, 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.

341. It is important to remember that different cultures have different concepts of what is normal behaviour in an interview. Cultural humility and understanding will assist in navigating cross-cultural evaluations (see paras. 294–295 above).

11. Difficulty recalling and recounting

342. Torture survivors may have difficulty recounting the specific details of the torture or ill-treatment for several important reasons, including:

(a) Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.;

(b) Fear of placing themselves or others at risk;

(c) A lack of trust in the examining clinician or interpreter;

(d) The psychological impact of torture and trauma, for example high emotional arousal, cognitive avoidance due to painful emotions, such as guilt and shame, and impaired memory, secondary to trauma-related mental illnesses, such as depression and PTSD;

(e) Neuropsychiatric memory impairment from head trauma, suffocation, near drowning or starvation;

(f) Protective coping mechanisms, such as denial, avoidance and dissociation;[411]

(g) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.[412]

12. Variability and inconsistencies in the history

343. It is important to keep in mind that there is often variability in the level of detail that an individual will recall with regard to the events of the trauma. This variability does not necessarily indicate that the narrator is providing false information or is unreliable.[413] The normal variability of memory, in which successive accounts may contain more and different details each time with omission of other details, is likely to be exacerbated by torture or ill-treatment. Torture victims are commonly subjected

410 Ronald P. Fisher and Ronald E. Geiselman, *Memory Enhancing Techniques for Investigative Interviewing: The Cognitive Interview* (Springfield, Charles C. Thomas Publisher, 1992), pp. 99–102.

411 Dissociation is a mental process of disconnecting or lack of continuity between thoughts, memories, surroundings, actions and identity. Dissociative disorders usually develop as a reaction to trauma to help keep difficult memories at bay.

412 Richard F. Mollica and Yael Caspi-Yavin, "Overview: the assessment and diagnosis of torture events and symptoms", in *Torture and Its Consequences: Current Treatment Approaches*, Metin Başoğlu, ed. (Cambridge, United Kingdom, Cambridge University Press, 1992), pp. 255–274; and Juliet Cohen, "Errors of recall and credibility: can omissions and discrepancies in successive statements reasonably be said to undermine credibility of testimony?", *Medico-Legal Journal*, vol. 69, No. 1 (2001), pp. 25–34.

413 Cohen, "Errors of recall and credibility".

to multiple forms of abuse, often simultaneously. This is often the case when an individual is subjected to repeated or prolonged episodes of torture or ill-treatment. Furthermore, individuals may have been detained under conditions in which they lose a sense of time and place, for example, being kept blindfolded or held in solitary confinement in a dark cell, or in a weakened state as a result of being deprived of food, water and/or sleep. As such, individuals are susceptible to making "source monitoring" errors, in which they confuse one episode with another and find it difficult to say with certainty that the source of the information that they are providing is from their memory of a specific episode.

344. Memory of events can be affected in one or more of at least three ways:

(a) A failure to lay down memory (e.g. secondary to head injury or extreme emotional arousal);

(b) Motivated forgetting of unpleasant memories;

(c) Impaired ability to recall.

345. In extreme emotional arousal, when the body is under threat, memory storage is impaired. Memories of traumatic experiences may as a result be fragmented and poorly located in the overall context of chronology or location. Details central to the experience are recalled better than peripheral details (date and number detail is particularly poorly recalled), but even some details core to the experience may not be reliably recalled. The ability to recall and recount details of traumatic events may vary over time, particularly when an individual has PTSD. Differences in the history (particularly, variable ability to recall details about torture and ill-treatment experiences) obtained from interviews conducted at different times are to be expected.

346. Interviewers should use judgment about how much specific detail is needed to document the alleged abuse. For example, if someone were repeatedly tortured or raped, it may be unnecessary, or inappropriate, to elicit all of the details about every episode. If it is important to elicit information about a number of different episodes, ask the interviewee to identify the ones that they remember most clearly or were most impactful. These might be the first occasion, the last occasion, or a specific episode that was memorable for a particular reason. Let the interviewee name these by differentiating among them and then address each episode in turn, one at a time, to ask about in more detail. This instruction is even more important when a child is being interviewed, as children are more vulnerable to mixing up details from repeated events.

347. Inconsistencies between a person's allegations of abuse and the findings of the evaluation may arise from any or all of the aforementioned factors and should not be assumed to indicate untruthfulness. Clinicians have a duty to pursue possible explanations of such inconsistencies. If possible, the clinician should ask for further clarification. When this is not possible, the clinician should look for other evidence that supports or refutes the account of events. A network of consistent supporting details can corroborate and clarify the person's allegations. Although the individual may not be able to provide the details desired by the interviewer, such as dates, times, places, frequencies and the exact identities of the perpetrators, a broad outline of the alleged traumatic events will emerge and stand up over time. In a judicial context, differences in the narrative obtained over time may be interpreted as influencing the credibility assessment; therefore, it is imperative that the testimony presented by the evaluator include a discussion about how variability and inconsistency should be interpreted.

348. It is important to recognize that some people falsely allege torture for a range of reasons. Others may exaggerate a relatively minor experience for personal or political reasons. The clinician must always be aware of these possibilities and try to identify possible exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess. Effective documentation of physical and psychological evidence of torture or ill-treatment requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report. If the clinician suspects fabrication, additional interviews should be scheduled to clarify the inconsistencies in the report. Family or friends may be able to corroborate details of the account of events. If the clinician conducts additional examinations and still suspects fabrication, the clinician should refer the individual to another clinician and ask for the colleague's opinion. In some cases, the suspicion of fabrication should be documented with the opinion of two clinicians.

13. Addressing variability and inconsistencies

349. The reliability of clinical evidence is often based on elements of internal and external consistency. Internal consistency refers to corroboration between elements of an individual case, whereas external consistency refers to consistency between individual case findings and knowledge of torture and ill-treatment methods and practices within a particular region or additional witness information.

350. Internal consistency within the context of a clinical evaluation may be supported by a wide range of general and specific observations. First and foremost, the reliability of clinical evidence is reflected in the level of consistency between specific allegations of abuse and the documentation of physical and psychological findings. Similarly, the degree of consistency between the description of physical injuries and reports of subsequent acute symptoms, the healing process (taking into consideration relevant mitigating factors) and chronic symptoms and disabilities may also support the internal consistency of the clinical findings. Observations of congruency between an alleged victim's observed affect (emotional state) during the interview and the content of the evaluation, for example, psychological distress in relating painful experiences, may reflect internal consistency of the clinical findings, bearing in mind that appropriate affect can vary widely due to an individual's circumstances and coping mechanisms.

351. Inconsistencies are common in the accounts of events by victims of torture and occur for many reasons. Adequate explanation of such inconsistencies should be understood as an indication of the reliability of the clinical findings rather than a matter of untruthfulness. It is important to note that without medical knowledge of human anatomy and pathophysiology, most individuals would not be able to fabricate accurate historical information regarding the physical sequalae of specific forms of torture or ill-treatment.

352. Clinicians who conduct evaluations of psychological evidence of torture or ill-treatment may consider a number of additional factors that may be relevant to the reliability of psychological findings – for example, the temporal relationship between the alleged abuse and onset of psychological symptoms as well as fluctuations in psychological symptoms in relation to internal and external psychological stressors and mitigating factors. The individual meaning assigned to the alleged abuse in light of individuals' psychosocial history may also be an indicator of internal consistency, as well as the congruency between individuals' emotions (both reported and observed by the clinician) and their coping mechanisms. Some psychological symptoms of PTSD may refer specifically to the alleged abuse rather than other traumatic experiences. For example, intrusive recollections and nightmares or triggers for intrusive recollections, reliving experiences and avoidance thoughts and behaviour that refer to the alleged torture or ill-treatment are more likely to be caused by the experience of torture or ill-treatment rather than by other traumatic experiences.

353. Examples of external consistency may include descriptions of torture and ill-treatment methods or specific devices, body positions used in applying torture and ill-treatment methods, methods of restraint during torture and ill-treatment, and identifying information about perpetrators and places of detention. In addition, other external sources of corroboration of the alleged events may be obtained from witnesses such as other detainees, family, friends, legal representatives, as well as medical reports, treatment records and photographs.

C. Content of interviews

354. All clinical evaluations of alleged or suspected cases of torture or ill-treatment in medico-legal settings must be conducted in accordance with the Istanbul Principles (see annex I) summarized as follows:

(a) Clinical evaluators should behave in conformity with the highest ethical standards and obtain informed consent before any examination is conducted;

(b) Clinical evaluations must:

(i) Be conducted promptly and in private;

(ii) Conform to established standards of clinical practice;

(iii) Be under the control of clinical experts, not security personnel;

(c) Written reports must be accurate and include the following:

(i) Identification of the alleged victim; time and location of the interview, documentation of any physical restraint of the interviewee and/

or presence of police or third parties during the evaluation;

(ii) A detailed record of the subject's allegations, including torture or ill-treatment methods and all complaints of physical and psychological symptoms;

(iii) A record of all physical and psychological findings on clinical examination, including appropriate diagnostic tests, body diagrams to record the location and nature of all injuries (see annex III) and, where possible, colour photographs of all injuries;

(iv) An interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment;

(v) A recommendation for any necessary medical and psychological treatment and/or further examination;

(vi) Identification and signature of the evaluating clinician(s).

355. It is important to note that the Istanbul Principles apply to clinical evaluations in legal and non-legal contexts with one exception – that clinical evaluations in non-legal contexts do not require an interpretation of the level of consistency between the clinical findings and the allegations of torture or ill-treatment or an opinion on the possibility of torture (see para. 635 below). Nevertheless, in these non-legal contexts, clinicians who have knowledge and experience of applying the Istanbul Protocol and its Principles should still consider providing an interpretation of the level of consistency between the clinical findings and the alleged method(s) of injury, as well as an opinion on the possibility of torture or ill-treatment as defined in the Convention against Torture.

356. The Istanbul Protocol includes minimum standards for the State's obligation to effectively investigate torture and ill-treatment, which are articulated in the Istanbul Principles and further elaborated in the present manual. The Istanbul Protocol and its Principles provide detailed guidance to clinicians who conduct medico-legal evaluations, which should be applied in accordance with a reasonable assessment of available resources and clinical judgment (see annex IV). It is important to understand that comprehensive clinical evaluations typically take several hours or longer to conduct and that medico-legal affidavits may be many pages in length. If time is limited, clinicians should endeavour to elicit the most critical information in accordance with the Istanbul Protocol and its Principles and report the time limitation.

357. A detailed clinical evaluation of cases in which torture or ill-treatment is alleged or suspected includes a number of components, many of which are common to assessments of both physical and psychological evidence. The following guidance on interview content focuses on common components of clinical evaluations. Additional guidance on the clinical evaluations of physical and psychological evidence of torture or ill-treatment is included in chapters V and VI respectively.

1. Introduction and identification

358. Interviews for clinical evaluations usually begin with examiners introducing themselves followed by:

(a) An explanation of the purpose of the evaluation and the role of the interviewer as an examiner rather than a treating clinician;

(b) A review of the conditions of the evaluation:

(i) Independence of the evaluator or lack thereof;

(ii) Confidentiality of the clinician's findings and any applicable limits, such as mandatory reporting requirements;

(iii) Right to refuse to answer questions or participate in examinations;

(iv) Importance of detail and accuracy of information;

(v) Possible difficulty of recalling certain events and potential for retraumatization and emotional reactions;

(vi) Ability to take breaks;

(vii) Access to refreshments and toilet facilities;

(c) A statement on the overall content of the evaluation including: detailed questions on events before during and after the alleged torture or ill-treatment, followed by a physical and psychological examination, should this be the case, and the possibility of photographs;

(d) A discussion of the likely benefits and risks of the evaluation;

(e) Responses to any questions or concerns that the individual may have;

(f) A request for informed consent to proceed with the evaluation.[414]

359. For medico-legal evaluations, the clinician should establish the identity of the subject. As previously mentioned, law enforcement officials should not be present during the evaluation. If such officials refuse to leave the examination room, it should be noted in the clinician's report or the evaluation can be cancelled.

2. Background/case information

360. *General information.* Clinicians should obtain relevant background information, which typically includes the individual's legal name, date and place of birth, the reason(s) for the evaluation, the name of the individual or authority requesting the evaluation, the name of any interpreter or third party present during the evaluation, the language used to conduct the interview and whether there were any restrictions on the evaluation, including physical restraints on the alleged victim or time constraints.

361. *Past medical and mental health history.* Clinicians should obtain a complete history, including prior medical, surgical and/or psychiatric problems. The clinician should document any history of injuries before the period of detention and any possible after-effects. Knowledge of prior injuries may help to differentiate physical findings related to torture from those that are not. The clinician should enquire about medication being taken by the individual; this is particularly important because medication may be denied to a person in custody with significant adverse health consequences.

362. *Review of prior clinical evaluations of alleged torture or ill-treatment.* Clinicians should enquire about the possibility of any prior clinical evaluation of the alleged torture or ill-treatment, whether in custody or after release. With the individual's consent, clinicians should do their utmost to obtain a copy of any such reports as it may provide corroborating or conflicting clinical information.

3. Psychosocial history before arrest

363. The examiner should enquire into the person's social history, daily activities, relationships with friends and family, work or school, occupation, interests, future plans and use of alcohol and drugs prior to the alleged torture or ill-treatment. Information should also be elicited regarding the person's post-detention psychosocial history. Inquiries into political activities, identity, beliefs and opinions are relevant insofar as they help to explain why a person was detained, tortured or ill-treated. The clinician should be aware of the fact that including information on political activities of a person in the clinical documentation may cause additional risks for the individual and, as such, might be against the ethical principle of "do no harm". Such inquiries can sometimes elicit informative responses when made indirectly by asking the person what accusations have been made.

4. Allegations of torture and ill-treatment

364. In many cases of alleged torture or ill-treatment, there may be multiple interviewers, such as other fact-finders, lawyers and others, who are also involved. Any communication, sharing of information or other interaction with these actors should be conducted thoughtfully and in accordance with ethical principles.

(a) Summary of detention and torture or ill-treatment

365. Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, and frequency and duration of sessions involving torture or ill-treatment. A summary will help to make effective use of time. In some cases in which survivors have been subjected to torture or ill-treatment on multiple occasions, they may be able to recall what happened to them, but often they cannot recall exactly where and when each event occurred. In such circumstances, it may be advisable to elicit the historical account according to methods of torture or ill-treatment rather than relating a series of events during specific arrests. Places of detention are operated by different security, police or armed forces, and understanding what occurred in different places may be useful for a full picture of the torture system. Obtaining a map of where the alleged torture or ill-treatment occurred may be useful in piecing

414 If there is any doubt about the individual's mental competency before or during the evaluation, an assessment of possible cognitive impairment should be conducted as the consent of individuals deemed to be mentally incompetent is not valid.

together the accounts of different people. This will often prove very useful for the overall investigation.

(b) Circumstances of arrest and detention

366. The circumstances of detention should be elicited. Consider questions about perpetrators, their appearance, witnesses, types of detention and descriptions of events. Some focused or probing questions may include: What time was it? Where were you? What were you doing? Who was there? How would you describe the appearance of those who detained you? Who were they and what were they wearing? What type of weapons, if any, were they carrying? What was said? Were there any witnesses? Was this a formal arrest, administrative detention or disappearance? Was violence used, threats spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination and names of officials, if known.

(c) Place and conditions of detention

367. The clinician should document any contact with family, lawyers or health professionals, conditions of overcrowding or solitary confinement, the dimensions of the place of detention and whether there are other people who can corroborate the detention. Consider the following focused questions: What happened first? Where were you taken? Was there an identification process (personal information recorded, fingerprints or photographs)? Were you asked to sign anything? Describe the conditions of the cell or room (note size, others present, light, ventilation, temperature, presence of insects, rodents, bedding and access to food, water and the toilet). What did you hear, see and smell? Did you have any contact with people outside or access to medical care? What was the physical layout of the place in which you were detained?

(d) Narrative account of torture or ill-treatment

368. The clinician should elicit a detailed description of any allegations of torture or ill-treatment, including both physical and psychological forms. To reduce the risk of potential embellishment, clinicians should exercise caution in the use of direct questions suggesting specific forms of abuse as described in paragraph 372 below. However, eliciting negative responses to questions about various forms of torture may also help establish the credibility of the clinical findings. Questions should be designed to elicit a coherent narrative account. Consider the following questions: Where did the alleged abuse take place, when and for how long? Were you blindfolded? Before discussing forms of abuse, note who was present (give names and positions). Describe the room or place. Which objects did you observe? If possible, describe each instrument of alleged torture or ill-treatment in detail; for electrical torture, the type of current, device, number and shape of electrodes. Ask about clothing, disrobing and change of clothing. Record quotations of what was said during the interrogation, insults used against the alleged victim, etc. What was said among the perpetrators?

369. In assessments of physical evidence of torture or ill-treatment, for each form of alleged abuse, the clinician may note: body position, restraint, nature of contact, including duration, frequency, anatomical location and the area of the body affected. Was there any bleeding, head trauma or loss of consciousness? Was the loss of consciousness due to head trauma, asphyxiation or pain? The clinician should also ask about the condition of the person, how the person was at the end of the "session", such as gait, any difficulty walking, ability to function in the following days and physical signs, such as swelling of the feet. These details provide enhanced descriptions, compared with a checklist. The history should include the date(s) of alleged torture or ill-treatment, how many times and for how many days the torture or ill-treatment lasted, the period of each episode and the description and style of the suspension (reverse-linear, being covered by a thick cloth blanket or being tied directly with a rope, weight applied to the legs or pulling down) or position. In cases of torture involving suspension, the clinician should ask which sort of material was used as rope, wire and cloth leave different marks, if any, on the skin after suspension. The clinician must remember that statements about the length of the session involving torture or ill-treatment by the alleged victim are subjective and may not be precise, since disorientation of time and place during torture and ill-treatment is a commonly observed finding. The alleged victim should be asked to describe any episodes of sexual harassment, threats or abuse and the clinician should elicit what was said during the alleged torture or ill-treatment. For example, during torture involving electric shocks to the genitals, perpetrators may often tell their victims that they will no longer be capable of normal sexual relations or something similar. For a detailed discussion of assessments of allegations of sexual torture, including rape, see paragraphs 455–479 below.

370. As stated in chapter I, torture and ill-treatment include a wide range of acts wherein physical and/or

mental pain or suffering is inflicted. Many acts of violence that constitute torture or other ill-treatment occur in non-detention settings, for example, physical and psychological harm inflicted on the basis of sexual orientation and gender identity, and the use of unnecessary and disproportionate force in crowd control settings. The interviewer should be prepared to inquire about the nature and extent of such harms and their physical and psychological effects.

5. Review of torture methods

371. After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. Questioning about specific forms of torture and ill-treatment is helpful when:

(a) Psychological symptoms cloud recollections;

(b) The alleged torture or ill-treatment was associated with impaired sensory capabilities;

(c) There is a case of possible organic brain damage;

(d) There are mitigating educational and cultural factors that influence the account of events.

372. The distinction between physical and psychological methods of torture is artificial. What may be commonly referred to as "physical torture" has psychological components and what is referred to as "psychological torture" has physical components. Furthermore, victims are frequently subjected to multiple forms of abuse simultaneously, for example being threatened while being punched and kicked when restrained and blindfolded. The following list of torture methods is provided to illustrate some of the categories of possible torture and ill-treatment. It is not meant to be used by interviewers as a checklist or as a model for listing torture and ill-treatment methods in a report. A method-listing approach may be counterproductive, as the entire clinical picture produced by torture and ill-treatment is much more than the simple sum of lesions produced by methods on a list. Torture and ill-treatment methods to consider include, but are not limited to:

(a) Blunt trauma, such as a punch, kick, slap, whipping, a beating with wires or truncheons or forced contact with hard surfaces, such as floors and walls;

(b) Positional torture, using suspension, stretching limbs apart, prolonged constraint of movement and forced positioning;

(c) Burns with cigarettes, heated instruments, scalding liquids or caustic substances;

(d) Electric shocks;

(e) Asphyxiation, such as wet and dry methods, near-drowning, smothering, confinement in small or coffin-like boxes, choking or use of chemicals;

(f) Crush injuries, such as smashing fingers or using a heavy roller to injure the thighs or back;

(g) Penetrating injuries, such as stab and gunshot wounds or wires under nails;

(h) Chemical exposure to salt, chili pepper, gasoline, etc. (in wounds or body cavities);

(i) Sexual violence to genitals, molestation, instrumentation or rape;

(j) Traumatic or surgical amputation of body parts, such as ears, digits or limbs;

(k) Surgical removal of organs;

(l) Pharmacological torture using toxic doses of sedatives, neuroleptics or paralytics, hallucinogens or other substances;

(m) Conditions of detention, such as a small or overcrowded cells, unhygienic conditions, no access to toilet facilities, irregular or contaminated food and water, exposure to extremes of temperature, denial of privacy and forced nakedness;

(n) Deprivation of normal sensory stimulation, such as sound, light, sense of time, and physical and social contacts;

(o) Denial of medical and mental health care and treatment;

(p) Incommunicado detention and denial of social contacts in detention and/or with the outside world;

(q) Prolonged use of restraint devices, such as handcuffs, chains, irons and straitjackets;

(r) Solitary confinement and other forms of isolation;

(s) Sensory overload, such as loud music, bright lights and prolonged interrogations;

(t) Exhaustion from prolonged, forced exercise often in combination with sleep deprivation;

(u) Humiliation, guilt and shame, often resulting from verbal abuse and the performance of humiliating acts on the basis of one's identity, gender and/or (actual or presumed) sexual orientation;

(v) Threats of death, harm to family, further torture, imprisonment and mock executions; or attacks by animals, such as dogs, cats, rats or scorpions;

(w) Psychological techniques to break down the individual, including forced betrayals, amplifying feelings of helplessness, exposure to ambiguous situations or contradictory messages and violation of taboos;

(x) Behavioural coercion, such as forced engagement in practices against the religion of the victim (e.g. forcing Muslims to eat pork), forced harm to others through torture or other abuses, forced destruction of property, and forced betrayal of someone placing them at risk of harm;

(y) Manipulation of affect and emotions;

(z) Forcing victims to witness torture or atrocities being inflicted on others, including members of their families.

6. Assessments of physical and psychological evidence

373. When the evaluation of an alleged victim is conducted by more than one clinician, for example one for physical evidence and another for psychological evidence, the content of the interview should focus on the information most relevant to the clinician's expertise. Chapters V and VI provide detailed guidance on these evaluations. In summary, the evaluation of physical evidence includes: (a) a review of acute and chronic symptoms and disabilities; (b) a thorough physical examination; (c) diagnostic studies and clinical consultations, if indicated; (d) the use of anatomical diagrams (see annex III) and photographic documentation to describe physical findings; and (e) an assessment of functional disability. The psychological evaluation typically includes: (a) methods of assessment; (b) current psychological complaints; (c) pre-torture history; (d) post-torture history; (e) past psychological/psychiatric history; (f) substance abuse history; (g) a mental status examination; (h) an assessment of social functioning; (i) psychological testing, if indicated; and (j) neuropsychological testing, if indicated.

374. In assessing the health consequences of torture and ill-treatment, it is important to consider and to probe into the interrelationship between the physical, psychological and social consequences of ill-treatment. For example, beatings may result in chronic musculoskeletal pain, which in turn can trigger terrifying memories, which in turn results in social isolation. Such probing can provide a more complete picture of the ill-effects of torture or ill-treatment suffered.

7. Closing and indications for referral

375. To conclude an evaluation, clinicians should review the next steps in the process of medico-legal documentation, for example forwarding a copy of their reports to an individual's lawyer or recommending additional tests or consultations. Clinicians should consider acknowledging the emotional difficulty of the interview, thank interviewees for their time and effort, and address any ongoing concerns or disabilities by making appropriate referrals. The emotional state of the interviewee should be assessed and clinicians should take steps to mitigate signs of stress. Clinicians have an ethical obligation to make appropriate referrals for medical and psychological services if needed, particularly if there is a risk of self-harm or suicide. During psychological evaluations, clinicians may have reassured individuals that their symptoms are normal reactions to extreme experiences. This is particularly helpful when individuals feel that their symptoms are a sign of "going crazy". Clinicians may consider reviewing this point with the individual at the end of the interview. Clinicians should also discuss how the interview and examination process may exacerbate psychological symptoms.

376. When clinicians detect evidence of torture or ill-treatment, they have legal and ethical obligations to report such evidence to the appropriate authorities. As discussed in chapter II (see paras. 174–182 above), the decision to report clinical evidence of torture or ill-treatment ultimately should rest on the informed consent of the alleged victim. Statutory law may require clinicians to report evidence of

crimes including torture and ill-treatment, but doing so may place the alleged victim at risk of reprisals by State officials, including additional ill-treatment or legal sanctions. In addition, international monitoring bodies, national preventive mechanisms and national human rights institutions should seek to make appropriate referrals for accountability purposes within their official mandates.

377. Wherever possible, examinations to document torture and ill-treatment for medico-legal reasons should be combined with an assessment of ongoing medical, psychological and social needs. When asked to provide advice or give medical care during or after the examination, clinicians must balance their role as an independent examiner with ethical obligations. For non-urgent matters, advice and referral to specialist physicians, psychologists, physiotherapists or those who can offer social advice and support may be appropriate. If medical care is required urgently, clinicians are obliged to ensure that the interviewee is provided with assistance. Clinicians should not hesitate to make a referral for any consultation that they consider clinically necessary within the clinical evaluation. Evaluators should be aware of local rehabilitation and support services.

D. Post-interview considerations

378. After a medico-legal evaluation of alleged torture or ill-treatment has been conducted, clinicians begin the process of writing up a formal report, which includes an interpretation of all relevant findings and a conclusion on the possibility of torture or ill-treatment.

1. Interpretation of findings

379. The Istanbul Principles require clinicians to provide an "interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment". At a minimum this should include an assessment of the level of consistency between all clinical evaluation findings and the allegations of torture or ill-treatment. If the clinician considers that there are clinical reasons for an inconsistent finding, this should be discussed (see paras. 342–353 above and 386 below).

380. The levels of consistency for such correlations are commonly expressed as follows:

(a) "Not consistent with": the finding could not have been caused by the alleged torture or ill-treatment;

(b) "Consistent with": the finding could have been caused by the alleged torture or ill-treatment, but it is non-specific and there are many other possible causes;

(c) "Highly consistent with": the finding could have been caused by the alleged torture or ill-treatment and there are few other possible causes;

(d) "Typical of": the finding is usually observed with this type of alleged torture or ill-treatment, but there are other possible causes;

(e) "Diagnostic of": the finding could not have been caused in any way other than that described.

> The level of consistency denoted by "typical of" is not commonly used to assess psychological evidence of torture or ill-treatment as psychological findings tend to depend on individual factors. In addition, the level of consistency denoted by "diagnostic of" is used more frequently in the interpretation of physical evidence of torture or ill-treatment and is rarely used in the interpretation of psychological evidence.

381. Additional guidance on the interpretation of physical and psychological evidence of torture or ill-treatment is further elaborated in chapters V and VI and annex IV. While interpretations of physical and psychological evidence have some differences, both evaluations require clinicians to determine the level of consistency between all of the clinical evidence that the clinician has documented and the allegations of torture or ill-treatment. In some cases, the overall evaluation may report a higher level of consistency than each individual clinical finding, especially if there are many clinical findings that, when taken together, confirm the same conclusion. It is important to note that the highest level of consistency of an individual finding often determines the level of consistency for all of the clinical evidence.

2. Conclusions and recommendations

382. The Istanbul Principles require clinicians to provide a clinical opinion on the overall possibility of torture or ill-treatment. In formulating a clinical opinion on the possibility of torture or ill-treatment, clinicians should consider all relevant clinical evidence, including

"physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc.", as stated in annex IV. The clinician's opinion on the possibility of torture or ill-treatment is expressed using the same levels of consistency as those used for interpretation of findings. Because of the capacity of children, clinicians should take into account that: "The threshold at which treatment or punishment may be classified as torture or ill-treatment is therefore lower in the case of children, and in particular in the case of children deprived of their liberty."[415]

383. Ultimately, it is the overall evaluation of all clinical findings and not the consistency of one finding in particular that is important in assessing allegations of torture or ill-treatment. When physical and psychological evidence are documented in a single report by one examiner, the conclusion on all of the clinical evidence should be the highest level of consistency reported. Similarly, when considering a conclusion on physical and psychological evidence that are reported in separate clinical evaluations, the conclusion on all of the clinical evidence should be the highest level of consistency reported in either of the separate clinical evaluations or, if confirming the same conclusion, it could be higher.

384. Medico-legal evaluations that fail to assess and provide an opinion on the possibility of torture or ill-treatment are not consistent with the Istanbul Principles and should be considered deficient. Clinical opinions on the possibility of torture or ill-treatment are sometimes contested in medico-legal settings. It is important to understand that clinical opinions on the possibility of torture are based on the probability that the totality of clinical evidence was caused by the alleged torture or ill-treatment as defined by the Convention against Torture or other applicable legal definitions.[416] Causation is expressed in terms of consistency rather than judicial standards of proof (e.g. "more likely than not" or "beyond a reasonable doubt") to avoid the conflation of clinical opinions with judicial determinations. Clinicians routinely consider the cause of the symptoms of their patients. In the case of medico-legal evaluations of torture or ill-treatment, clinicians have the necessary knowledge and experience to formulate an opinion on the possibility of whether the clinical findings that they observe were caused by the infliction of the severe physical and/or mental pain or suffering alleged.

385. In addition to providing a conclusion on the possibility of torture or ill-treatment, clinicians should reiterate the current symptoms and disabilities and the likely effects on social functioning and provide any recommendations for further evaluations and care for the individual. As noted in annex IV, medico-legal reports may also include a statement of truthfulness of the clinician's medico-legal report, a statement of any restrictions on the evaluation, the clinician's identifying information and signature, and any relevant annexes.

3. Self-infliction and simulation

386. The question of self-inflicted injuries (or self-infliction by proxy, i.e. by someone else) and the simulation of physical or psychological symptoms may be raised in medico-legal settings. Clinicians and adjudicators alike should understand that the Istanbul Protocol is a useful tool for corroborating specific allegations of abuse with relevant clinical findings, such as physical and psychological evidence. If the clinician suspects fabrication, another clinician should conduct additional interviews. Documentation of the possibility of self-infliction or simulation should be noted with the agreement of both clinicians in the interpretation of findings and conclusion. Clinicians do not have a duty, however, to consider these possibilities in the absence of an evidentiary foundation since judicial decisions are based on the existence and weight of evidence and not hypothetical possibilities in the absence of supporting evidence.

4. Reliability of clinical evidence and credibility

387. In medico-legal cases, lawyers, prosecutors and adjudicators are often concerned with the credibility of an alleged victim or suspect. Credibility determinations are often used by such legal experts to weigh the veracity of an individual's claims and often have a significant effect on judicial decisions. Judicial determinations of an individual's credibility vary among States, but generally include a number of factors – clinical evidence representing only one of these factors. Legal experts sometimes ask clinicians for their opinions on the credibility

415 A/HRC/28/68, para. 33. See, also, ibid., para. 17.

416 In some countries, the definition of torture may vary from that of the Convention against Torture and adjudicators may request or require clinicians to opine on whether torture occurred or not. In such circumstances, clinicians may consider explaining the limits of their expertise and the ethical obligations to work within the limits of their professional competence.

of alleged victims and suspects. In fact, in some countries, clinicians may be required in asylum cases to opine on an alleged victim's credibility in order for the individual's case to be considered.

388. Clinical opinions on the credibility of an alleged victim or suspect should be considered in light of the clinician's expertise and circumscribed, if possible, to the reliability of the clinical evidence and the extent to which the clinical evidence is consistent or inconsistent with specific allegations of torture or ill-treatment. The reliability of clinical evidence is often based on elements of internal and external consistency as described in paragraphs 349–353 above. In situations in which courts request or require a clinician to render an opinion on the credibility of individuals, rather than the clinical findings, the clinician should note that the credibility assessment of an individual is beyond the scope of the Istanbul Protocol, which advises that clinical opinions should be limited to opinions on the reliability of the clinical evidence and the extent to which the clinical evidence is consistent or inconsistent with specific allegations of torture or ill-treatment.

389. Clinicians are not advised to comment on the credibility of an alleged victim or suspect in their medico-legal reports or witness testimony. If the clinician is asked by a legal expert to provide an assessment of credibility, the clinician should provide their assessment of the reliability of clinical evidence as it relates to credibility and be sure to distinguish their assessment and opinion from a judicial determination of credibility.

5. Limitations, misinterpretation or deliberate misuse of the Istanbul Protocol

390. It is important to recognize limitations and potential misinterpretation or deliberate misuse of the Istanbul Protocol. While the Istanbul Protocol and its Principles may aid in the discovery of clinical evidence of alleged torture or ill-treatment, the absence of physical and/or psychological evidence of torture or ill-treatment, however, does not mean that it did not take place. Many factors may account for the absence of physical and psychological findings and documenting these factors can be useful in corroborating specific claims of torture or ill-treatment. Unfortunately, in some instances, parties accused of torture or ill-treatment have misinterpreted or deliberately misused the Istanbul Protocol by successfully arguing that they should be exonerated when physical or psychological findings are absent, for example in the absence of diagnostic criteria for PTSD. In such circumstances, misinterpretation or deliberate misuse of the standards enshrined in the Istanbul Protocol to disregard or conceal evidence of torture or ill-treatment may constitute a form of complicity or other forms of responsibility.

391. In such circumstances and in the courts of some countries, misinterpretation or deliberate misuse of such standards is likely to represent efforts by State officials to disregard or conceal evidence of torture or ill-treatment and, in some cases, prosecute individuals for making "false allegations" against law enforcement officials. The inherent value of the Istanbul Protocol is its capacity to discover clinical evidence that may support specific claims of abuse. It is not a tool to prove that a hypothetical act did not take place.

392. In dismissing evidence of torture or ill-treatment, some courts have also rejected relevant clinical opinions by asserting incorrectly that they are beyond the remit or expertise of the clinician. On the contrary, as directed by the Istanbul Principles, all clinicians should always include opinions on the possibility of torture or ill-treatment in their medico-legal evaluations.[417]

417 In a 2019 judgment of the Supreme Court of the United Kingdom, the Istanbul Protocol was recognized as an authoritative guidance on clinical evaluations of alleged torture and ill-treatment, including the formulation of opinion on the possibility of torture as the cause of clinical findings. See United Kingdom, Supreme Court, *KV (Sri Lanka) v. Secretary of State for the Home Department*, Judgment, 6 March 2019.

393. Clinical evaluations of alleged torture or ill-treatment should be conducted in accordance with chapters IV, V and VI. The present chapter provides specific information on the clinical evaluation of physical evidence of torture or ill-treatment and, therefore, should be understood as an integral component of clinical evaluation. To the extent that physical evidence of torture or ill-treatment exists, it provides important confirmatory evidence that a person has been tortured or ill-treated. However, the absence of such physical evidence should not be construed to suggest that torture or ill-treatment did not occur, since such acts of violence against persons frequently leave no permanent marks.

A. Medical history

394. The clinician should obtain a complete medical history, including information about prior medical, surgical or psychiatric problems and be sure to document any history of injuries before each period of alleged torture or other ill-treatment and any possible after-effects. Leading questions should be avoided and inquiries structured to elicit an open-ended, chronological account of the events experienced. If the individual is not able to do this, clinicians should remember that some people may have difficulty both due to the effects of the torture or ill-treatment on them and because they may come from a culture in which giving an account of one's own individual experiences is not prioritized. The clinician should enquire specifically about physical punishment in childhood, domestic abuse and injuries from living in a conflict zone or from military service, as these might most closely resemble physical signs of torture and need to be distinguished from them. A full review of symptoms is important as it may reveal effects of torture that were not disclosed during the examination phase dealing with medical history, particularly, but not exclusively, in relation to the possibility of sexual torture.

395. Specific historical information may be useful in correlating regional practices of torture with individual allegations of torture or ill-treatment. Examples of useful information include descriptions of torture devices, body positions, methods of restraint, descriptions of acute or chronic wounds and disabilities and identifying information about perpetrators and places of detention. However, practices may change over time and vary from one location to another, so caution should be exercised when reviewing other source information. All complaints made by an alleged torture victim are significant. Although there may be no direct correlation with the physical findings, they should be reported. Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented.

396. In those seeking asylum, medical records and reports from the country of origin may sometimes be available and may corroborate the account of past treatment of injuries or mental health conditions due to the torture or ill-treatment. In some cases, they may not be an accurate record of the torture as they may deliberately omit mention of torture or assault, for example in cases in which this requires a mandatory report that might draw the attention of the authorities. Medical records in general may only contain brief notes on a condition and treatment and are typically prepared to convey clinically relevant information from one clinician to another or to their patient. They cannot be reviewed in the same light as a medico-legal report prepared by a qualified clinician and may not contain an opinion about the cause of the clinical findings.

1. Acute symptoms

397. Individuals should be asked to describe any symptoms and signs of injuries that may have resulted from the specific methods of alleged torture or ill-treatment. These can be, for example, bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint pain, paralysis, haemoptysis, pneumothorax, visual disturbances, tympanic membrane perforation, genito-urinary system injuries as associated with red or dark urine, dysuria, incontinence, vaginal discharge and bleeding, burns (colour, bulla or necrosis according to the degree of burn), electrical injuries (their colour and surface characteristics), injuries from exposure to chemicals (colour and signs of necrosis), pain, numbness, constipation, incontinence of faeces or flatus, nausea and vomiting, impaired consciousness, seizures or gaps in their memory. The intensity, chronology, frequency and duration of each symptom should be noted. The development of any subsequent skin lesions[418] should be described, indicating whether

418 A lesion is any physical finding in an examination or investigation. In terms of the skin, healed or healing lesions include wounds, scars and areas of altered pigmentation. Some skin lesions may contain areas of both scarring and altered pigmentation. Inflammatory processes after injury may lead to increased or reduced pigmentation in the affected skin. Lesions also include bony injury, neurological deficits and impaired joint function.

they left scars. Clinicians should ask about the health of individuals following the traumatic events: Were they able to walk or were they confined to bed? If they were confined, for how long? How long did the wounds take to heal? Were they infected? What treatment was received? Was it a physician or a traditional healer? Clinicians should be aware that the alleged victim's ability to make such observations may have been compromised by the torture itself or its after-effects and should be documented.

2. Chronic symptoms

398. The clinician should elicit information on all of the physical ailments that the individual believes were associated with torture or ill-treatment and note the severity, frequency and duration of each symptom and any associated disability or need for medical or psychological care, or treatment received. Even if the after-effects of acute lesions cannot be seen months or years later, some physical findings may still remain, such as scars, increased or reduced pigmentation, skeletal deformities, bone abnormalities associated with fractures, dental injuries, loss of hair and myofibrosis. Common symptoms include headache, back and joint pain, gastrointestinal discomfort, sexual dysfunction and muscle pain. Common psychological symptoms include depressive affect, anxiety, insomnia, nightmares, flashbacks and memory difficulties (see paras. 499–522 below).

3. Importance of medical history

399. Torture victims may have injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the injuries described, most lesions heal within weeks of torture, leaving no scars or, at the most, non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury. Blunt trauma is one of the most common modes of injury in torture and tends to cause mainly bruising and abrasions, which may heal without lasting physical evidence. Under such circumstances, the physical examination may be within normal limits, but this in no way negates allegations of torture. A detailed account of the person's observations of acute lesions and the subsequent healing process often represents an important source of evidence in corroborating specific allegations of torture or ill-treatment.

B. Physical examination

400. Typically, the physical examination is conducted by a qualified physician at the end of the clinical evaluation and only with the alleged victim's consent. Whenever possible, the alleged victim should be able to choose the gender of the physician and, where used, of the interpreter. If the physician is not of the same gender as the patient, a chaperone who is of the same gender as the alleged victim should be offered (see para. 283 above). Alleged victims must understand that they are in control and have the right to limit the examination or to stop it at any time. While it is important to examine the whole body, it should be done in sections, keeping as much of the body covered as possible at any one time. Exposing the body can be retraumatizing for the victim, since forced nakedness is a common form of torture. A complete examination should be made, as there may be findings of which victims are unaware (e.g. on their back) or which they forgot to mention when the history was taken.

401. Clinical evaluations of physical evidence of torture or ill-treatment may require specialist referral and further investigation. Unless the alleged victim is in detention, it is important for physicians to have access to physical and psychological treatment facilities, so that any identified need can be followed up. In many situations, certain diagnostic test techniques will not be available and their absence must not invalidate the report. For many investigations, while a positive result may support the account of torture, a negative result does not necessarily mean that torture did not occur.

402. In cases of alleged recent torture or ill-treatment and when the clothes worn during torture or ill-treatment are still being worn by the alleged victim, they should be taken for examination without having been washed and a fresh set of clothes should be provided. Local procedures for ensuring chain of evidence should be followed. Wherever possible, the examination room should be equipped with sufficient light and medical equipment for the examination. Any deficiencies should be noted in the report. The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and nature of all injuries (see annex III). Some forms of torture, such as electric shock or blunt trauma, may be initially undetectable, but may be detected during a follow-up examination. Although it may be unusual to be able to record photographically lesions of prisoners while they are in the custody of their torturers, photography is a useful component of

examinations. If a camera is available, the clinician should obtain the best photographs possible and supplement them with detailed descriptions and body diagrams, then follow up with professional photographs as soon as possible (see para. 234 above). Specific informed consent is needed for photographs, including an explanation of their nature and purpose, and protocols should be in place for intimate images with regard to how they are stored and who may view them. Image quality may vary widely and a number of practical guidelines are available. Images can be taken on a variety of devices, including smartphones and tablets. Clinicians should always ensure that rules and colour scales are included. Cross-polarized light photography can also demonstrate some blunt trauma injuries no longer visible on the skin.

403. It should be noted that if a lesion cannot be seen on a photograph it does not mean that it was not there, especially if the clinician is not a trained forensic photographer with good quality equipment. When there are no skin lesions, bone scintigraphy may be a useful method to detect non-fracture bone lesions following beatings, particularly when torture has been prolonged.[419]

1. Skin

404. The examination should include the entire body surface in order to detect signs of generalized skin disease, including signs of vitamin A, B and C deficiencies, pre-torture lesions or lesions inflicted by torture, such as abrasions, bruises, pigmentation changes, lacerations, puncture wounds, burns from cigarettes, chemicals, scalding liquids or heated instruments, electrical injuries, incised wounds, alopecia and nail removal. Torture lesions should be described by their localization, symmetry, shape, size, colour and surface (e.g. scaly, crusty or ulcerating), as well as their demarcation and level in relation to the surrounding skin. Clinicians should note if normal hair growth is absent or there are any areas of numbness. Lesions may be described as fresh/acute or healed. Photography is recommended whenever possible. For injury interpretation it is useful to consider if the lesion is a pigmented or depigmented lesion, a scar or contains areas of scarring.

2. Face

405. The face should be palpated for evidence of fracture, crepitation, swelling or pain. All cranial nerves should be examined. Appropriate radiological techniques should be used when possible to confirm facial fractures, determine alignment and diagnose associated soft tissue injuries and complications. Intracranial and cervical spinal injuries are often associated with facial trauma.

(a) Eyes

406. Direct trauma to the eyes can present in many ways, including conjunctival haemorrhage, lens dislocation, subhyaloid haemorrhage, retrobulbar haemorrhage, retinal haemorrhage, traumatic optic neuropathy, ruptured globe and visual field loss. Specific injuries to the globe can cause scars from choroidal haemorrhage or an irregular pupil from injuries to the iris. Ophthalmologic consultation should be obtained whenever there is a suspicion of ocular trauma or disease. Radiological techniques must be used to confirm orbital fractures and soft tissue injuries to the bulbar and retrobulbar structures. Forced solar gazing can cause eye damage, including burns to the retina. Retinal examination should also be conducted to rule out retinal bleeding, which may be associated with whiplash/impact head trauma.

(b) Ears

407. Trauma to the ears, especially rupture of the tympanic membrane, is a frequent consequence of harsh beatings. The ear canals and tympanic membranes should be examined with an otoscope and injuries described. A common form of torture, known in Latin America as *teléfono*, is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the tympanic membrane. This type of impact may also cause ipsilateral subdural bleeding, which may need to be explored by CT scan. Prompt examination is necessary to detect tympanic membrane ruptures, which may heal within 10 days, although healing may be delayed. Fluid may be observed in the middle or external ear. If haemotorrhea is confirmed by laboratory analysis, MRI or CT should be performed to determine the fracture site. The presence of hearing loss should be investigated, using simple screening methods. If necessary, audiometric

419 Onder Ozkalipci and others, "A significant diagnostic method in torture investigation: bone scintigraphy", *Forensic Science International*, vol. 226, No. 1–3 (2013), pp. 142–145.

tests should be conducted by a qualified audiometric technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain requires specialized radiological imaging.

(c) Nose

408. The nose should be evaluated for alignment, crepitation and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. Radiological techniques should be used to confirm fractures and identify soft tissue injury.

(d) Jaw, oropharynx and neck

409. Mandibular fractures or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings, including forceful slaps about the lower face and jaw. The alleged victim should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilage resulting from blows to the neck. Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electric shock or other trauma. The maxillary labial frenum may be torn. Gingival haemorrhage and the condition of the gums should also be noted.

410. Where strangulation by ligature or hand has been attempted, potential findings include:

(a) No injury seen;

(b) Pain or tenderness – at site of application of force with no visible injury on swallowing or on neck movement;

(c) Reddening (erythema), which may resolve after a few hours;

(d) Skin bruising, abrasions or swelling at the point of compression – for example, at sites of finger/thumb/ligature application – this may appear early or later and persist for days;

(e) Pinpoint bruising (petechiae) above the site of compression;

(f) Damage to the larynx – thyroid cartilage (voice box) – causing hoarseness and/or hyoid bone (bone at base of neck);

(g) Scratches to neck – from assailant or victim or both, or from accidental application of a ligature to the neck (as victim tries to pull away from an assailant's hands or ligature);

(h) Damage to mucosa of the mouth and tongue due to direct pressure on teeth internally and swelling of the tongue;

(i) Bleeding from mucosa where the intravenous pressure has been raised – for example, from the nose and ears;

(j) Additional non-specific features that may rarely be present include frank haemorrhage from orifices such as the nose and ear and spontaneous evacuation of faeces and urine. These may appear alone or in combination.

411. It is essential in possible cases of neck compression or strangulation that all areas of the eyes, skin and mucosa (including inside the mouth, the eyelids, the palate and the uvula, and the skin of the scalp) above the level of compression are examined with a good light to identify any localized areas of petechiae. It is important to identify petechiae at an early stage as they fade and disappear within 24 hours or so. In cases of manual strangulation or neck compression petechiae may be florid and may coalesce to form larger bruises. There may also be difficulty breathing, ptosis or facial nerve palsy. Late complications include aspiration pneumonia, pulmonary oedema and seizures.[420] In many cases in which an asphyxial mechanism is applied for only a short time, the findings may be completely absent or minor. Such findings may also be absent in severe compression for longer periods of time. In general, the longer and the more powerful the force applied, the more likely it is that visual evidence of compressive force will be apparent.[421]

(e) Oral cavity and teeth

412. Examination by a dentist should be considered a component of periodic health examinations in detention. This examination is often neglected, but it is an important component of the physical

420 International Association of Forensic Nurses, *Non-Fatal Strangulation Documentation Toolkit* (Elkridge, 2016).
421 Jason Payne-James, "Asphyxia: clinical findings", in *Encyclopedia of Forensic and Legal Medicine*, 2nd ed., Jason Payne-James and Roger Byard, eds. (Elsevier, 2015).

examination. Dental care may be purposefully withheld to allow caries, gingivitis or tooth abscesses to worsen. A careful dental history should be taken and, if dental records exist, they should be requested. Tooth avulsions, fractured teeth, dislocated fillings and broken prostheses may result from direct trauma or electric shock torture. Dental caries and gingivitis should be noted. Poor quality dentition may be due to conditions in detention or may have preceded the detention. The oral cavity must be carefully examined. During application of an electric current, the tongue, gums or lips may be bitten. Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current. Impact to the face may result in patterned abrasions or bruises on the buccal aspect of the cheek. The frena may be torn. Radiological techniques should be used to confirm the extent of soft tissue, mandibular and dental trauma. Caries are more likely to develop in broken teeth, possibly leading to the loss of the tooth. Absence of a tooth may therefore be due to trauma directly or indirectly.

3. Chest and abdomen

413. Examination of the torso, in addition to noting lesions of the skin, should be directed towards detecting regions of pain, tenderness or discomfort that would reflect underlying injuries of the thoracic muscles and skeleton or abdominal organs. The examiner must consider the possibility of intramuscular, retroperitoneal and intra-abdominal haematomas, as well as laceration or rupture of an internal organ. Radiological techniques are required to confirm such injuries. Blood tests and urinalysis may be useful screens for such injuries. Routine examination of the cardiovascular system, lungs and abdomen should be performed in the usual manner. Pre-existing respiratory disorders are likely to be aggravated in custody and new respiratory disorders frequently develop.

4. Musculoskeletal system

414. Complaints of musculoskeletal aches and pains are very common in torture survivors.[422] They may be the result of repeated beatings, suspension, other positional torture or the general physical environment of detention.[423] They may also be psychosomatic or somatic (see para. 507 below) in nature, but should still be documented. Pain may be specific to the torture mechanism or non-specific and generalized. Physical examination should include testing for mobility of the joints, spine and extremities. Clinicians should note: pain on palpation or with motion, muscle strength, contracture, evidence of compartment syndrome, fractures with or without deformity and dislocations. In the case of severe beatings, muscle tissue breakdown may lead to myoglobin release into the blood circulation in large amounts, potentially leading to acute kidney failure. The urine myoglobin level may be tested when and if available in severely beaten survivors during the acute phase.[424] Suspected dislocations, fractures and osteomyelitis should be evaluated radiologically. Injuries to tendons, ligaments and muscles are best evaluated with MRI, although arthrography can also be performed. In the acute stage, this can detect haemorrhage and possible muscle tears. Muscles usually heal completely without scarring; thus, later imaging studies will be negative. MRI and CT images of denervated muscles and chronic compartment syndrome may demonstrate muscle fibrosis. Bone bruises can be detected by MRI or scintigraphy. Bone bruises usually heal without leaving traces. Vitamin D deficiency due to lack of sunlight and poor diet can also be a cause of musculoskeletal pain and responds to replacement therapy.

5. Genito-urinary system

415. If genital examination is necessary, it must be performed only with the specific consent of the alleged victim and may need to be postponed to a later examination. A chaperone must be offered if the examining physician's gender is different from that of the patient. For more information, see paragraph 283 above. See paragraphs 455–479 below on sexual torture, including rape, and further information regarding examination of victims of sexual assault. Ultrasonography, kidney function tests, urinalysis and dynamic scintigraphy can be used for detecting genito-urinary trauma.

6. Central and peripheral nervous systems

416. The neurological examination should evaluate the cranial nerves, sensory organs and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin

422 Emma Baird and others, "Interventions for treating persistent pain in survivors of torture", *Cochrane Database of Systematic Reviews* (2017).
423 Duncan Forrest, "Examination for the late physical after effects of torture", *Journal of Clinical Forensic Medicine*, vol. 6, No. 1 (1999), pp. 4–13.
424 Michael S. Pollanen, "The pathology of torture", *Forensic Science International*, vol. 284 (2018), pp. 85–96.

deficiencies or disease. Cognitive ability and mental status must also be evaluated (see paras. 523–598 below on the psychological/psychiatric evaluation). In patients who report being suspended, special emphasis should be placed on examining for brachial plexopathy (asymmetrical hand strength, wrist drop, and arm weakness with variable sensory and tendon reflexes) is necessary. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, paraesthesia, hyperaesthesia, change in position sense, temperature sensation, motor function, gait and coordination may all result from trauma associated with torture or ill-treatment. In patients with a history of dizziness and vomiting, a vestibular examination should be conducted and evidence of nystagmus noted. Radiological evaluation should include MRI or CT. MRI is preferred over CT for radiological evaluation of the brain and posterior fossae. Seizures may occur as a result of head injury, and require careful history and investigation to distinguish from panic attacks and vasovagal episodes.

C. Interpretation of findings

417. The Istanbul Principles require clinicians to provide an "interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment" (see para. 379 above and annex I). In this sense, "physical and psychological findings" can include symptoms, signs, historical information, diagnostic test results, photographs and prior medical evaluations. The clinician should correlate the following:

(a) To what extent is the history of acute and chronic physical symptoms and disabilities consistent with the allegations of torture and/or ill-treatment?

(b) To what extent are the findings of the physical examination consistent with the allegations of torture and/or ill-treatment? (Note: the absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)

(c) To what extent are the findings of the examination consistent with known torture methods and their common after-effects used in a particular region?

418. In conducting evaluations of physical evidence of alleged torture or ill-treatment, clinicians should consider the following terms for levels of consistency:

(a) "Not consistent with": the finding could not have been caused by the alleged torture or ill-treatment;

(b) "Consistent with": the finding could have been caused by the alleged torture or ill-treatment, but it is non-specific and there are many other possible causes;

(c) "Highly consistent with": the finding could have been caused by the alleged torture or ill-treatment and there are few other possible causes;

(d) "Typical of": the finding is usually observed with this type of alleged torture or ill-treatment, but there are other possible causes;

(e) "Diagnostic of": the finding could not have been caused in any way other than that described.

419. Consideration of the correlation of symptoms may be of particular importance when methods of torture or ill-treatment have been used that leave no lasting physical evidence. This may apply, for example, to experiences of asphyxia, head injury, electric shocks, suspension and stress positions, sexual torture and environmental torture. In the correlation of examination findings with knowledge of torture effects used in a particular region, the changing pattern of torture and ill-treatment over time and from one location to another should be kept in mind.

420. In correlating the consistency between the findings of the physical examination and the alleged torture or ill-treatment, the clinician should indicate the level of consistency for each individual examination finding. If the clinician considers there are clinical reasons for an inconsistent finding, this should be discussed (see paras. 342–353 and 386 above). Sometimes a group of similar lesions or lesions with the same attribution can be considered together and a level of consistency applied to the group as a whole. The clinician should consider possible causes of the physical findings as suggested by the evidence, for example, torture or other deliberate harm, accidental injury, skin disease, medical procedures, cultural medical care, ritual scarification, self-harm and deliberate infliction to fabricate evidence of injury. It is common for there to be attribution of some physical findings on the body to causes other than torture, such as accidental injury, or for there to be physical findings for which the person cannot recall the cause. An individual may innocently mistake a physical finding for torture (e.g. striae distensae on the lower back) because they did not notice it before the alleged torture or ill-treatment

but only afterwards, when there is pain at the site or it is pointed out by the examining doctor.

421. It may be that the cause of a particular finding cannot be described, because individuals could not see clearly due to multiple perpetrators around them or being blindfolded or hooded, or because they were partially or completely unconscious at the time, or have other clinical reasons for impaired memory of the event. In these cases, the clinician may be able to indicate a level of consistency between the physical finding(s) and the likely cause of the finding(s). More commonly, with less characteristic findings that have no attribution, a specific assessment of consistency may not be made, but general comment may be possible about the size, number and location of the finding(s) in terms of the characteristics of injuries from torture or other causes. There may be findings that are not specifically attributed to torture, but to falls while trying to evade perpetrators, for example. If the person was within the control of the perpetrator at the time, then these still fall within the definition of torture injuries and should be assessed for consistency with the attribution given. If there are findings attributed to other experiences of assault, unrelated to the specific allegation of torture under examination, such as domestic violence, child abuse, female genital mutilation, physical punishment, criminal assault or war- and conflict-related violence, these can be assessed for consistency with the attribution given, where relevant for the legal procedure for which the medical report is required.

422. *Accidental injuries*. Accidental injuries are more commonly found on the extremities compared with the central parts of the body,[425] that is those parts of the body most often exposed rather than protected by clothing and in first contact with a hard surface during a fall. Thus, the knees, shins, iliac crest, elbows, palms, bony spinal protuberance, forehead and crown of the head are more common sites of accidental injury. The central parts of the body – ears, cheeks, eyes, mouth, upper arm, inner forearm, chest, genitals, front of thigh, inner thigh, back of thigh, buttocks, abdomen, backs of hands, shoulders and neck – are more commonly associated with non-accidental injury. On the face, for example, it is not unusual for an individual to have one or two small scars from accidental injuries, but as the number of such lesions increases, so the chance of them all being due to accidents correspondingly decreases. The expected number of accidental injuries and their location is also influenced by the person's occupational history.

423. *Self-injury*. Self-injury by cutting may be found in a wide variety of anatomical locations, including particularly the volar aspect (palm-side) of the wrist or forearm of the non-dominant upper limb. It is often not the site but the nature and multiplicity that are relevant. The back is generally spared, but the forearms, upper arms, neck, chest, abdomen and thighs may be other typical sites for self-harm. Other parts of the body may also be injured in other ways, for example the forehead if the person bangs their head against the wall or a fist if punching a wall. The most common form of self-harm injury is cutting and cuts are usually superficial, multiple and closely grouped. Self-inflicted burn injury with cigarettes or other heat sources may be found. Victims of torture may disclose these injuries readily and may explain that they self-inflicted these injuries in response to their torture, as an expression of the pain of their torture or a way of coping with that pain. Other victims may find it very difficult to disclose self-harming, as it is associated with shame and stigma. The most severe self-inflicted injuries can be associated with more severe mental illness, such as psychosis. Deliberate injury for secondary gain is rare and such injuries tend to be superficial, of a single mechanism of causation, on accessible body parts and poorly congruent with the history, examination findings and timeline. Signs of injuries in unusual locations and a diffuse spread of injuries all suggest torture, as does the finding of multiple modalities of blunt force, sharp force and burn injury. The overall evaluation of all the physical evidence, together with the psychological evidence, in the context of the account given is key to the consideration of fabrication (see para. 348 above).

D. Conclusions and recommendations

424. Clinicians should formulate a clinical opinion on the possibility of torture or ill-treatment based on all relevant clinical evidence, including physical and psychological findings,[426] historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc., as stated in paragraphs 382–383

425 Terry Allen, Shannon A. Novak and Lawrence L. Bench, "Patterns of injuries: accident or abuse", *Violence against Women*, vol. 13, No. 8 (2007), pp. 802–816.

426 Clinical evaluations that are conducted specifically to assess "physical evidence" may or may not include some "psychological findings", for example, observations of psychological distress during the interview and/or a report of psychological symptoms.

above and annex IV. The clinician's opinion on the possibility of torture or ill-treatment should be expressed using the same levels of consistency as that used for interpreting findings: not consistent with, consistent with, highly consistent with, typical of and diagnostic of. Ultimately, it is the overall evaluation of all the clinical findings, and not the consistency of each lesion or symptom with a particular form of torture or ill-treatment, that is important in assessing allegations of torture or ill-treatment.

425. In addition to providing a conclusion on the possibility of torture or ill-treatment, clinicians should reiterate current symptoms and disabilities and the likely effects on social functioning and provide any recommendations for further evaluations and care for the individual.

E. Examination and evaluation following specific forms of torture

1. Beatings and other forms of blunt trauma

(a) Skin damage

426. Acute lesions are often characteristic of torture and ill-treatment, because they show a pattern of inflicted injury that differs from non-inflicted injuries in, for example, their shape, size, distribution on the body and number. Since most lesions heal within a few weeks of torture or ill-treatment leaving no scars, or non-specific scars, a characteristic history of the acute lesions and their development until healing might be the only support for an allegation of torture or ill-treatment. Permanent changes in the skin due to blunt trauma are non-specific and usually without diagnostic significance. Prolonged application of tight ligatures may result in characteristic findings, including a linear zone extending circularly around the arm or leg, usually at the wrist or ankle, containing few hairs or hair follicles, a form of cicatricial alopecia. These findings may be diagnostic of the alleged torture or ill-treatment as there are no other skin diseases or injuries that could account for such findings. These findings are relatively rare, however; it is more common to see short, linear, narrow scars over the bony sides of the wrists from handcuff abrasions, especially in situations in which the person has been beaten while suspended by handcuffs. These findings can be distinguished from self-harm injuries by their location on the bony aspects, and often relative symmetry, whereas self-harming is more common on the non-dominant forearm. Ligature injuries will depend on the tightness of the ligature, the nature of the ligature used,[427] and the force applied, such as twisting of handcuffs or suspension and beating while handcuffed.[428]

427. Acute abrasions resulting from superficial scraping lesions of the skin may appear as scratches, brush-burn type lesions or larger scraped lesions. At times, acute abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Repeated or deep abrasions may create areas of hypo or hyperpigmentation, depending on skin type. This occurs on the inside of the wrists if the hands have been tied together tightly.

428. Bruises are areas of haemorrhage into soft tissue due to the rupture of blood vessels from blunt trauma. The extent and severity of a bruise depends not only on the amount of force applied but also on the structure and vascularity of the bruised tissue. Bruises occur more readily in areas of thin skin overlying bone or in fatty areas. Many medical conditions, including vitamin and other nutritional deficiencies, age and medication may be associated with easy bruising or purpura. Bruises and abrasions indicate that blunt force was applied to a particular area. The absence of a bruise or abrasion, however, does not indicate that there was no blunt force to that area. Bruises may be patterned, reflecting the shape of the inflicting instrument. For instance, "tramline" bruising may occur when an instrument, such as a truncheon or cane, has been used. The shape of the object may be inferred from the shape of the bruise. The colour of a bruise does not assist in assessing age of injury. The perception of bruise colour varies according to skin tone and cannot be determined accurately from images. In some skin types, bruising can lead to hyperpigmentation, which can last several years. Bruises that develop in deeper subcutaneous tissues may not appear until several days after injury, when the extravasated blood has reached the surface. In cases of an allegation but an absence of a bruise, the victim should be re-examined after several days. It should be taken into consideration that the final position and shape of bruises may bear no relationship

427 Muhammed Nabi Kantarci and others, "Evaluation of plastic and metal handcuff-related injuries under custody in medical examinations", *Turkiye Klinikleri Journal of Medicine Sciences*, vol. 33, No. 2 (2013), pp. 360–365 (in Turkish with summary in English).

428 Miriam Y. Neufeld and others, "Forensic evaluation of alleged wrist restraint/handcuff injuries in survivors of torture utilizing the Istanbul Protocol", *International Journal of Legal Medicine*, vol. 135, No. 2 (2021), pp. 583–590.

to the original trauma and that some lesions may have faded by the time of re-examination.[429]

429. Lacerations, a tearing or crushing of the skin and underlying soft tissues by the pressure of blunt force, develop easily on prominent bony landmarks of the body, since the skin is compressed between the blunt object and the bone surface under the subdermal tissues. However, with sufficient force the skin can be torn on any part of the body. Whether a laceration rather than a bruise is sustained from blunt force trauma depends not only on the part of the body affected but also on other factors, including the force applied, the contour of the implement and the presence or absence of protective clothing.

430. Scars resulting from whipping may be seen if full thickness wounds have been caused. These scars may be hypo or hyperpigmented and may be hypertrophic, often depending on skin tone and location. Whipping may not cause scars, it may only cause wheals and bruising depending on the nature of the implement, the force used, the number of lashes and any protection afforded by clothing. Self-flagellation as part of religious ritual may produce scars similar to those from punitive whipping. Symmetrical, atrophic, depigmented linear changes of the abdomen, lower back, axillae and legs, which are sometimes claimed to be torture sequelae, may be striae distensae and represent previous growth, pregnancy or increase in weight, and must be distinguished from those related to torture.[430] An individual who describes being beaten or whipped on the back may have been previously unaware of striae there until they are identified in the examination and so innocently assume that they are a result of the torture. Striae distensae may be found around the axilla after reported suspension and attributed by the person to the torture. Use of skin lightening creams may exacerbate the appearance and size of striae.

431. Burns may leave permanent changes in the skin, in the form of pigmented lesions or scars, depending on the depth of the burn and the skin type. Pigmented lesions following a partial thickness burn may persist for months or years before gradual resolution. The temperature of the heated object or substance and, secondarily, contact time are the chief determinants of the appearance and depth of a burn. Burns from hot liquid will vary in depth and shape depending on the viscosity of the liquid – for example, a highly viscous burn from molten plastic will be deep and relatively circumscribed, compared with a burn from hot water, which may show initial impact, spread according to gravity and sometimes satellite burns from splashes. Cigarette burns often leave 5–10-millimetre diameter circular or ovoid macular scars with a hypo or hyperpigmented centre and a hyperpigmented, relatively indistinct, periphery. The diameter of such scars may vary with the type of cigarette. Brush burns from cigarettes may leave less distinctive lesions. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis. Burning with hot objects may produce lesions that reflect the shape of the instrument and are initially sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. Burn edges, which are initially sharply demarcated, over time become blurred, from migration of melanocytes, particularly noted in those with more pigmented skin. This may, for instance, be seen after burning with a heated metal rod or a gas lighter. Spontaneously occurring inflammatory processes lack the characteristic marginal zone and only rarely show a pronounced loss of tissue. Following a burn produced by burning rubber or molten plastic, hypertrophic or keloid scars may form.

432. When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If a nail has been pulled off, an overgrowth of tissue may be produced from the proximal nail fold, resulting in the formation of pterygium. However, it is possible for a normal nail to regrow. Changes in the nail caused by *Lichen planus* constitute the only relevant differential diagnosis, but they will usually be accompanied by widespread skin injury. On the other hand, fungus infections are characterized by thickened, yellowish, crumbling nails, different from the above changes. Fungal infection may coexist in the damaged nail.

433. Sharp trauma wounds are produced when the skin is cut with a sharp object, such as a knife, bayonet or broken glass, and include stab wounds, cut or slash wounds and puncture wounds. The acute appearance is usually easy to distinguish from the irregular and torn appearance of lacerations and scars found upon

429 Jason Payne-James, Jack Crane and Judith A. Hinchliffe, "Injury assessment, documentation, and interpretation", in *Clinical Forensic Medicine: A Physician's Guide*, 2nd ed., Margaret M. Stark, ed. (Totowa, New Jersey, Humana Press), pp. 127–158.

430 Karlijn Clarysse and others, "Skin lesions, differential diagnosis and practical approach to potential survivors of torture", *Journal of the European Academy of Dermatology and Venereology*, vol. 33, No. 7 (2019), pp. 1232–1240.

later examination that may be distinctive. Regular patterns of small incisional scars could be due to traditional healers.[431] If pepper or other noxious substances are applied to open wounds, the scars may become hypertrophic. Juju ritual scars may have pigment, such as soot, rubbed in to them.

434. Clinicians may be asked to estimate the age of scars. It is unlikely that much can be said unless a wound appears very recent with redness and crusting. During the process of wound healing the initial crusting is followed by scar tissue formation, which appears red at first and gradually becomes paler and flatter. Scar redness is variable and influenced by factors other than the elapse of time, including skin tone. The time taken for a scar to evolve from the acute form to the flat pale mature form is variable, depending on multiple factors, including trauma to wound edges, depth of wound, infection, wound closure method, a "dirty" or clean wound, access to wound hygiene, the position on the body, tension on and movement of the wound, nutrition, chronic disease, pressure and friction of clothing. Some wounds (e.g. cigarette burns) may be intensely itchy during healing, leading to a habit of scratching or rubbing them, which may leave them red or pink long after other wounds have become quiescent. For these reasons, scars caused at the same time and by the same mode of injury may heal at different rates. While it is not usually possible therefore to give an exact opinion on the date of a lesion, it may be possible to state that the appearance is in keeping with the timeline stated.

(b) Fractures

435. Fractures produce a loss of bone integrity due to the effect of a blunt mechanical force on various vector planes. A direct fracture occurs at the site of impact or the site at which the force was applied. The location, contour and other characteristics of a fracture reflect the nature and direction of the applied force. It is sometimes possible to distinguish a fracture inflicted through accidental injury by the radiological appearance of the fracture. Radiological dating of relatively recent fractures should be done by an experienced trauma radiologist.

(c) Head trauma

436. Head trauma is one of the most common forms of torture. In cases of recurring head trauma, even if not always of serious dimensions, cortical atrophy and diffuse axonal damage can be expected. In cases of trauma caused by falls, contrecoup (location in opposition to the trauma) lesions of the brain may be observed, whereas in cases of direct trauma, contusions of the brain may be observed directly under the region in which the trauma was inflicted. Scalp bruises are frequently invisible externally unless there is swelling. Bruises may be difficult to see in dark-skinned individuals, but will be tender upon palpation. Estimates of a period of loss of consciousness following head injury are unlikely to be accurate as a person may suffer a period of peri-traumatic amnesia.

437. Having been exposed to blows to the head, a torture survivor may complain acutely of pain, dizziness, nausea, vomiting and visual disturbance. Chronically, there may be persistent headaches dizziness and memory or other cognitive deficits. There may be seizure disorders. The pain may be somatic or may be referred from the neck. The victim may report pain when touched in that region, and diffuse or local fullness or increased firmness may be observed by means of palpation of the scalp. Scars can be observed in cases in which there have been lacerations of the scalp. Acutely after head trauma, headaches may be the initial symptom of an expanding subdural haematoma. They may be associated with the acute onset of mental status changes and a CT scan must be performed urgently. Soft tissue swelling or haemorrhage will usually be detected by CT or MRI. It may also be appropriate to arrange psychological or neuropsychological assessments (see paras. 549–565). Late effects of brain injury can be detected with specialized radiological techniques. Minor traumatic brain injury, even without loss of consciousness, may affect memory and concentration in the short and long term. Brain injury from asphyxia torture may also lead to cognitive deficit.

438. Violent shaking as a form of torture may produce cerebral injury without leaving any external marks, although bruises may be present on the upper chest or shoulders where victims or their clothing has been grabbed. At its most extreme, shaking can produce injuries identical to those seen in the shaken baby syndrome: cerebral oedema, subdural haematoma and retinal haemorrhages. More commonly, victims complain of recurrent headaches, disorientation or mental status changes. Shaking episodes are usually brief, only a few

431 Ibid.

minutes or less, but may be repeated many times over a period of days or weeks. Radiological and retinal examinations are recommended.

(d) Chest and abdominal trauma

439. Rib fractures are a frequent consequence of beatings to the chest. If displaced, they can be associated with lacerations of the lung and possible pneumothorax. Fractures of the vertebral pedicles may result from direct use of blunt force. When rib fracture is suspected, plain radiographs should be obtained.

440. In cases of acute abdominal trauma, the physical examination should seek evidence of abdominal organ and urinary tract injury. However, the examination is often negative. Gross haematuria is the most significant indication of kidney contusion. Peritoneal lavage may detect occult abdominal haemorrhage. Free abdominal fluid detected by radiological investigation after peritoneal lavage may be from the lavage or haemorrhage, thus invalidating the finding. Organ injury may be present as free air, extraluminal fluid or areas of low attenuation, which may represent oedema, contusion, haemorrhage or a laceration. Peripancreatic oedema is one of the signs of acute traumatic and non-traumatic pancreatitis. Ultrasound is particularly useful in detecting subcapsular haematomas of the spleen. Renal failure due to crush syndrome may be acute after severe beatings. Renal hypertension can be a late complication of renal injury.

2. Beating of the feet

441. *Falanga*, or *falaka*, are the common terms for repeated application of blunt trauma to the feet (or more rarely to the hands or hips), usually applied with a truncheon, a length of pipe or similar weapon. Victims may describe the pain going right through to their head. Because the injuries are usually confined to soft tissue, CT or MRI are the preferred methods for radiological documentation of the injury, but it must be emphasized that physical examination in the acute phase should be diagnostic. *Falanga* may produce chronic disability. Walking may be painful and difficult. Squeezing the plantar (sole) of the foot and dorsiflexion of the great toe may produce pain.

442. Numerous complications and syndromes can occur:[432]

(a) *Compartment syndrome*. This is the most severe complication. Oedema in a closed compartment results in vascular obstruction and muscle necrosis, which may result in fibrosis, contracture or gangrene in the distal foot or toes. It is usually diagnosed by measuring pressure in the compartment;

(b) *Crushed heel and anterior footpads*. The elastic pads under the calcaneus and proximal phalanxes are crushed during *falanga*, either directly or as a result of oedema associated with the trauma. Also, the connective tissue bands that extend through adipose tissue and connect bone to the skin are torn. Adipose tissue is deprived of its blood supply and atrophies. The cushioning effect is lost and the feet no longer absorb the stresses produced by walking;

(c) *Rigid and irregular scars involving the skin and subcutaneous tissues of the foot*. In a normal foot, the dermal and subdermal tissues are connected to the planter aponeurosis through tight connective tissue bands. However, these bands can be partially or completely destroyed due to the oedema, which ruptures the bands after exposure to falanga;

(d) *Rupture of the plantar aponeurosis and tendons of the foot*. Oedema in the post-*falanga* period may rupture these structures. When the aponeurosis cannot tighten normally, the supportive function necessary for the arch of the foot disappears, the act of walking becomes more difficult and foot muscles, especially the quadratus plantaris longus, are excessively forced and become fatigued. Passive extension of the big toe may reveal whether the aponeurosis has been torn;

(e) *Plantar fasciitis*. This may occur as a further complication of foot beatings. In cases of *falanga*, irritation is often present throughout the whole aponeurosis, causing chronic aponeurositis. Studies on the subject have shown that, in prisoners released after 15 years of detention who claimed to have been subjected to *falanga* when first arrested, positive bone scans of hyperactive points in the calcaneus or metatarsal bones were observed;[433]

(f) *Permanent deformities of the feet*. Such deformities are uncommon but do occur, as do fractures of the tarsal bones, metatarsals and phalanges. Tarsal bones may be fixed or have increased motion;

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432 Kristine Amris, Søren Torp-Pedersen and Ole Vedel Rasmussen, "Long term consequences of falanga torture – what do we know and what do we need to know", *Torture*, vol. 19, No. 1 (2009), pp. 33–40.

433 Veli Lök and others, "Bone scintigraphy as clue to previous torture", *Lancet*, vol. 337, No. 8745 (1991), pp. 846–847. See also Mehmet Tunca and Veli Lök, "Bone scintigraphy in screening of torture survivors", *Lancet*, vol. 352, No. 9143 (1998), p. 1859.

(g) *Painful peripheral neuropathy*. This may be a late complication of *falanga*. Other causes, such as diabetes, should be ruled out.

443. Routine radiographs are recommended as the initial examination. MRI is the preferred radiological examination for detecting soft tissue injury. MRI or scintigraphy can detect bone injury in the form of a bruise, which may not be detected by routine radiographs or CT.[434]

3. Suspension

444. Suspension is a common form of torture that can produce extreme pain, but which leaves little, if any, visible evidence of injury. Oedema of the dependent or constricted limbs may be found with the risk of deep vein thrombosis with prolonged restraint in a single position, including forced standing. The finding of peripheral neurological deficits, diagnostic of brachial plexopathy, virtually proves the diagnosis of suspension torture. Suspension can be applied in various forms:

(a) Cross suspension, which is applied by spreading the arms and tying them to a horizontal bar;

(b) Butchery suspension, which is applied by fixation of the hands upwards, either together or one by one;

(c) Reverse butchery suspension, which is applied by fixation of the feet upward and the head downward;

(d) Reverse suspension, which is applied by suspending the victim with the forearms bound together behind the back, the elbows flexed at 90 degrees and the forearms tied to a horizontal bar. Alternatively, the prisoner is suspended from a ligature tied around the elbows or wrists with the arms behind the back. A similar effect can be produced when a victim is forced to lie prone with handcuffs behind their back, then pulled upwards by the handcuffs;

(e) "Parrot perch" suspension, which is applied by suspending a victim by the flexed knees from a bar passed behind the knees, usually while the wrists are tied to the ankles.

445. Suspension may last from minutes to several hours or even longer. The amount of time described as spent suspended is often inaccurate as victims are disoriented or lose consciousness. Careful examination should be made for ligature marks, which may vary depending on the type of ligature (e.g. metal handcuffs, plastic ties or rope). Reverse suspension may produce permanent brachial plexus injury in a short period. The "parrot perch" may produce tears in the cruciate ligaments of the knees. Victims will often be beaten while suspended or otherwise tortured or ill-treated. In the chronic phase, it is usual for pain and tenderness around the shoulder joints to persist, as the lifting of weight and rotation, especially internal, will cause severe pain many years later. Complications in the acute period following suspension include weakness of the arms or hands, pain and paraesthesia, numbness, insensitivity to touch, superficial pain and tendon reflex loss. Intense deep pain may mask muscle weakness. In the chronic phase, weakness may continue and progress to muscle wasting. Numbness and, more frequently, paraesthesia are present. Raising the arms or lifting weight may cause pain, numbness or weakness. In addition to neurologic injury, there may be tears of the ligaments of the shoulder joints, dislocation of the scapula and muscle injury in the shoulder region. On visual inspection of the back, a "winged scapula" (prominent vertebral border of the scapula) may be observed with injury to the long thoracic nerve or dislocation of the scapula.

446. Neurologic injury is usually asymmetrical in the arms. Brachial plexus injury manifests itself in many different ways, including motor, sensory and reflex dysfunction. Subtle changes may be difficult for a non-specialist to detect or diagnose. By the time of evaluation, the injury may have resolved, but a careful history of the symptoms suffered is of value in the assessment and there should be a low threshold for specialist referral. Assessments of possible neurologic injury should include:

(a) *Motor examination*. Asymmetrical muscle weakness, more prominent distally, is the most expected finding. Acute pain may make the examination for muscle strength difficult to interpret. If the injury is severe, muscle atrophy may be seen in the chronic phase;

(b) *Sensory examination*. Complete loss of sensation or paraesthesia along the sensory nerve pathways is common. Positional perception, two-point discrimination, pinprick evaluation and perception of heat and cold should all be tested. If, at least three

434 Ozkalipci and others, "A significant diagnostic method in torture investigation: bone scintigraphy".

weeks later, deficiency or reflex loss or decrease is present, appropriate electrophysiological studies should be performed by a neurologist experienced in the use and interpretation of these methodologies;

(c) *Reflex examination*. Reflex loss, a decrease in reflexes or a difference between the two extremities may be present. In reverse suspension, even though both brachial plexuses are subjected to trauma, asymmetric plexopathy may develop due to the manner in which the torture victim has been suspended, depending on which arm is placed in a superior position or the method of binding. Although research suggests that brachial plexopathies are usually unilateral (commonly after being catapulted from a motorcycle and landing on one shoulder), that is at variance with experience in the context of torture, in which bilateral injury is common;

447. Among the shoulder region tissues, the brachial plexus is the structure most sensitive to traction injury. The incidence and severity of this complication after suspension will depend on the duration and frequency of the torture and the degree of musculature – a well-muscled individual may well escape such injury. Reverse suspension causes brachial plexus damage due to forced posterior extension of the arms. As observed in the classical type of reverse suspension, when the body is suspended with the arms in posterior hyperextension, typically the lower plexus and then the middle and upper plexus fibres are damaged if the force on the plexus is severe enough. If the suspension is of a "crucifixion" type, but does not include hyperextension, the lower and middle plexuses fibres are likely to be damaged due to hyperabduction. Brachial plexus injuries may be categorized as follows:

(a) *Damage to the lower plexus*. Deficiencies are localized in the forearm and hand muscles. Sensory deficiencies may be observed on the forearm and at the fourth and fifth fingers of the hand's medial side in an ulnar nerve distribution;

(b) *Damage to the middle plexus*. Forearm, elbow and finger extensor muscles are affected. Pronation of the forearm and radial flexion of the hand may be weak. Sensory deficiency is found on the forearm and on the dorsal aspects of the first, second and third fingers of the hand in a radial nerve distribution. Triceps reflexes may be lost;

(c) *Damage to the upper plexus*. Shoulder muscles are especially affected. Abduction of the shoulder, axial rotation and forearm pronation-supination may be deficient. Sensory deficiency is noted in the deltoid region and may extend to the arm and outer parts of the forearm.

4. Other positional torture

448. There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions, which cause severe pain and may produce injuries to ligaments, tendons, nerves and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiological findings, despite subsequent frequently severe chronic disability. Wrist restraints may cause superficial bruising, abrasions and lacerations, particularly over the bony parts of the wrist. They may also cause hand oedema, symptoms of tenosynovitis, fracture of the styloid process of the radius or ulna or neurological deficit of variable duration due to nerve compression, most commonly of a superficial branch of the radial nerve.

449. Positional torture primarily affects tendons, joints and muscles. Additional positional torture methods include: the "banana stand" or the "banana tie" over a chair just on the ground, or on a motorcycle; forced standing; forced standing on a single foot; prolonged standing with arms and hands stretched high on a wall; prolonged forced squatting; and forced immobilization in a small cage. In accordance with the characteristics of these positions, complaints are characterized as pain in a region of the body, limitation of joint movement, back pain, pain in the hands or cervical parts of the body and swelling of the lower legs. The same principles of neurological and musculoskeletal examination apply to these forms of positional torture as apply to suspension. MRI is the preferred radiologic modality for evaluation of injuries associated with all forms of positional torture.

5. Electric shock torture

450. In electric shock torture, electric current is transmitted through electrodes placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips and genital area. The power source may be a hand-cranked or combustion generator, wall source, stun gun, cattle prod or other conducted energy device. Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applied are characteristic. For example, if electrodes are placed

on a toe of the right foot and on the genital region, there will be pain, muscle contraction and cramps in the right thigh and calf muscles. Excruciating pain will be felt in the genital region. Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder, and lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used cannot be determined with certainty upon physical examination of the victim. Torturers often use water or gels in order to increase the efficiency of the torture, expand the entrance point of the electric current on the body and prevent detectable electric burns. Trace electrical burns can be a reddish-brown circular lesion a few millimetres in diameter, usually without inflammation, which may result in a hyperpigmented scar. Skin surfaces must be carefully examined because the lesions are not often easily discernible. Hypersalivation may be reported, but often history is limited due to loss of consciousness during the torture.

6. Dental torture

451. Dental torture may be in the form of breaking or extracting teeth or through application of electrical current to the teeth. It may result in a loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement and, in some cases, subluxation of this joint due to muscle spasms occurring as a result of the electrical current or blows to the face.

7. Asphyxiation

452. Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no mark and recuperation is rapid. This method of torture was so widely used in Latin America that its name in Spanish, *submarino*, has become part of human rights vocabulary. Normal respiration might be prevented through such methods as covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, petrol, hot peppers etc. This is also known as "dry *submarino*". Various complications might develop, such as petechiae of the skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth and acute or chronic respiratory problems. Petrol in the plastic bag may cause burns to the facial skin. Forcible immersion of the head in water, often contaminated with urine, faeces, vomit or other contaminants, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is called "wet *submarino*".

453. Another form of asphyxia, waterboarding, involves pouring water onto a cloth held over the victim's nose and mouth, causing the sensation of, or actual, drowning. The victim is lying face-up, either horizontal or with the feet higher than the head. In hanging or in other ligature asphyxiation, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured by partial strangulation or from blows to the neck.

454. Any of these forms of asphyxia may cause loss of consciousness due to insufficient oxygen supply to the brain and the consequences of this type of loss of consciousness may be similar to that from blunt trauma head injury, in terms of loss of short or long-term memory or other cognitive deficits.

8. Sexual torture, including rape[435]

455. Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. An individual is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the threat of potential sexual torture or ill-treatment, including rape. Furthermore, verbal sexual threats, verbal abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects. Sexual torture includes forced nudity, sexual assault by touching intimate parts of the body, digital penetration, forced masturbation, forced insertion of an object into the vagina or anus, oral rape, anal rape and vaginal rape, ejaculation or urination onto the victim, sexual slavery, forced pregnancy and enforced sterilization. A sexual torture experience is often a prolonged ordeal for the victim, in which many different traumatic events occur. While some victims are able to recount every moment of their ordeal, many are not and block out certain parts of it that are too distressing to relate

435 For additional guidance on the investigation and documentation of sexual violence, see Ferro Ribeiro and van der Straten Ponthoz, *International Protocol on the Documentation and Investigation of Sexual Violence* (see footnote 357).

or that they fear their interviewer will be unable to accept hearing. Disclosure of sexual torture may be difficult and delayed (see paras. 274–276 above).

456. There are some differences between sexual torture of men and sexual torture of women, but several issues apply to both. There may be verbal abuse of a sexual nature, physical torture of intimate body areas, such as breasts and buttocks, and torture targeted specifically at the genitals. Electricity and blows are often aimed at the genitals in men, with or without additional anal torture. The physical trauma is enhanced by verbal abuse. Prisoners may be placed naked in cells with family members, friends or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities. Additionally, prisoners may be forced to sexually abuse each other, which can be particularly difficult to cope with emotionally. The fear of potential rape, given the profound cultural stigma associated with rape, can add to the trauma. For women, there is also the trauma of potential pregnancy, the fear of losing their virginity and the fear of not being able to have children (even if the rape can be hidden from a potential husband and the rest of society). Rape is always associated with the risk of developing sexually transmitted infections, including HIV/AIDS. Currently, the only effective prophylaxis against HIV/AIDS must be taken within 72 hours of the incident, the earlier the more effective, and it is unlikely to be available while the victim is still in detention.

457. A national study found that the most common effects suffered by victims of serious sexual assault are mental or emotional problems (63 per cent), followed by difficulty trusting people or difficulty in other relationships (53 per cent).[436] In this study, only 27 per cent of victims had minor bruising or a black eye and more serious injuries were rare.[437] However, the notion that a victim who has not sustained physical injuries must have consented is still widely held. Fear of further violence often limits the resistance of victims or they may simply "freeze". In a global review of sexual assault cases, an average of 65 per cent of victims had some kind of physical injury (namely, 35 per cent did not) and an average of 30 per cent had evidence of anogenital trauma (namely, 70 per cent did not).[438] A previously undisclosed history of sexual violence may be found by making a full review of symptoms, particularly of the genito-urinary and anorectal systems and a full examination. If injuries to an intimate part of the body, such as the breasts, buttocks or thighs, are found, this may indicate that sexual violence occurred. It should be noted that absence of genital injury cannot be taken to indicate sexual violence did not occur. Vulvovaginitis occurring as a result of repeated douching may be an indicator of past sexual violence.

458. Violent and repeated rape or sexual assault by anal penetration with an object can cause significant physical damage to the anal sphincter and rectum with long-lasting effects, including pain on defaecation, chronic anal fissure and piles, and incontinence of faeces or flatus. Disclosure of these symptoms can be difficult but, paradoxically, an enquiry about such symptoms as part of a body systems review by the doctor can lead to a disclosure of the assault that caused them. Other clues may be an inability to sit comfortably or for long, complaints about lower back problems and high levels of anger and irritability.[439] According to UNHCR guidance: "Many male survivors only report their experiences when they require urgent medical intervention."[440] Another possible opening for disclosure is when conducting a risk assessment for harm to self or others, when a detailed exploration for thoughts triggering impulsive acts of violence may facilitate disclosure.

459. If, in cases of sexual torture, the victim does not wish the event to be known due to sociocultural pressures or personal reasons, the physician who carries out the medical examination, investigative agencies and the courts have an obligation to cooperate in maintaining the victim's privacy. Establishing a rapport with torture survivors who have recently been sexually assaulted requires special psychological education and appropriate psychological support. Any treatment that would increase the psychological trauma of a torture survivor should be avoided. Before starting the examination, specific consent must be obtained from the individual. The individual should be informed about the importance of the examination and its possible findings in a clear and comprehensible manner.

436 United Kingdom, Office for National Statistics, "Sexual offences in England and Wales" (see footnote 401).
437 Ibid.
438 Ibid.
439 UNHCR, "Working with men and boy survivors" (see footnote 402).
440 Ibid., p. 11.

(a) Review of symptoms

460. A thorough history of the alleged sexual torture or ill-treatment should be recorded as described earlier in the present manual (see paras. 394–396 above). There are, however, some specific questions that are relevant only to an allegation of sexual torture. These seek to elicit current symptoms resulting from a recent assault, for example bleeding, vaginal or anal discharge and location of pain, bruises or sores. In cases of sexual assault in the past, questions should be directed to ongoing symptoms that resulted from the assault, such as urinary frequency, incontinence or dysuria, irregularity of menstruation, subsequent history of pregnancy, abortion or vaginal haemorrhage, problems with sexual function, including intercourse and anal pain, bleeding, constipation or incontinence of urine, flatus or faeces, and lower abdominal pain. Patients may describe vomiting, retching and nausea on recall of oral rape.

461. Ideally, there should be adequate physical and technical facilities for appropriate examination of survivors of sexual violation by a team of experienced psychiatrists, psychologists, gynaecologists and nurses, who are trained in the treatment of survivors of sexual torture. An additional purpose of the consultation after sexual assault is to offer support, advice and, if appropriate, reassurance. This should cover issues such as sexually transmitted diseases, HIV/AIDS, pregnancy, if the victim is a woman, and permanent physical damage, because torturers often tell victims that they will never normally function sexually again, which can become a self-fulfilling prophecy. Examination of anorectal injuries may need to be performed under sedation, if symptoms indicate the victim could not cope otherwise. The aim should be to do only one examination to minimize retraumatization, with all necessary expertise and equipment present for evidence collection, swabs and treatment.

(b) Examination following a recent assault

462. It is rare that a victim of rape during torture is released while it is still possible to identify acute signs of the assault. In these cases, there are many issues to be aware of that may impede the medical evaluation. Recently assaulted victims may be troubled and confused about seeking medical or legal help due to their fears, sociocultural concerns or the destructive nature of the torture or ill-treatment. In such cases, a doctor should explain to the victim all possible medical and judicial options and should act in accordance with the victim's wishes. The duties of the physician include obtaining voluntary informed consent for the examination, recording all medical findings of torture or ill-treatment and obtaining samples for forensic examination. Whenever possible, the examination should be performed by an expert in documenting sexual assault. Otherwise, the examining physician should speak to an expert or consult a standard text on clinical forensic medicine. When the physician is of a different gender from the victim, the victim should be offered the opportunity of having a chaperone of the same gender in the room. Given the sensitive nature of investigation into sexual assault, it is not appropriate for this person to be a relative of the victim or the interpreter (see para. 219 above). Physicians should allow examinations to proceed at a pace dictated by the alleged victims, minimizing exposure of their body by examining one part at a time if they find this easier to cope with. Physicians should observe the behaviour and emotions of the alleged victims and be ready to stop if they become too distressed. A thorough physical examination should be performed, including meticulous documentation of all physical findings, including size, location and colour and, whenever possible, these findings should be photographed and evidence collected of specimens from the examination.

463. The physical examination should not initially be directed at the genital area. Any deformities should be noted. Particular attention must be given to ensure a thorough examination of the skin, looking for cutaneous lesions that could have resulted from an assault. These include bruises, lacerations and petechiae from sucking or biting. When genital lesions are minimal, lesions located on other parts of the body may be the most significant evidence of an assault, especially, for example, those in forced contact with the ground, such as back, buttocks or knees. Even during examination of the female genitalia immediately after rape, injury is present in only a minority of cases. Anal examinations of men and women after anal rape similarly show injuries in a minority of cases. In cases in which injury is present, most will be healed within a few days. In situations in which relatively large objects have been used to penetrate the vagina or anus, the likelihood of identifiable damage increases, but absence of injury is not uncommon.

464. In situations in which a forensic laboratory is available, the facility should be contacted before the examination to discuss which types of specimen can be tested and, therefore, which samples should be taken and how. Many laboratories provide kits to allow physicians to

take all the necessary samples from individuals alleging sexual assault. If there is no laboratory available, it may still be worthwhile to obtain wet swabs and dry them later in the air. These samples can be used later for DNA testing. Strict precautions must be taken to prevent allegations of cross-contamination when samples have been taken from several different victims, particularly if they are taken from alleged perpetrators. There must be preservation and documentation of the chain of custody for all forensic samples.

(c) Examination after the immediate phase

465. In cases in which the alleged sexual torture or ill-treatment occurred more than a week earlier and there are no signs of bruises or lacerations, there is less immediacy in conducting a pelvic examination. Time can be taken to try to find the most qualified person to document findings and the best environment in which to interview the individual. However, it may still be beneficial to photograph residual lesions properly, if this is possible.

466. The clinical evaluation should be recorded as described above, then examination and documentation of the general physical findings. In women who have delivered babies before the rape, and particularly in those who have delivered them afterwards, pathognomonic findings are not likely. It may take some time before individuals are willing to discuss those aspects of the torture that they find most shameful or stigmatizing. Similarly, alleged victims may wish to postpone the more intimate parts of the examination to a subsequent consultation, if time and circumstances permit.

467. In only a minority of cases is physical evidence found when examining genitalia after an assault. When examining later on, when the person may have had subsequent sexual activity, whether consensual or not, or given birth, caution must be taken in attributing any findings to a specific incident of alleged torture or ill-treatment. Therefore, for both women and men, the most significant component of a medical evaluation may be the examiner's assessment of background information (e.g. correlation between allegations of torture or ill-treatment and acute injuries observed by the individual), the demeanour of the individual and the psychological impact of the experience.

(d) Follow-up

468. Many infectious diseases can be transmitted by sexual torture or ill-treatment, including sexually transmitted infections, such as gonorrhoea, chlamydia, syphilis, HIV, HPV, hepatitis B and C, herpes simplex, anogenital warts, vulvovaginitis resulting from trichomoniasis, monilial vaginitis, bacterial vaginosis and pinworm infection, as well as urinary tract infections.

469. Appropriate laboratory tests and treatment should be prescribed in all cases of sexual torture or ill-treatment. In the case of gonorrhoea and chlamydia, concomitant infection of the anus or oropharynx should be considered at least for examination purposes. Initial cultures and serologic tests should be obtained in cases of sexual assault and appropriate therapy initiated. The presence of sexually transmitted infection may be consistent with an account of sexual torture but does not necessarily confirm torture was the cause.

470. Sexual dysfunction is common among survivors of torture or ill-treatment, particularly among those who have suffered sexual torture or rape, but not exclusively. Sexual dysfunction may occur in those who have not suffered sexual torture or it may be that they have not yet disclosed it. Symptoms may be physical or psychological in origin or a combination of both and include:

(a) Aversion to members of the opposite sex or decreased interest in sexual activity;

(b) Fear of sexual activity because a sexual partner will "know" that the victim has been sexually tortured or fear of having been damaged sexually. Torturers may have threatened this and instilled fear of homosexuality in men who have been anally tortured. Some men have had an erection and, on occasion, ejaculated during anal rape. They should be reassured that this is a physiological response and does not imply consent, enjoyment or necessarily reflect their sexual orientation;

(c) Profound effects on the psyche due to forced transgressions of sexual orientation and gender identity;

(d) Inability to trust a sexual partner;

(e) Disturbance in sexual arousal and erectile dysfunction;

(f) Dyspareunia (painful sexual intercourse in women) or infertility due to acquired sexually transmitted infection, direct trauma to reproductive organs or poorly performed abortions of pregnancies following rape.

(e) Genital examination of females

471. In many cultures or social groups, it is completely unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. If the woman demonstrates evidence of vaginal penetration on external visual inspection, it may be unnecessary to conduct an internal pelvic examination. Genital examination findings may include:

(a) *Small lacerations or tears of the vulva*. These may be acute and are caused by excessive stretching. They normally heal completely, but can scar, although repeated penetration does not necessarily result in visual evidence;

(b) *Abrasions of the female genitalia*. Abrasions can be caused by contact with rough objects, such as fingernails or rings or the absence of lubrication;

(c) *Vaginal lacerations*. They cannot necessarily be differentiated from incisions caused by inserted sharp objects;

(d) *Healed scarring around the genital area*. This may have been caused by cigarette burns or cutting wounds.

472. Many of the genital examination findings listed above may result from "virginity examinations", which are practised in many countries often forcibly, including in detention places, on women who allege rape or are accused of prostitution; and as part of public or social policies to control sexuality. In its statement of 2014 on the matter,[441] the Independent Forensic Expert Group concludes that virginity examinations are medically unreliable and have no clinical value. These examinations are inherently discriminatory and, in almost all instances, when conducted forcibly, result in significant physical and mental pain and suffering. When conducted by, or at the instigation of, a public official or other person acting in an official capacity, the virginity examination will thereby constitute cruel, inhuman or degrading treatment or torture. When virginity examinations are forcibly conducted and involve vaginal penetration, the examination should be considered as sexual assault and rape. The involvement of health professionals in these examinations violates the basic standards and ethics of the relevant professions.

473. Female genital mutilation should be identified if present. Despite international efforts to eliminate female genital mutilation, it is still commonly practised, with 200 million women and girls alive worldwide who have been subjected to this practice for sociocultural reasons. Mutilation of the genitalia may also have been part of the sexual torture. Female genital mutilation is categorized by the World Health Organization as follows:

(a) Type I: partial or total removal of the clitoral glans, and/or the prepuce/clitoral hood;

(b) Type Ia: removal of the clitoral hood or prepuce only;

(c) Type Ib: removal of the clitoral glans with the prepuce/clitoral hood;

(d) Type II: partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision);

(e) Type IIa: removal of the labia minora only;

(f) Type IIb: partial or total removal of the clitoral glans and the labia minora;

(g) Type IIc: partial or total removal of the clitoral glans, the labia minora and the labia majora;

(h) Type III: narrowing of the vaginal opening with creation of a covering seal by cutting and repositioning the labia minora or the labia majora, with or without excision of the clitoral prepuce/clitoral hood and glans (infibulation);

(i) Type IIIa: removal and repositioning of the labia minora;

(j) Type IIIb: removal and repositioning of the labia majora;

441 Independent Forensic Expert Group, "Statement on virginity testing" (see footnote 309).

(k) Type IV: all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

474. A woman should be asked how the procedure has affected her, and if she has had complications as a result. Acutely, women and girls can suffer haemorrhage or overwhelming infection. Female genital mutilation/cutting is associated with long-term medical complications, including recurrent infections, cysts and abscesses, keloid scar formation resulting in pain, damage to the urethra resulting in urinary incontinence, complications of future childbirth (including increased risk of haemorrhage and death), sexual dysfunction and psychological trauma, including PTSD, anxiety and depression. In addition, infants born to women who have undergone female genital mutilation are more likely to suffer perinatal morbidity and mortality.

(f) Genital examination of males

475. Men who have been subjected to torture of the genital region, including the crushing, wringing or pulling of the scrotum or direct trauma to that region, usually complain of pain and sensitivity in the acute period. Hyperaemia, marked swelling and ecchymosis can be observed. The urine may contain a large number of erythrocytes and leucocytes. If a mass is detected, it should be determined whether it is a hydrocele or haematocele, which could have resulted from torture or an inguinal hernia. In the case of an inguinal hernia, the examiner cannot palpate the spermatic cord above the mass. With a hydrocele or a haematocele, normal spermatic cord structures are usually palpable above the mass. A hydrocele results from excessive accumulation of fluid within the tunica vaginalis due to inflammation of the testis and its appendages or to diminished drainage secondary to lymphatic or venous obstruction in the cord or retroperitoneal space. A haematocele is an accumulation of blood within the tunica vaginalis, secondary to trauma. Unlike the hydrocele, it does not transilluminate. Peyronie's disease can arise secondary to trauma to the penis (e.g. having a drawer slammed shut on it).

476. Testicular torsion may also result from trauma to the scrotum. With this injury, the testis becomes twisted at its base, obstructing blood flow to the testis. This causes severe pain and swelling and constitutes a surgical emergency. Failure to reduce the torsion immediately will lead to infarction of the testis. Under conditions of detention, where medical care may be denied, late sequelae of this lesion may be observed.

477. Individuals who were subject to scrotal torture may suffer from chronic urinary tract infection, erectile dysfunction or atrophy of the testes. Symptoms of PTSD are not uncommon. In the chronic phase, it may be impossible to distinguish between scrotal pathology caused by torture and that caused by other disease processes. Failure to discover any physical abnormalities on full urological examination suggests that urinary symptoms, impotence or other sexual problems may be explained on psychological grounds. Scars on the skin of the scrotum and penis may be very difficult to visualize. For this reason, the absence of scarring at these specific locations does not demonstrate the absence of torture. On the other hand, the presence of scarring usually indicates that substantial trauma was sustained.

(g) Examination of the anal region

478. Penetration of the anus with an object or an erect penis does not always result in injury. Initial pain and bleeding may be observed. Most injuries heal within a few days. Occasionally pain and bleeding can occur for days or weeks. This may lead to constipation, which can be exacerbated by the poor diet in many places of detention. Haemorrhoids or a fissure may arise secondary to the constipation. Gastrointestinal and urinary symptoms may also occur. In the acute phase, any examination beyond visual inspection may require local or general anaesthesia and should be performed by a specialist. In the chronic phase, several symptoms may persist and they should be investigated. There may be anal scars of unusual size or position and these should be documented. Anal fissures may persist for many years, but it is not possible to differentiate by visual inspection between those caused by torture and those caused by other mechanisms, such as gastrointestinal disease. On examination of the anus, the following findings should be looked for and documented:

(a) Fissures tend to be non-specific findings as they can occur in a number of "normal" situations (constipation or poor hygiene). However, when seen in an acute situation (i.e. within 72 hours), fissures are a more specific finding and may be consistent with penetration;

(b) Rectal tears with or without bleeding may be noted;

(c) Disruption of the rugal pattern may manifest as smooth fan-shaped scarring. When these scars are seen out of midline (i.e. not at 12 or 6 o'clock), they can be an indication of penetrating trauma;

(d) Skin tags, which can be the result of healing trauma;

(e) Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

479. Anal examinations are forcibly conducted in many countries in which consensual anal intercourse is considered a criminal act.[442] They are conducted almost exclusively on males in an effort to "prove" that they engage in "homosexual behaviour". In a statement made in 2016, the Independent Forensic Expert Group concluded that there was no clinical validity in such a test. Such examinations are inherently discriminatory. In many circumstances in which anal examinations are forcibly conducted, they are accompanied by other forms of physical torture or ill-treatment, such as beatings by police and demeaning remarks about the individual's alleged homosexuality by police and medical personnel. Threats, coercion and physical force are often applied. The fact that an examination may be conducted with non-medical personnel being present is an additional source of concern. In addition, the elements of forced nudity and physical restraint, when used, amplify the sense of helplessness, fear, humiliation and degradation that individuals experience. The Committee against Torture, the Special Rapporteur on torture and the Working Group on Arbitrary Detention have stated that the practice of forced anal examinations contravenes the prohibition against torture and ill-treatment.[443] When anal examinations are forcibly conducted and involve anal penetration, the examination should be considered a form of sexual assault and rape. Involvement of health professionals in these examinations violates the basic standards and ethics of the relevant professions. Anal examinations carried out as body cavity checks should only be carried out in accordance with the Bangkok Rules (rules 19–21), the Nelson Mandela Rules (rules 50–52) and the WMA statement on body searches of prisoners.

F. Specialized diagnostic tests

480. Diagnostic tests are not an essential part of the clinical assessment of a person alleging torture or ill-treatment. In many cases, a medical history and physical examination are sufficient. There are circumstances in which such tests are valuable supporting evidence, for example, in situations in which there is a legal case against members of the authorities or a claim for compensation. However, it must be remembered that any test will have a false negative rate and this is often higher the greater the interval between performing the test and the time when the injury occurred. If diagnostic tests are performed for clinical rather than legal reasons, the results should be added to the clinical report. It must be recognized that the absence of a positive diagnostic test result, as with physical findings, must not be used to suggest that torture or ill-treatment did not occur. There are many situations in which diagnostic tests are not available for technical reasons, but their absence should never invalidate an otherwise properly written report.

481. Diagnostic tests are being developed and evaluated all the time. For this reason, reference here to specific tests is limited, but when additional supporting evidence is required, investigators should utilize the most up-to-date resources available to them.

482. In the acute phase of injury, various imaging modalities may be useful in providing additional documentation of skeletal and soft tissue injury. Once the physical injuries of torture or ill-treatment have healed, however, the residual sequelae are generally no longer detectable by the same imaging methods. This is often true even when survivors continue to suffer significant pain or disability from their injuries. In addition, the more sophisticated and expensive technology may not be universally available or at least not to a person in custody.

483. MRI may detect bone contusion and stress or occult fractures before it can be imaged by either routine radiographs, CT or scintigraphy.

484. Use of open scanners and sedation may alleviate anxiety and claustrophobia, which are prevalent among torture survivors.

442 Independent Forensic Expert Group, "Statement on anal examinations" (see footnote 309), p. 85.
443 A/HRC/19/41, para. 37. See also A/HRC/22/53, para. 79.

G. Assessment of functional disability

485. Assessment of functional disability is particularly useful in circumstances in which a compensation claim is made, but is also helpful in planning individual rehabilitation strategies and goals. The World Health Organization Disability Assessment Schedule version 2.0 is a tool that can be used for this purpose to produce standardized disability levels and profiles applicable across cultures. It is the operational tool for the International Classification of Functioning, Disability and Health.[444]

486. The Schedule covers six domains of functioning, namely: cognition (understanding and communication); mobility (moving and getting around); self-care (hygiene, dressing, eating and staying alone); getting along (interacting with other people); life activities (domestic responsibilities, leisure, work and school); and participation (joining in community activities and participating in society).

487. When scoring, the following numbers are assigned to responses in each domain: 1 ("none"); 2 ("mild"); 3 ("moderate"); 4 ("severe"); and 5 ("extreme or cannot do"). Item scores in each domain are summed up and then the scores of all six domains are added up. The summary score is then converted to a metric ranging from 0 to 100 (where 0 = no disability; and 100 = full disability).[445]

H. Children

488. Medical examinations should be carried out in a child friendly setting by trained clinicians with experience in assessing and documenting physical injury (including those resulting from sexual assault) in children and young persons. Consent for the examination should be obtained from children's guardians and, where appropriate, from the children or young persons themselves (see paras. 165–171 and 285 above). Ideally clinicians should have access to additional diagnostic facilities (e.g. X-rays and other imaging techniques), haematological testing and further specialist advice as needed. In interpreting their findings, clinicians usually need to seek additional information from children, young persons and their caregivers over and above that available from non-medical interviews.

489. Children who have endured torture and other forms of ill-treatment and human right violations must have access to trained, competent paediatric examiners, wherever possible, who can provide medical assessments and recommendations for care. In children, part of the evaluation must include safeguarding for the prevention of further torture and ill-treatment, recommendations for recovery and reintegration and reduction of exposure to experiencing or witnessing violence. Access to appropriate and confidential medical and psychological follow-up care is an entitlement[446] for children.

490. Genital examination of children should be performed by clinicians experienced in documenting and interpreting the findings. In settings in which video recording can be carried out, other experts can give opinions on the physical and genital findings without the child having to be examined again. However, the clinician should be aware that an examination may be reminiscent of the original assault and should therefore be carried out sensitively with appropriate explanations to the child and the child's caregiver. Examination of the genital and anal areas under general anaesthesia may result in changes to physical findings and carries additional clinical risks; it should not normally be carried out unless concurrent surgical treatment to the area is being considered. Clinicians should be aware that scar formation in children may be different from that in adults as wounds might heal faster. Bony injuries, depending on their position related to the growth plate, may not be apparent on initial X-rays or months after a fracture has healed. Radiological techniques should be used scrupulously in children given the anxiety that they may cause and potential after-effects of childhood radiation.

444 World Health Organization, *How to Use the ICF: A Practical Manual for Using the International Classification of Functioning, Disability and Health – Exposure Draft for Comment* (Geneva, 2013).

445 Scoring templates can be obtained from: www.who.int/classifications/icf/more_whodas/en.

446 The Convention on the Rights of the Child, art. 39, stipulates that: "States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child."

A. General considerations

1. Central role of the psychological evaluation

491. It is a widely held view that torture is an extraordinary life experience capable of causing a broad range of physical and psychological suffering. Research and clinical experience have shown that psychological sequelae of torture are often more persistent and protracted than physical sequelae[447] and documentation of torture frequently takes place when the physical lesions have already disappeared. These circumstances confer upon the psychological evaluation a central role in evidencing torture, holding perpetrators responsible and claiming redress. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pre-torture psychological status. The psychological consequences of torture, however, vary according to the nature of the harm inflicted and the context of personal attribution of meaning, personality development and social, political and cultural factors. For this reason, it cannot be assumed that all forms of torture have the same consequences in every individual. For example, the psychological consequences of a mock execution are not the same as those due to a sexual assault, and solitary confinement and isolation are not likely to produce the same effects as physical acts of torture. Likewise, the effects of detention and torture on an adult will usually not be the same as those on a child. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

492. Perpetrators often attempt to justify their acts of torture or ill-treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions.[448] Thus, torture is a means of attacking an individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate a victim physically but also to disintegrate the individual's personality.[449] The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims, torturers offer a horrific warning for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children, other family members and between the victims and their communities.

493. It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness.[450] However, most victims experience profound emotional reactions and psychological symptoms often also including serious cognitive and behavioural changes. The main psychiatric disorders associated with torture are PTSD and depression. While these disorders are present in the general population, their prevalence, though varying among studies, is much higher among torture survivors. Epidemiological studies with torture survivors and refugees show prevalence rates of 23–88 per cent for PTSD and 28–95 per cent for depression.[451] The high variability among studies is likely due to different population samples (including studies with torture survivors seeking treatment), different assessment methods, coexisting stressors and other factors. However, the unique cultural, social and political implications that torture has for each individual influence the ability of that person to describe and speak about it. Such effects on the victim's ability to make sense of and describe the experience of torture must be considered especially when performing an evaluation of an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most useful approaches when attempting to evaluate psychological or psychiatric disorders. What is considered disordered

447 José Quiroga and James M. Jaranson, "Politically-motivated torture and its survivors. A desk review of the literature", *Torture*, vol. 15, No. 2–3 (2005).

448 José A. Saporta and Bessel A. van der Kolk, "Psychobiological consequences of severe trauma", in *Torture and its Consequences: Current Treatment Approaches*, Metin Başoğlu, ed. (Cambridge, United Kingdom, Cambridge University Press, 1998), pp. 151–181.

449 Almerindo E. Ojeda, ed., *The Trauma of Psychological Torture* (Westport, Praeger, 2008); and Pau Pérez-Sales, *Psychological Torture: Definition, Evaluation and Measurement* (Routledge, 2016).

450 It should be kept in mind that the qualification of an act as torture is not dependent on the existence of subsequent prolonged mental harm. See, in this respect, Manfred Nowak, "What practices constitute torture?: US and UN standards", *Human Rights Quarterly*, vol. 28, No. 4 (2006), pp. 809–841.

451 Hiba Abu Suhaiban, Lana Ruvolo Grasser and Arash Javanbakht, "Mental health of refugees and torture survivors: a critical review of prevalence, predictors and integrated care", *International Journal on Environmental Research and Public Health*, vol. 16, No. 13 (2019).

behaviour or a disease in one culture may not be viewed as pathological in another.[452]

494. In recent years, the diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. However, the utility of this diagnosis has been questioned on many grounds, including its universal applicability. Nevertheless, evidence suggests that there are high rates of PTSD and depressive symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds.[453] A cross-cultural study of depression provides helpful information.[454] While some symptoms may be present across different cultures, it is important to consider culture-specific ways of experiencing, expressing and describing psychological distress in order to recognize and document the broad range of suffering that may remain invisible if the PTSD concept is uncritically applied. Such expressions of distress shaped by culture might be more relevant to the survivor than PTSD symptoms.

2. Context of the psychological evaluation

495. Evaluations take place in a variety of political contexts. This results in important differences in the manner in which an evaluation should be conducted. The clinician must adapt the following guidelines to the particular situation and purpose of the evaluation (see para. 185 above), maintaining under any circumstances the highest ethical standards, as set forth in chapter II above. Psychological evaluations can help to identify post-traumatic conditions (e.g. memory problems, flashbacks, avoidance and dissociation),[455] which may cause victims to act unconsciously or unintentionally and are likely to affect or alter the victims' ability and capacity to recall and present what they have experienced, which in turn may affect their ability to participate and testify in various forms of legal proceedings, including adjudication related to the investigation of torture.[456] Assessment and documentation of these barriers to full participation in legal proceedings as a consequence of the sequelae of torture can help prevent inaccurate conclusions being drawn in legal proceedings by lawyers and judges.[457]

496. What can be asked about and documented safely will vary considerably and depends on the degree to which confidentiality and security can be ensured. For example, an examination in a prison by a visiting clinician that is limited to 15 minutes cannot follow the same course as a psychological evaluation in a private office that may last for several hours. Additional problems arise when trying to assess whether psychological symptoms or behaviours are pathological or adaptive. When a person is examined while in detention or living under considerable threat or oppression, some symptoms may be adaptive. For example, diminished interest in activities and feelings of detachment or estrangement would be understandable in a person in solitary confinement. Likewise, hypervigilance and avoidance behaviours may be necessary for persons living in repressive societies.[458] Despite the possible limitations imposed by the conditions in which the interview is conducted, every effort towards adherence to the guidelines of the Istanbul Protocol should be pursued. It is especially important in difficult circumstances that the Governments and authorities involved be held to these standards as much as possible.

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452 H. Tristram Engelhardt, Jr., "The concepts of health and disease", in *Evaluation and Explanation in the Biomedical Sciences*, H. Tristram Engelhardt, Jr. and Stuart F. Spicker, eds. (Dordrecht, D. Reidel Publishing Co., 1975), pp. 125–141. See also Joseph Westermeyer, "Psychiatric diagnosis across cultural boundaries", *American Journal of Psychiatry*, vol. 142, No. 7 (1985), pp. 798–805.

453 See Richard F. Mollica and others, "The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps", *Journal of the American Medical Association*, vol. 270, No. 5 (1993), pp. 581–586; Kathleen Allden and others, "Burmese political dissidents in Thailand: trauma and survival among young adults in exile", *American Journal of Public Health*, vol. 86, No. 11 (1996), pp. 1561–1569; J. David Kinzie and others, "The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees", *American Journal of Psychiatry*, vol. 147, No. 7 (1990), pp. 913–917.

454 Norman Sartorius, "Cross-cultural research on depression", *Psychopathology*, vol. 19, No. 2 (1986), pp. 6–11.

455 Andrea R. Ashbaugh, Julia Marinos and Brad Bujaki, "The impact of depression and PTSD symptom severity on trauma memory", *Memory*, vol. 26, No. 1 (2018), pp. 106–116.

456 Karen E. Krinsley and others, "Consistency of retrospective reporting about exposure to traumatic events", *Journal of Traumatic Stress*, vol. 16, No. 4 (2003), pp. 399–409; Amina Memon, "Credibility of asylum claims: consistency and accuracy of autobiographical memory reports following trauma", *Applied Cognitive Psychology*, vol. 26, No. 5 (2012), pp. 677–679; Hannah Rogers, Simone Fox and Jane Herlihy, "The importance of looking credible: the impact of the behavioural sequelae of post-traumatic stress disorder on the credibility of asylum seekers", *Psychology, Crime & Law*, vol. 21, No. 2 (2015), pp. 139–155.

457 Belinda Graham, Jane Herlihy and Chris R. Brewin, "Overgeneral memory in asylum seekers and refugees", *Journal of Behavior Therapy and Experimental Psychiatry*, vol. 45, No. 3 (2014), pp. 375–380; Urs Hepp and others, "Inconsistency in reporting potentially traumatic events", *British Journal of Psychiatry*, vol. 188, No. 3 (2006), pp. 278–283; Jane Herlihy, Peter Scragg and Stuart Turner, "Discrepancies in autobiographical memories – implications for the assessment of asylum seekers: repeated interviews study", *British Medical Journal*, vol. 324 (2002), pp. 324–327; and Cohen, "Errors of recall and credibility" (see footnote 412).

458 Michael A. Simpson, "What went wrong?: Diagnostic and ethical problems in dealing with the effects of torture and repression in South Africa", in *Beyond Trauma: Cultural and Societal Dynamics*, Rolf J. Kleber, Charles R. Figley and Berthold P.R. Gersons, eds. (New York, Plenum Press, 1995), pp. 187–212.

B. Psychological consequences of torture and ill-treatment

1. Cautionary remarks

497. Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that psychiatric classifications are generally considered to be based on Western medical concepts and that their application to non-Western populations presents certain difficulties.[459] It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a disorder that resides in an individual and features a set of typical symptoms may be unacceptable to many members of non-Western societies. Nonetheless, there is considerable evidence of biological changes that occur in PTSD and, from that perspective, PTSD is a diagnosable syndrome amenable to treatment biologically and psychologically.[460] As much as possible, the evaluating clinician should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms. This includes respect for the political context, as well as cultural and religious beliefs. Given the severity of torture and its consequences, when performing a psychological evaluation, an attitude of informed learning should be adopted rather than one of rushing to diagnose and classify. Ideally, this attitude will communicate to victims that their complaints and suffering are being recognized as real and understandable under the circumstances. In this sense, an empathic attitude may offer the victim some relief from the experience of alienation.

498. In most cases, the intensity of trauma-related psychological symptoms changes over time depending on personal trauma processing, the effectiveness of available coping strategies, as well as external factors. There might be subthreshold symptoms at the time of assessment or reported for phases since the traumatic event that do not amount to a diagnosable mental disorder. The expression of distress may be nuanced or mediated by culture and social context, for example according to the experience of shame, fear of reprisals and fear of further stigma or ostracization within the family or community. It is important to recognize that the absence of a formal diagnosis does not exclude the presence of severe mental suffering and disability and is not inconsistent with torture or ill-treatment having taken place. The psychological assessment should aim to reach an understanding of the multiple short- and long-term psychological, psychosomatic and psychosocial reactions beyond and not limited to a possible psychiatric classification.

2. Common psychological responses

499. This section describes some of the frequent psychological responses to torture. It is not meant to be an exhaustive list, as other reactions may occur as well.

(a) Re-experiencing the trauma

500. A person who has experienced torture may have unwanted intrusive memories or flashbacks, in which the traumatic event is experienced as occurring again, even while the person is awake and conscious, or recurrent nightmares, which include elements of the traumatic event in their original or symbolic form. Such episodes of reliving the traumatic event cause significant emotional distress and/or physiological reactions and the person may feel or act as if the event is recurring. The person may also experience emotional distress and physiological reactions on exposure to cues that symbolize or resemble the trauma. This may include a lack of trust and fear of persons in authority, including health professionals, as they might evoke memories of the experienced torture and its perpetrators.

(b) Avoidance

501. As the memories of torture are generally accompanied by severe emotional distress, often experienced as overwhelming and uncontrollable, survivors might avoid circumstances or cues that are likely to trigger these memories. Avoidance can include places, persons, activities, conversations, thoughts, feelings or any other cue that arouses a recollection of torture. Avoidance can seriously limit the survivors' capacity to participate in daily activities and social interactions and pursue plans and projects. It may even lead survivors to avoid seeking help for their symptoms and thus inhibit treatment or therapy.

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459 Derek Summerfield, "The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category", *British Medical Journal*, vol. 322 (2001), pp. 95–98; and Nimisha Patel, "The psychologization of torture", in *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*, Mark Rapley, Joanna Moncrieff and Jacqui Dillon, eds. (London, Palgrave Macmillan, 2011), pp. 239–255.

460 Matthew Friedman and James Jaranson, "The applicability of the post-traumatic stress disorder concept to refugees", in *Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees*, Anthony J. Marsella and others, eds. (Washington, D.C., American Psychological Association, 1994), pp. 207–227.

(c) Hyperarousal

502. Hyperarousal includes:

(a) Difficulty either falling or staying asleep;

(b) Irritability or outbursts of anger;

(c) Difficulty concentrating;

(d) Hypervigilance, exaggerated startled response.

(d) Damaged self-concept and negative changes in cognition and mood

503. For many survivors, the experience of torture marks a profound rupture in their lives. They have a subjective feeling of having been irreparably damaged and having undergone an irreversible personality change,[461] often believing that they will never be the same person again. Overly negative beliefs and assumptions about oneself and the world – distrust, expectations of the worst to happen, hopelessness and blame of self and others for causing the trauma – frequently characterize the relation with the environment. Feelings of detachment from others further affect relationships and can also lead to social withdrawal and isolation. Survivors have a sense of a foreshortened future without expectation of a career, marriage, children or normal lifespan. Difficulties experiencing positive feelings, such as happiness or love, and/or the predominance of negative emotions (e.g. fear, horror, anger, guilt and shame), as well as general emotional constriction, are also common in torture survivors.

(e) Feelings of guilt and shame

504. Guilt and shame are self-conscious emotions. Shame is caused by an internal belief of inadequacy, unworthiness, dishonour or regret, which others may or may not be aware of. Another person, a failure or particular circumstance may trigger shame. Guilt is a cognitive or an emotional experience that occurs when individuals believe or realize, accurately or not, that they have compromised their own standards of conduct or violated a universal moral standard and bear significant responsibility for that violation. It is closely related to the concept of remorse. Given that feelings of guilt and shame may lead to conclusions that the whole self is flawed, bad or subject to exclusion, it makes individuals want to withdraw or hide themselves. Sexual violence particularly brings about feelings of shame and guilt.

(f) Symptoms of depression

505. The following symptoms of depression may be present: depressed mood, anhedonia (markedly diminished interest or pleasure in activities), appetite disturbance or weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, difficulty paying attention, concentrating or recalling from memory, thoughts of death and dying, suicidal ideation or attempted suicide. The assessment of suicide risk is critical, and clinicians should keep in mind that some persons will not readily admit such behaviour and thoughts as they may be seen as a sign of weakness and are often stigmatized. The exploration of self-harming behaviour may lead to additional disclosure of torture, such as sexual torture, not revealed previously.

(g) Dissociation, depersonalization and atypical behaviour

506. Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. Individuals may be cut off or unaware of certain actions and may feel detached from themselves or their bodies as if observing themselves from a distance (depersonalization). Derealization describes the subjective experience of the unreality or distortion of the outside world or environment. Dissociative phenomena can be present during traumatic events as a result of the extreme physical and psychological stress, leading to changes in perception and information processing with a feeling of distance and detachment from the traumatic event and the accompanying emotions. Certain sensory impressions are not registered whereas others might be perceived very intensely. Peritraumatic dissociation, as well as repression and avoidance of traumatic memories, may cause incomplete or fragmented memories of the traumatic event and may impede a coherent and complete narration of it. Dissociation can also occur when the victim is confronted with the traumatic event during the evaluation. In this case, individuals frequently appear to be distant, cut off from their emotions, showing indifference or other emotional states incongruent with the trauma

461 Neal R. Holtan, "How medical assessment of victims of torture relates to psychiatric care", in *Caring for Victims of Torture*, James M. Jaranson and Michael K. Popkin, eds. (Washington, D.C., American Psychiatric Press, 1998), pp. 107–113.

narrative. Survivors may also exhibit impulse control problems resulting in behaviours that they consider highly atypical with respect to their pre-trauma personality. For example, a previously cautious individual may engage in high-risk behaviour.

(h) Physical complaints (somatic symptoms)

507. Pain, headaches or other physical complaints, with or without objective physical findings, are common problems among torture survivors. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to the physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches. Headaches are very common among torture survivors and may be due to torture-inflicted injury (head and neck injuries are a common part of torture), as well as being caused or exacerbated by poor sleep patterns, stress and anxiety.

(i) Sexual problems

508. Sexual dysfunction is common among torture survivors, particularly among those who have suffered sexual torture or rape, but not exclusively (see para. 470 above). Sexual problems include reduced or absent sexual interest/arousal/desire, erectile dysfunction, genito-pelvic pain, painful intercourse, disgust or fear of intimacy and sexual involvement, flashbacks and dissociation triggered by sexual intercourse and concerns related to sexual orientation, gender identity and fertility. Sexual violence may also lead to risky, self-destructive or reckless behaviour. Talking about sexual problems is often difficult due to feelings of worthlessness, shame and guilt and additionally hampered by cultural, religious or gender taboos. If the perpetrator was male, anxiety from men is a frequent symptom. For male survivors, the sense of humiliation after sexual torture is often particularly deep, and they might also experience a crisis of sexual identity (i.e. concerns about being gay after having been raped). They often experience themselves as being weak, not strong enough to defend themselves, rather than as a victim. For men, it is therefore often extremely difficult to disclose their experience with sexual violence.

(j) Psychotic symptoms

509. Cultural and linguistic differences, as well as flashbacks and anxieties, may cause misinterpretation of psychotic symptoms. Before diagnosing someone as psychotic (suffering from a mental disorder characterized by a distorted perception or processing of reality), the symptoms must be evaluated within the individual's unique cultural context. Psychotic reactions may be brief or prolonged, and the symptoms may occur while the person is detained and tortured or afterwards. The following findings are possible:

(a) Delusions;

(b) Auditory, visual, tactile and olfactory hallucinations;

(c) Bizarre ideation and behaviour;

(d) Illusions or perceptual distortions that may take the form of pseudo-hallucinations and border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for torture victims to report occasionally hearing screams, their name being called or seeing shadows, but not to have florid signs or symptoms of psychosis. Additionally, some survivors report dissociative symptoms that can be mistaken for psychosis, such as feeling that the physical environment is not real, or that their body is altered or disconnected. Vivid perceptual experiences may occur during a dissociative episode. Hallucinations may also occur in the context of traumatic loss. It is important to enquire about the origin and person's understanding of the symptoms. Many survivors recognize that these experiences are not what other people are perceiving them to be and that they are emanating from their own mentation. This distinction can help distinguish dissociative from psychotic phenomena in which individuals believe that others see the distortions in reality as they do. The distinction between a flashback and hallucinations may not be easily drawn during the experience but the dissociated individual can later recognize that the experience does not represent current reality;

(e) Paranoia and delusions of persecution. As persecution, harassment and hostilities may be a reality for torture survivors, clinicians should take special care not to confound these real situations with paranoia and delusions of persecution;

(f) Recurrence of psychotic disorders or mood disorders with psychotic features among those who have a history of mental illness. Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder as a result of the extreme stress of torture.

(k) Substance misuse

510. Alcohol and drug misuse, including misuse of prescription medicine (e.g. sedatives, hypnotics and analgesics), often develop secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect and managing anxiety, pain and sleeping problems.

(l) Neuropsychological and neurocognitive impairment

511. Extensive alterations in cognitive processes may be found in persons who have been exposed to dramatic or ongoing exposure to life-threatening situations, such as torture, and who develop PTSD. They are not necessarily related to brain injuries and may also be found in persons who have been forced to witness violence perpetrated against others. They may include changes in memory functions, attention, information processing, planning and problem solving. Methods of torture, such as isolation or sleep and sensory deprivation, are also known to cause severe cognitive impairment, including in the areas of memory, learning, logical reasoning, complex verbal processing and decision-making.[462] On the other hand, torture can cause physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation and prolonged malnutrition may have long-term neurological and neuropsychological consequences that may not be readily assessed during the course of a medical examination. Diagnosis of blunt traumatic brain injury is especially challenging and even a correctly performed MRI of the brain might yield negative results. Symptoms of blunt traumatic brain injury include headaches, confusion or disorientation, concentration or memory problems, irritability, emotional instability and disturbed sleep. As in all cases of brain impairment that cannot be documented through head imaging or other medical procedures, a diagnosis might have to be based on a clinical symptom profile and neuropsychological assessment and testing may be the only reliable way of documenting the effects. Frequently, the target symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and depressive disorder described above. Therefore, specialized skills in neuropsychological assessment and awareness of problems in cross-cultural validation of neuropsychological instruments are necessary when such distinctions and diagnostics are of relevance (see paras. 550–565 below).

3. Diagnostic classifications

512. While the chief complaints and most prominent findings among torture survivors are very diverse and relate to their unique life experiences, coping mechanisms and the cultural, social and political context in which they live, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is more common than not for more than one mental disorder to be present, as there is considerable co-morbidity among trauma-related mental disorders. Various manifestations of depression, anxiety and trauma-related syndromes are the most common consequences resulting from torture. The two most widely accepted classification systems are the International Statistical Classification of Diseases and Related Health Problems (ICD), produced by the World Health Organization,[463] and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[464] produced by the American Psychiatric Association. The current versions of ICD and DSM are broadly compatible, but significant differences remain, which may result in differing diagnoses. Both manuals are revised periodically and new editions reflect new research data and conceptual developments. This review will focus on the most common trauma-related diagnoses: depression and PTSD. For complete descriptions of diagnostic categories, the reader should refer to ICD-10/11 and DSM-5, which are the latest editions currently in use.

462 Physicians for Human Rights, *Break Them Down: Systematic Use of Psychological Torture by US Forces,* (Cambridge, Massachusetts, 2005).

463 ICD-11 was adopted by the World Health Assembly in May 2019 and came into effect on 1 January 2022. Clinicians should always refer to the latest edition currently in use in the specific region. See www.who.int/classifications/classification-of-diseases.

464 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5,* 5th ed. (Washington, D.C., 2013).

(a) Depressive disorders

513. Depressive states are extremely common among torture survivors. In the context of evaluating the consequences of torture, it is problematic to assume that PTSD and depressive disorder are two separate disorders with clearly distinguishable aetiologies. There is a significant overlap of symptoms and co-morbidity between depression and PTSD is high. Depressive disorders can manifest as a single or recurrent episode that may vary in severity (mild, moderate or severe). Depressive symptoms cause significant distress or impairment in social, occupational or other important areas of functioning. Depressive disorders can be present with or without psychotic, catatonic, melancholic or atypical features. The key symptoms of depressive disorders are:

(a) Depressed mood (sad, irritable, empty);

(b) Markedly diminished interest or pleasure in all or almost all activities;

(c) Weight loss/gain or decrease/increase in appetite;

(d) Insomnia or hypersomnia;

(e) Observable slowing down of thought and reduction of physical movement;

(f) Fatigue or reduced energy;

(g) Feelings of worthlessness or excessive or inappropriate guilt;

(h) Diminished ability to think or concentrate or indecisiveness;

(i) Recurrent thoughts of death, recurrent suicidal ideation or suicide attempt or specific plan for committing suicide.

(b) Post-traumatic stress disorder

514. The diagnosis most commonly associated with the psychological consequences of torture is PTSD. The association between torture and this diagnosis has become very strong in the minds of health providers, judges, immigration courts and the informed lay public. This has created the mistaken and simplistic impression that PTSD is the main and inevitable psychological consequence of torture.

515. DSM-5 classifies PTSD under the category of "trauma and stress-related disorders". In order to diagnose PTSD, the individual must have been directly or indirectly exposed to death, life-threatening events, serious injury or sexual violence. This definition of trauma underlines the severity of the event and marks a clear difference between other stressors, for example general insecurity. Four main groups of symptoms are distinguishable:

(a) Intrusive symptoms: unwanted upsetting memories, nightmares, flashbacks, emotional distress or physiological reactions after exposure to trauma-related stimuli;

(b) Avoidance of trauma-related stimuli: memories, thoughts, feelings and external reminders, such as places or persons;

(c) Negative changes in cognitions and mood: inability to recall important aspects of the trauma, persistent overly negative thoughts and assumptions about oneself and the world, exaggerated blame of self and others for causing the trauma, negative affect (e.g. fear, shame and guilt), loss of interest, feelings of isolation and detachment and difficulties experiencing positive affect;

(d) Alterations in arousal and reactivity: irritability and angry outbursts, risky or destructive behaviour.

516. The diagnosis requires that the symptoms last for at least one month and the disturbance must cause significant distress or impairment in important areas of functioning. DSM-5 also describes a dissociative subtype of PTSD that includes additional experience of high levels of depersonalization and derealization.

517. ICD-11 distinguishes between PTSD and Complex PTSD. Complex PTSD includes the core symptoms of re-experiencing, avoidance and hyperarousal, as well as persistent and broad disturbances of affective functioning (emotional dysregulation, elevated emotional reactivity, aggressive outbursts, dissociative states), perception of self (negative self-perception and feelings of shame and guilt) and social functioning (difficulties in maintaining social relations and difficulties in feeling close to others). The concept of Complex PTSD is able to capture complex symptomatologies that profoundly affect the victim's capacity to integrate and function in social relationships, respond to the requirements of daily life and lead a fulfilling life.

518. The onset of PTSD symptoms is usually within the first month after the experience of torture, but there may also be a delay of months or years before symptoms start to appear. Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability may dominate the clinical picture. At these times, the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times, the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. Consistent avoidance behaviour sometimes is not easy to detect, but can result in low levels of intrusive symptoms. External stressors, the breakdown of individual coping mechanisms and loss of social support are among the factors that influence the course of the disorder and possible aggravation. On the other hand, social support, individual coping strategies, ideological or religious commitment, justice and official recognition of responsibility may contribute to a process of recovery.

(c) Acute stress disorder

519. Acute stress disorder (DSM-5)[465] captures post-traumatic symptoms that may begin immediately after trauma exposure but do not persist longer than one month. It has essentially the same symptoms as PTSD from any of the categories of intrusion, negative mood, dissociation, avoidance and arousal, with dissociative symptoms often being predominant. In contrast to PTSD, which requires symptoms to be present for at least a month, the symptoms of acute stress disorder disappear within the first month after trauma exposure. Many torture survivors who do not present PTSD at a later stage will nevertheless report symptoms that amount to acute stress disorder for the first weeks after torture has taken place. Clinicians evaluating torture survivors shortly after torture has taken place should therefore enquire explicitly about such symptoms. In addition, when evaluating months or years after the alleged traumatic events, the course of the symptoms over time as well as eventual peritraumatic symptoms and symptoms that might have occurred in the period right after torture should be asked about. Sometimes persisting symptoms of PTSD or depression are not presented at the time of the psychological assessment, but symptoms described for the peritraumatic or early post-traumatic period can, from a clinical point of view, be consistent with the alleged torture.

(d) Substance use disorder

520. Clinicians have observed that substance use disorder often develops secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant effects, managing anxiety and chronic pain or mitigating sleep disturbances (self-medication). Trauma survivors often present comorbidity of PTSD and substance use disorder.[466] The findings of large epidemiological studies showed that between one third (34 per cent)[467] and almost one half (46 per cent)[468] of persons with PTSD also met the criteria for substance use disorder, mostly alcohol use, and that more than 20 per cent met the criteria for substance dependence. In summary, there is considerable evidence from other populations at risk of PTSD that substance use disorder is a potential co-morbid diagnosis for torture survivors. This co-morbidity seems to be gender-related, more often seen in men than women.[469] There is also a co-morbidity between substance use disorder and chronic pain, since torture survivors often have chronic pain that is difficult to treat.

(e) Other diagnoses

521. There are other diagnoses to be considered in addition to those described above. These include but are not limited to:

(a) Anxiety disorders: (i) generalized anxiety disorder features excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity; (ii) panic disorder is manifested by recurrent and unexpected attacks of intense fear or discomfort, including symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flushes; and (iii) phobias, such as social phobia, agoraphobia or claustrophobia;

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465 In ICD-11, the category of "acute stress disorder" was modified into "acute stress reaction". It is not a diagnostic category anymore, but a non-pathologic reaction in which symptoms emerge after the trauma in some hours or days and fade within a week.

466 Jenna L. McCauley and others, "Posttraumatic stress disorder and co-occurring substance use disorders: advances in assessment and treatment", *Clinical Psychology: Science and Practice*, vol. 19, No. 3 (2012), pp. 283–304.

467 Katherine L. Mills and others, "Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well-Being", *American Journal of Psychiatry*, vol. 163, No. 4 (2006), pp. 652–658.

468 Robert H. Pietrzak and others, "Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions", *Journal of Anxiety Disorders*, vol. 25, No. 3 (2011), pp. 456–465.

469 Marianne Kastrup and Libby Arcel, "Gender specific treatment of refugees with PTSD", in *Broken Spirits: the Treatment of Traumatized Asylum Seekers, Refugees and War and Torture Victims*, John P. Wilson and Boris Drozdek, eds. (New York, Routledge, 2005), pp. 547–571.

(b) Dissociative disorders, featuring a partial or complete loss of normal integration among memories of the past, awareness of identity, immediate sensations and control of bodily movements. The capacity of voluntary and conscious control of movements and attention seems to be distorted and can change within short periods of time;

(c) Somatic symptoms disorders, characterized by somatic symptoms, accompanied by excessive and disproportionate thoughts, feelings and behaviours and high distress or significant disruption of functioning. Symptoms may or may not be associated with a medical condition. In ICD-11 this is classified as bodily distress disorder;

(d) Bipolar disorder featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena;

(e) Disorders due to a general medical condition (e.g. traumatic brain injury) often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning;

(f) Psychotic disorders, either as a first manifestation or exacerbation after torture;

(g) Sexual dysfunction.

522. It should also be considered that non-torture-specific, pre-torture disorders (e.g. recurrent depressive episodes) can worsen or resurface as a result of torture.

C. Psychological/psychiatric evaluation

1. Ethical and clinical considerations

523. Psychological evaluations can provide critical evidence of abuse among torture victims for several reasons: torture often causes devastating psychological symptoms; torture methods are often designed to leave no physical lesions; and physical methods of torture may result in physical findings that either resolve or lack specificity.

524. Psychological evaluations provide critical evidence for medico-legal examinations, asylum applications, establishing conditions under which confessions may have been forcibly obtained, understanding domestic, regional and international practices of torture, identifying the therapeutic needs of victims, supporting claims for reparation and redress and as testimony in human rights investigations, fact-finding missions and inquiries. As the emotional impact of torture is profound and resulting psychological symptoms are so prevalent among torture survivors, it is highly advisable for any evaluation of alleged torture victims to include a comprehensive psychological assessment. The overall goal of a psychological evaluation for a medico-legal report in accordance with the Istanbul Protocol is to assess the degree of consistency between an individual's account of torture and the psychological findings obtained in the course of the evaluation and to provide an opinion on the probable relationship between the psychological findings and the possible torture or ill-treatment. Psychological evidence comprises not only the alleged victim's statement, but a variety of information, including observations on verbal and non-verbal communication, emotional reactions, affective resonance and behaviour. To this end, the evaluation should provide a detailed description of the methods of assessment, current psychological complaints, pre- and post-torture history, history of torture and ill-treatment, past psychological/psychiatric history, substance use/misuse history, mental status examination, assessment of social functioning, results of psychological/neuropsychological testing if indicated and the formulation of clinical impressions. A psychiatric diagnosis should be made, if appropriate.

525. The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context. Awareness of how the cultural background and language of the survivor shape the individual psychological expression of distress is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge of the alleged victim's culture, the assistance of an interpreter is essential. Ideally, an interpreter from the alleged victim's country knows the language, customs, religious traditions and other beliefs that must be taken into account during the evaluation. Interviews may induce fear and mistrust on the part of victims and possibly remind them of previous interrogations. To reduce the risk of retraumatization, the clinician should communicate a sense of understanding of the individual's experiences and

cultural background. It is inappropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy, during which the clinician is inactive and says little. The clinician should communicate in a transparent and empathic way and adopt a supportive, non-judgmental approach.

2. Interview process

526. Clinicians should present themselves and introduce the purpose and process of the interview in a manner that explains in detail the procedures to be followed and the topics to be addressed and that prepares the individual for the difficult emotional reactions that the questions may provoke. Clinicians need to be sensitive and empathetic in their questioning, while remaining objective in their clinical assessment. At all times they have to balance their need to obtain detailed information and the needs of the alleged victims to maintain or regain their emotional balance. Interviews must be conducted in a way that reduces the risk of retraumatization and, at all times, allows the alleged victim to maintain a sense of control. Chapter IV describes comprehensive guidelines for conducting clinical interviews.

527. An appropriate structuring of the clinical interview is fundamental in building adequate rapport and trust. Generally, it is advisable to start the interview with less sensitive issues and then proceed to more difficult or stressful content. In many cases, it might be useful to start with the pre-torture history and follow a chronological order. In other cases, especially when the person is under a high level of emotional distress, it may be better to start with the current psychological complaints and current social functioning. The clinician is advised to use a flexible approach instead of following a predetermined order. The following description of the components of the psychological/psychiatric evaluation follows the suggested order for the written report (see annex IV), but not for the clinical interview.

3. Components of the psychological/psychiatric evaluation

528. The introduction should contain mention of the referral source, a summary of collateral sources (such as medical, legal and psychiatric records) and a description of the methods of assessment used (e.g. interviews, symptom inventories, checklists and neuropsychological testing).

(a) History of torture and ill-treatment

529. Every effort should be made to document the full history of the alleged torture or ill-treatment and other relevant traumatic experiences as stated by the alleged victim (see paras. 364–372 above). This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in several sessions. The interview should start with a general summary of events before eliciting the details of the alleged torture or ill-treatment experience. The interviewer needs to know the legal issues at hand because that will determine the nature and amount of information necessary to achieve a comprehensive documentation of alleged torture or ill-treatment.

(b) Current psychological complaints

530. An assessment of the current psychological condition and complaints constitutes the core of the evaluation. In addition to the spontaneous description of the interviewee, specific questions regarding common psychological responses to torture (as described in paras. 499–522) should be asked. All affective, cognitive and behavioural symptoms should be described in detail, including their severity, frequency, onset and evolution over time, regardless of whether they amount to a specific diagnosis. It is important to give a detailed description of the specific symptom presentation as this helps to substantiate the level of consistency between the alleged torture or ill-treatment and the psychological findings at a later stage. This may include the description of the content of nightmares, recurrent thoughts or memories, flashbacks or hallucinations. Triggers for emotional distress, sadness, fear or reliving experiences should also be explored and described. Questions about sleep (how many hours, what interrupts sleep, feelings when waking up from a nightmare), of how the day is spent (in social isolation, trying to keep busy at all costs, obsessive/compulsive behaviours and the ability to carry out the activities involved in daily living), as well as questions to identify avoidance behaviour related to triggers for re-experience should be asked. An absence or subthreshold level of symptoms at the time of assessment can be due to the episodic nature or delayed onset of specific symptoms or to denial of symptoms because of shame. Therefore, the exploration and assessment of the symptom evolution since the alleged torture is of paramount importance.

(c) Post-torture history

531. This component of the psychological evaluation seeks information about current life circumstances. It is important to enquire about current sources of stress, such as separation or loss of loved ones, flight from the home country and life in exile. Interviewers should also enquire about the ability of individuals to be productive, earn a living, care for their families, engage in social interactions, form trusting relationships and the availability of social supports. Furthermore, the possible impact of past sexual torture on sexual orientation, gender identity, the ability to enjoy sexual intimacy and partnership should be considered.

(d) Pre-torture history

532. The pre-torture history should include information regarding the alleged victims' childhood, adolescence, early adulthood, their family backgrounds, family illnesses and family composition. There should also be a description of the alleged victim's educational and occupational history. It should also include a description of any history of past trauma, such as childhood abuse, war trauma or domestic violence, as well as the alleged victim's cultural and religious background.

533. The description of pre-trauma history is important to assess the mental health status and level of psychosocial functioning of the alleged victim prior to the traumatic events reported. In this way, the interviewer can compare the current psychological status with the one the individual reports for the time before the alleged torture or ill-treatment and assess the relative contribution of different experiences, including the alleged torture or ill-treatment. In evaluating background information, the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. These factors include, but are not limited to, the circumstances of the torture, the perception and interpretation of torture by the victim, the social context before, during and after torture, community and peer resources, personal values and attitudes about traumatic experiences, political and cultural factors, severity and duration of the traumatic events, genetic and biological vulnerabilities, developmental phase and age of the victim, prior history of trauma and coping mechanisms. In many interview situations, because of time limitations and other problems, it may be difficult to obtain this information. It is important, nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to form an impression of the degree to which the alleged torture or ill-treatment has contributed to the psychological condition.

(e) Medical history

534. The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and its side effects, relevant sexual history, past surgical procedures and other medical data (see paras. 394–399 above).

(f) Psychiatric history

535. Inquiries should be made about a history of mental or psychological conditions, the nature of such conditions and whether the alleged victims received treatment or required psychiatric hospitalization. The inquiry should also cover prior therapeutic use of psychotropic medication.

(g) Substance use and misuse history

536. The clinician should enquire about substance use and misuse, including the route of use, frequency, amount and time periods of use, before and after the alleged torture, changes and evolution of the pattern of use and whether substances are being used to cope with insomnia, pain or psychological/psychiatric problems. Such substances include alcohol, cannabis and opium but also prescribed medication and regional substances of abuse, such as betel nut and many others.

(h) Mental status examination

537. The mental status examination begins the moment the clinician meets the individual. 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, mood, concentration, occurrence of dissociative reactions or flashbacks, intercurrent reactions on triggers, use of language, presence of eye contact, ability to relate to the interviewer and the means the individual uses to establish communication. The following components should be covered and all aspects of the mental status examination should be included in the report of the psychological evaluation; aspects such as general appearance, motor activity, speech, concentration, mood (subjective and objective assessment) and affect, sleep, appetite disturbance, thought content, thought process, suicidal and homicidal ideation

and a cognitive examination (orientation, long-term memory, intermediate recall and immediate recall).

(i) Assessment of social function

538. Trauma and torture can directly and indirectly affect a person's ability to function. Torture can also indirectly cause impairment or loss of functioning and disability, if the psychological consequences of the experiences impair the ability of individuals to care for themselves, earn a living, support a family and pursue an education. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role (e.g. student, worker or parent), social and recreational activities and perception of health status. The interviewer should ask individuals to assess their own health conditions, to state the presence or absence of feelings of chronic fatigue and to report potential changes in overall functioning. Because social function, by definition, encompasses an individual's behaviour, social skills, feelings and overall well-being, it is important to assess social function through multiple dimensions. Changes in social function could stem from the physical consequences of torture (such as the inability to lift weights due to shoulder joint dysfunction) or be related to the psychological consequences of torture. For example, an individual's activity level (including one's willingness to engage in previously enjoyable activities), as well as an individual's participatory level (including involvement in family reunions or engagement in society), could be detrimentally affected. Thus, the interviewer should take these dimensions into consideration during the interview.

(j) Psychological testing and the use of checklists and questionnaires

539. Individuals who have survived torture may have trouble expressing in words their experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires.[470] If the clinician believes that it may be helpful to use these, there are numerous questionnaires available, although none are specific to torture victims. Before using psychological tests/questionnaires, the clinician must take special care to evaluate their cultural appropriateness and potential negative impact on torture survivors in specific situations. The lack of standardization for the specific group of reference, the lack of cross-cultural validity, and linguistic differences can severely limit the meaningfulness and reliability of the results. Little published data exist on the use of projective and objective personality tests in the assessment of torture survivors and their use should therefore be evaluated with special care. There is no evidence that specific personality traits as measured in these tests typically result from the experience of torture or that certain personality traits are inconsistent with having been tortured. Also, psychological tests of personality lack cross-cultural validity. Personality tests have frequently been misused to stigmatize alleged victims, question their overall credibility or ascribe the emotional state to personality traits. In any case, psychological testing can only complement the clinical interview, it can never be a substitute for a comprehensive psychological evaluation as described in the present chapter. The use of psychological tests should not be considered as an imperative, nor as generally more objective or more evidentiary than the clinician's evaluation. Nevertheless, they can be an important source of additional information and, when inconsistent with the clinical impression, this should cause further exploration of the phenomena in question. Neuropsychological testing may, however, be helpful in assessing cases of brain injury resulting from torture, although issues of reliability, validity and cultural relevance must be considered seriously (see paras. 549–565 below).

(k) Interpretation of findings

540. The psychological findings resulting from the evaluation include all self-reported information offered by the alleged victim as well as objective findings observed or recollected by the clinician during the evaluation. In order to interpret the psychological findings for the purpose of delivering an opinion on the possibility of torture, the following important questions should be considered by the evaluator:

(a) Are the psychological findings consistent with the alleged report of torture?

(b) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

470 Joseph Westermeyer and others, "Comparison of two methods of inquiry for torture with East African refugees: single query versus checklist", *Torture*, vol. 21, No. 3 (2011), pp. 155–172.

(c) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where is the individual in the course of recovery?

(d) What are the coexisting stressors 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?

(e) Which physical conditions may contribute to the clinical picture? Special attention should be paid to possible evidence of head injury sustained during torture or detention.

541. Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged torture or ill-treatment. To this end, the emotional state and expression of the person during the interview, the reported psychological, psychosocial and social impact of the alleged torture, clinical observations, the alleged history of detention and torture and the personal history prior to torture, the onset and evolution of specific symptoms related to the alleged torture, the specificity of any particular psychological findings and patterns of psychological functioning, as well as possible interactions, should be taken into consideration. Likewise, possible reasons for inconsistencies (e.g. memory gaps, cognitive impairment, dissociation, distrust, feelings of shame or guilt or other factors that may hinder disclosure) should be described and discussed (see paras. 343–353 above). Physical conditions, such as head trauma or brain injury, and additional factors should be considered, such as ongoing persecution, forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, and family and social status. The relationship and consistency between events and symptoms should be evaluated and described.

542. If the person has symptom levels that correspond with a DSM or ICD diagnosis, the diagnosis should be stated. More than one diagnosis may be applicable. Again, it must be stressed that, even though a diagnosis of a trauma-related mental disorder can support the claim of torture, not meeting the criteria for a psychiatric diagnosis does not mean that the person was not tortured. A survivor of torture may not have the level of symptoms required to meet diagnostic criteria for a DSM or ICD diagnosis fully. In these cases, as with all others, the symptoms that the survivor has and the alleged torture, as well as protective factors and coping mechanisms, should be considered as a whole. The degree of consistency between the alleged torture or ill-treatment and the entirety of the psychological findings should be evaluated and described in the report.

543. Depending on the legal and jurisdictional context and requirements under which clinicians prepare a medico-legal report, the consistency of psychological findings with the alleged torture and/or ill-treatment could be described as follows:

(a) "Not consistent with": the psychological findings could not have been caused by the alleged torture or ill-treatment;

(b) "Consistent with": the psychological findings could have been caused by the alleged torture or ill-treatment, but they are non-specific and there are many other possible causes;

(c) "Highly consistent with": the psychological findings could have been caused by the alleged torture or ill-treatment and there are few other possible causes;

(d) "Typical of": the psychological findings are typically found as a consequence of the alleged torture or ill-treatment and there are few other possible causes;

(e) "Diagnostic of": the psychological findings could not have been caused in almost any way other than the alleged torture or ill-treatment.

544. Specifying the degree of consistency is common in evaluating physical evidence of torture or ill-treatment and can be useful for psychological evidence as well. However, the underlying logic differs as consistency between psychological findings and alleged torture or ill-treatment does not refer to the connection between a specific symptom and a specific torture or ill-treatment method. Instead it refers to the connections between a set of traumatic experiences and the overall psychological, psychosocial and psychiatric presentation of the person. The primary question is whether these connections make sense and the extent to which they are explained by the abuse the person alleges to have suffered. If the clinician considers that there are clinical reasons for an inconsistent finding, this should be discussed (see paras. 343–353 above).

545. Clinicians should note that the level of consistency denoted by "typical of" refers to expected or typical

reactions to extreme stress within the cultural and social context of the individual. It is not commonly used to assess psychological evidence of torture or ill-treatment as the psychological consequences tend to depend on individual factors. The presence or absence of a "typical psychological reaction" should not be considered any more or less meaningful or corroborative than the level of consistency denoted by "highly consistent". Also, the level of consistency denoted by "diagnostic of" is used more frequently in the interpretation of physical evidence of torture or ill-treatment and is rarely used in the interpretation of psychological evidence.

(l) Conclusions and recommendations

546. Clinicians should formulate a clinical opinion on the possibility of torture or ill-treatment based on all relevant clinical evidence, including, "physical[471] and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc." as stated in paragraph 382 above and annex IV. The clinician's opinion on the possibility of torture or ill-treatment should be expressed using the same levels of consistency as that used for interpretation of findings: not consistent with, consistent with, highly consistent with, typical of and diagnostic of. Ultimately, it is the overall evaluation of all the clinical findings, and not the consistency of each lesion or symptom with a particular form of torture or ill-treatment, that is important in assessing the allegations of torture or ill-treatment.

547. In addition to providing a conclusion on the possibility of torture or ill-treatment, clinicians should reiterate current symptoms and disabilities and likely effects on social functioning and provide any recommendations for further evaluations and care for the individual.

548. The recommendations resulting from the psychological evaluation can vary and depend on the question posed at the time the evaluation was requested. The issues under consideration may concern legal and judicial matters, asylum, resettlement, the need for treatment or reparation. Recommendations can be for further assessment, such as neuropsychological testing, medical, psychological or psychiatric treatment, custody conditions or the need for security or asylum. Whenever the clinician detects a need for psychological or medical treatment, a referral should be made, independently of the question posed at the time the evaluation was requested.

4. Neuropsychological assessment

549. Clinical neuropsychology is an applied science concerned with the behavioural expression of brain dysfunction. Neuropsychological assessment, in particular, is concerned with the measurement and classification of behavioural disturbances associated with organic brain impairment and neuropsychological tests are designed to assess deficits in cognitive performance. Understanding the nature, the severity and the modality of cognitive complaints is best served by a neuropsychological assessment performed by a qualified psychologist with relevant competencies in neuropsychological assessments. Such an assessment provides useful information about the patient's cognitive functioning, something that is not easy to obtain otherwise. Neuropsychological evaluations of alleged torture victims are performed infrequently but may be helpful in identifying and quantifying some form of cognitive impairment. The following remarks are limited to a discussion of general principles to guide clinicians in understanding the utility of, and indications for, neuropsychological assessments of persons alleging torture. Before discussing the issues of utility and indications, it is essential to recognize the limitations of neuropsychological assessments in this population.

(a) Limitations of neuropsychological assessments

550. There are a number of common factors complicating the assessment of torture survivors in general that are outlined elsewhere in this manual. These factors apply to neuropsychological assessments in the same way as to medical or psychological examinations. Neuropsychological assessments may be limited by a number of additional factors, including lack of research on torture survivors, reliance on population-based norms, cultural and linguistic differences and the risk of retraumatization of those who have experienced torture.

551. As mentioned above, very few references exist in the literature concerning the neuropsychological assessment of torture survivors. The pertinent body of literature concerns various types of head trauma and

471 Clinical evaluations that are conducted specifically to assess "psychological evidence" may include some "physical findings", for example complaints of physical injuries and symptoms or observations of physical signs during the interview.

the neuropsychological assessment of PTSD in general. Therefore, the following discussion and subsequent interpretations of neuropsychological assessments are necessarily based on the application of general principles used with other subject populations.

552. Neuropsychological assessments as they have been developed and practised in Western countries rely heavily on an actuarial approach. This approach typically involves comparing the results of a battery of standardized tests to population-based norms. Although norm-referenced interpretations of neuropsychological assessments may be supplemented by a Lurian approach of qualitative analysis, particularly when the clinical situation demands it, a reliance on the actuarial approach predominates.[472] Moreover, a reliance on test scores is greatest when brain impairment is mild to moderate in severity, rather than severe, or when neuropsychological deficits are thought to be secondary to a psychiatric disorder.

553. Cultural and linguistic differences may significantly limit the utility and applicability of neuropsychological assessments among alleged torture victims. There are many neuropsychological tests available but the majority of them have been developed and "normed" in a Western/European context. The examiner should be aware of these limitations and should adapt the selection of methods and instruments to the specific background of the person, including education, language, culture and familiarity with testing.[473] Neuropsychological assessments are of questionable validity when standard translations of tests are unavailable and the clinical examiner is not fluent in the subject's language. Unless standardized translations of tests are available and examiners are fluent in the subject's language, verbal tasks cannot be administered at all and cannot be interpreted in a meaningful way. This means that only non-verbal tests can be used and this precludes comparison between verbal and non-verbal faculties. In addition, an analysis of the lateralization (or localization) of deficits is more difficult. This analysis is often useful, however, because of the brain's asymmetrical organization, with the left hemisphere typically being dominant for speech. If population-based norms are unavailable for the subject's cultural and linguistic group, neuropsychological assessments are also of questionable validity. An estimate of IQ is one of the central benchmarks that allow examiners to place neuropsychological test scores into proper perspective. Within the population of the United States of America, for example, these estimates are often derived from verbal subsets using the Wechsler scales, particularly the information subscale, because in the presence of organic brain impairment, acquired factual knowledge is less likely to suffer deterioration than other tasks and be more representative of past learning ability than other measures. Measurement may also be based on educational and work history and demographic data. Obviously, neither one of these two considerations apply to subjects for whom population-based norms have not been established. Therefore, only very coarse estimates concerning pre-trauma intellectual functioning can be made. As a result, neuropsychological impairment that is anything less than severe or moderate may be difficult to interpret.

554. Neuropsychological assessments may retraumatize those who have experienced torture. Great care must be taken in order to minimize any potential retraumatization of the alleged victim in any form of diagnostic procedure (see paras. 277–280 above). To cite only one obvious example specific to neuropsychological testing, it would be potentially very damaging to proceed with a standard administration of the Halstead-Reitan Neuropsychological Battery, in particular the Tactual Performance Test, and routinely blindfold the subject. For most torture survivors who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be very traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the instrument used. Being observed, timed with a stopwatch and asked to give maximum effort on an unfamiliar task, in addition to being asked to perform, rather than having a dialogue, may prove to be too stressful or reminiscent of the torture experience.

(b) Indications for neuropsychological assessment

555. In evaluating behavioural deficits in alleged torture victims, there are two primary indications for neuropsychological assessment: brain injury and PTSD

472 Alexander Romanovich Luria and Lawrance V. Majovski, "Basic approaches used in American and Soviet clinical neuropsychology", *American Psychologist*, vol. 32, No. 11 (1977), pp. 959–968. See also Robert J. Ivnik, "Overstatement of differences", *American Psychologist*, vol. 33, No. 8 (1978), pp. 766–767; and Uwe Jacobs and Vincent Iacopino, "Torture and its consequences: a challenge to clinical neuropsychology", *Professional Psychology Research and Practice*, vol. 32, No. 5 (2001), pp. 458–464.

473 Bahrie Veliu and Janet Leathem, "Neuropsychological assessment of refugees: methodological and cross-cultural barriers", *Applied Neuropsychology: Adult*, vol. 24, No. 6 (2017), pp. 481–492.

plus related diagnoses. While both sets of conditions overlap in some aspects, and will often coincide, it is only the former that is a typical and traditional application of clinical neuropsychology, whereas the latter is relatively new, not well researched and rather problematic. A typical neuropsychological assessment will include a clinical interview with the patient to determine: highest level of formal education obtained, the presence of pre-existing learning difficulties, medical and psychological history, previous head injuries, including ones from childhood, and a more detailed review of the patient's cognitive complaints and emotional status. Based on the information gathered during the interview and from the documentation and referral questions, the neuropsychologist then decides which cognitive and emotional domains need to be assessed and may identify tests that are validated, reliable and culturally appropriate for the person, or choose not to use tests but rely on a detailed clinical interview. Most neuropsychologists now use a flexible battery approach, in which the tests are chosen based on the information gathered, systematic hypotheses testing and an understanding of the underlying medical condition that is purportedly responsible for the cognitive and emotional difficulties.

556. Brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances inflicted during periods of torture or ill-treatment. This may include gunshot wounds, the effects of poisoning, malnutrition as a result of starvation or forced ingestion of harmful substances, the effects of hypoxia or anoxia resulting from asphyxiation or near drowning and, most commonly, from blows to the head suffered during beatings. Blows to the head are frequently inflicted during periods of detention and torture. For example, in one sample of torture survivors, 91 per cent reported beating of the head.[474] The potential for resulting brain damage is high among torture survivors.

557. Closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. The cognitive and emotional domains that are typically assessed in a comprehensive neuropsychological assessment are: intellect; higher cognitive abilities (executive functioning); attention; memory; visual-spatial abilities; motor and sensory abilities; and emotional status. Signs of injury may include scars on the head, but absence of scars does not exclude significant brain injury. Brain lesions sometimes cannot be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by mental health professionals because symptoms of depression and PTSD are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short-term memory, which can either be the result of brain impairment or reflect the psychological consequences of torture. Since these complaints are common in survivors suffering from PTSD or depression, the question whether they are actually due to head injury may not even be asked.

558. The diagnostician must rely, in an initial phase of the examination, on reported history of head trauma and the course of symptomatology. Deciding when to refer for a neuropsychological assessment needs to be done on a case-by-case basis. As is usually the case with brain-injured subjects, information from third parties, particularly relatives, may prove helpful. It must be remembered that brain-injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, "inside" the problem. In gathering first impressions regarding the difference between organic brain impairment and PTSD, an assessment concerning the chronicity of symptoms is a helpful starting point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of PTSD. On the other hand, if impairment seems to appear chronic, lacks fluctuation and is confirmed by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.

559. Once there is a suspicion of organic brain impairment, the first step for a mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation are among the possibilities to be considered. The use of neuropsychological evaluation procedures is usually indicated if there is a lack of gross neurological

474 Dorte Reff Olsen and others, "Prevalent pain and pain level among torture survivors: a follow up study", *Danish Medical Bulletin*, vol. 53, No. 2 (2006), pp. 210–214.

disturbance, reported symptoms are predominantly cognitive in nature or a differential diagnosis between brain impairment and PTSD has to be made.

560. The selection of neuropsychological tests and procedures is subject to the limitations specified above and, therefore, cannot follow a standard battery format, but rather must be case specific and sensitive to individual characteristics. The flexibility required in the selection of tests and procedures demands considerable experience, knowledge and caution on the part of the examiner. As has been pointed out above, the range of instruments to be used will often be limited to non-verbal tasks, and the psychometric characteristics of any standardized tests will most likely suffer when population-based norms do not apply to an individual subject. An absence of verbal measures represents a very serious limitation. Many areas of cognitive functioning are mediated through language and systematic comparisons between various verbal and non-verbal measures are typically used in order to arrive at conclusions regarding the nature of deficits.

561. The choice of instruments and procedures in neuropsychological assessments of alleged torture victims must be left to the individual clinician, who will have to select them in accordance with the demands and possibilities of the situation. Neuropsychological tests cannot be used properly without extensive training and knowledge in brain-behaviour relations. Comprehensive lists of neuropsychological procedures and tests and their proper application can be found in standard references.[475]

(c) Post-traumatic stress disorder

562. The considerations offered above should make it clear that great caution is needed when attempting neuropsychological assessment of brain impairment in alleged torture victims. This must be even more strongly the case in attempting to document PTSD in alleged victims through neuropsychological assessment. Even in the case of assessing PTSD subjects for whom population-based norms are available, there are considerable difficulties to consider. PTSD is a psychiatric disorder and traditionally has not been the focus of neuropsychological assessment. Furthermore, PTSD does not conform to the classical paradigm of an analysis of identifiable brain lesions that can be confirmed by medical techniques. With an increased emphasis on and understanding of the biological mechanisms involved in psychiatric disorders generally, neuropsychological paradigms have been invoked more frequently than in the past. However, the findings so far are diverse and thus not applicable for diagnostic purposes.

563. There is great variability among the samples used for the study of neuropsychological measures in post-traumatic stress. This may account for the variability of the cognitive problems reported from these studies. It was pointed out that "clinical observations suggest that PTSD symptoms show the most overlap with the neurocognitive domains of attention, memory and executive functioning".[476] This is consistent with complaints heard frequently from torture survivors. Subjects describing difficulties in concentrating and feeling unable to retain information and engage in planned, goal-directed activity.

564. Neuropsychological assessment methods appear able to identify the presence of neurocognitive deficits in PTSD, even though the specificity of these deficits is more difficult to establish. Some studies have documented the presence of deficits in PTSD subjects when compared with normal controls but they have failed to discriminate these subjects from matched psychiatric controls.[477] In other words, it is likely that neurocognitive deficits on test performances will be evident in cases of PTSD, but insufficient for diagnosing it. As in many other types of assessment, the interpretation of test results must be integrated into a larger context of interview information. In that sense, specific neuropsychological assessment methods can make a contribution to the documentation of PTSD in the same manner that they do for other psychiatric disorders associated with known neurocognitive deficits.

565. Despite significant limitations, neuropsychological assessment may be useful in evaluating individuals suspected of having brain injury and in distinguishing brain injury from PTSD. Neuropsychological assessment may also be used to evaluate specific

475 Esther Strauss, Elisabeth M.S. Sherman and Otfried Spreen, *A Compendium of Neuropsychological Tests: Administration, Norms and Commentary*, 3rd ed. (New York, Oxford University Press, 2006).

476 Jeffrey A. Knight, "Neuropsychological assessment in posttraumatic stress disorder", in *Assessing Psychological Trauma and PTSD*, John P. Wilson and Terence M. Keane, eds. (New York, Guilford Press, 1997), pp. 448–492.

477 John E. Dalton, Sanford L. Pederson and Joseph J. Ryan, "Effects of post-traumatic stress disorder on neuropsychological test performance", *International Journal of Clinical Neuropsychology*, vol. 11, No. 3 (1989), pp. 121–124; and Tzvi Gil and others, "Cognitive functioning in post-traumatic stress disorder", *Journal of Traumatic Stress*, vol. 3, No. 1 (1990), pp. 29–45.

symptoms, such as problems with memory and quantify actual impairment and resulting considerations for redress and rehabilitation. The assessment of cognitive capacities can also be useful in determining barriers to participate in adjudicative processes. Assessment of memory difficulties may inform judges and other decision makers about the weight to be given to discrepancies in the evidence. A person may lack the mental capacity[478] to instruct a legal representative, to consent to an examination, to be interviewed or to give evidence. Assessment of impairments in cognition might find a person with basic decision-making capacity has a lack of insight into how their memory and concentration difficulties affect their ability to give evidence and be interviewed or cross-examined. Their ability to understand the inferences others may draw from the ways in which these difficulties affect their evidence may be compromised.

5. Children and torture

566. Torture can affect a child directly or indirectly. The impact can be due to the child having been tortured or detained, the torture of parents or close family members, or witnessing torture and violence or learning that it occurred to meaningful others. Torture is a significant risk factor for disrupting children's psychological, physical, emotional and social development and negatively affecting children's mental and physical health. A complete discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this manual. Nevertheless, several important points can be summarized.

567. First, when evaluating a child who is suspected of having undergone torture, the clinician needs to be informed and adhere to the Istanbul Protocol and its Principles. The clinician must make sure that children receive support from caring individuals and that they feel secure during the evaluation. This may require a parent or trusted care provider to be present during the evaluation or parts of it. Second, the clinician must keep in mind that children do not often express their thoughts and emotions regarding trauma verbally, but rather behaviourally. The degree to which children are able to put feelings, thoughts and memories into words depends on the child's age, developmental level and other factors, such as family dynamics, personality characteristics, cultural norms and psychosocial context. There are several guidelines regarding how to best interview a child that clinicians can use to support their work (see paras. 284–293 above).

568. If a child has been physically or sexually assaulted, it is important, if at all possible, for the child to be seen by an expert in child abuse and by using appropriate guides.[479]

(a) Developmental considerations

569. Developmental factors affect the capacity of children and adolescents to perform tasks that are relevant to the assessment.[480] Research on forensic interviewing notes that children begin to manifest the capacity to recall events accurately between the ages of 3 and 6, but there is high variability.[481] Nonetheless, information that is valuable and truthful can be obtained from children. This will require careful interviewing procedures and an awareness of children's capacities.[482]

570. Infants can be evaluated and observed although they cannot be verbally interviewed. The clinician can comment on the level of activity, the nature of interaction and relationships with others, affect and state of regulation, general mood and involvement in play. The reports of parents or caregivers on the behaviour of their infant (eating, sleeping and temperament) may be useful, particularly in relation to changes in developmental milestones or noteworthy regressions or loss of previously held capabilities. Assessments using infant development scales may provide an indication of the infant's level of functioning in relation to age group.

571. Preschool children generally have high levels of suggestibility and social compliance with adults'

478 Mental capacity refers to the capacity to understand the information relevant for a decision, as well as retaining and weighing up the information and communicating the decision effectively. In torture survivors, these capacities may be affected as mood and psychotic disorders are likely to affect the ability to weigh and balance information and cognitive deficits may affect the ability to understand and retain relevant information.

479 Royal College of Paediatrics and Child Health, *The Physical Signs of Child Sexual Abuse: An Evidence-Based Review and Guidance for Best Practice* (Lavenham, United Kingdom, Lavenham Press, 2015). See also Astrid Heger, S. Jean Means and David Muram, eds., *Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas*, 2nd ed. (New York, Oxford University Press, 2000).

480 Linda Sayer Gudas and Jerome M. Sattler, "Forensic interviewing of children and adolescents", *Forensic Mental Health Assessment of Children and Adolescents*, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 115–128.

481 Ibid.

482 Ibid.

requests and their cognition is characterized by prelogical, magical and egocentric thinking that might be confused with factual events. They construct reality on their observable world, tend to think in absolute terms and experience rapid changes of emotional states. However, language develops rapidly between the ages of 3 and 5 and children can talk about their concerns and feelings and give truthful descriptions of events. They respond best to short, concrete, probing questions designed to expand on their ideas and clarify them.

572. Between the ages of 6 and 12, children can think more planfully and perform different mental tasks. However, thinking remains concrete, rigid and literal. They tend to think in terms of factual rather than logical relationships and cannot reflect on possible outcomes. At the same time, they do understand cause and effect relationships, have social consciousness and can comprehend inconsistencies in social behaviour. Capacity to discuss abstract issues is limited and there is vulnerability to negative feedback and misleading questions.

573. Adolescents are less concrete in their thinking and are capable of symbolic and rational thinking. They place a high value on peer influence and may hold an attitude of invincibility and be more likely to engage in risk-taking behaviour. But they are also more capable than younger children in recognizing the boundaries and ethical requirements of an evaluation, as well as the reason for an examination related to experiences of torture or ill-treatment. Researchers note that adolescents can accurately report symptoms, events and experiences with a proper sense of time and setting.[483] The clinician should let the adolescent know that their opinions and inputs are valued. Privacy can be of special concern to adolescents and confidentiality limitations should be reviewed carefully. It is advisable to begin with a focus on neutral issues and address sensitive issues later.[484]

574. There are important differences between autobiographical memory retrieval strategies and the capacities of preschool and older children: younger children tend to remember less information, provide briefer accounts of their experiences than older children do and are more likely than older children to respond erroneously to suggestive questions. Furthermore, the younger the children, the more their experience and understanding of the traumatic event will be influenced by the immediate reactions and attitudes of caregivers following the event.[485] Nevertheless, it is important to note that younger children's reports are no less accurate than those of older children.[486]

575. A child's reactions to torture depend on age, developmental stage and cognitive skills.[487] For children under the age of 3 who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.[488] The reactions of very young children to traumatic experiences typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance of people, places, physical reminders, interpersonal situations or conversations (such as a clinical interview) that arouse recollections of the trauma. Children older than 3 often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8–9 years old), when children develop the ability to provide a reliable chronology of events.[489] These new skills are still fragile and it is not usually until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a robust developmental period when the effects of torture can vary widely. Torture experiences may cause profound personality changes in adolescents resulting in chronically dysregulated emotional functioning, and behavioural and relational problems. Alternatively, the effects of torture on adolescents may be similar to those seen in younger children, with regression and diminishment of functioning.

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483 Ibid. See also Zoe Given-Wilson, Jane Herlihy and Matthew Hodes, "Telling the story: a psychological review on assessing adolescents' asylum claims", *Canadian Psychology*, vol. 57, No. 4 (2016), pp. 265–273.

484 Sayer Gudas and Sattler, "Forensic interviewing of children and adolescents".

485 Saskia von Overbeck Ottino, "Familles victimes de violences collectives et en exil: quelle urgence, quel modèle de soins? Le point de vue d'une pédopsychiatre", *Revue française de psychiatrie et de psychologie médicale*, vol. 14 (1998), pp. 35–39.

486 Michael E. Lamb and others. "Structured forensic interview protocols improve the quality and informativeness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol", *Child Abuse & Neglect*, vol. 31, No. 11–12 (2007), pp. 1201–1231.

487 Australian Child and Adolescent Trauma, Loss and Grief Network, "How children and young people experience and react to traumatic events" (2010), p. 4.

488 Michel Grappe, "La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés", in *Psychiatrie humanitaire en ex-Yougoslavie et en Arménie: face au traumatisme*, Marie Rose Moro and Serge Lebovici, eds. (Paris, Presses universitaires de France, 1995), pp. 89–106.

489 Jean Piaget, *La naissance de l'intelligence chez l'enfant*, 9th ed. (Neuchâtel, Delachaux et Niestlé, 1977).

(b) Considerations for conducting the evaluation

576. As a preparation for the evaluation, clinicians need to consider the individual and contextual circumstances that require an adjustment of the complexity of language and the expectations for the level of detail that the child will be able to provide.[490] Wherever possible, it is recommended to gather information from parents, teachers and others about the child's developmental history, special needs, psychiatric and medical history, social and school functioning, and behavioural adjustment.[491] Caregivers can also provide information about the child's emotions and alterations in mood and behaviour. If the child or adolescent is not accompanied by parents, or parental substitutes, as occurs in the case of unaccompanied minors in asylum cases, special attention should be given to establishing a trustful and welcoming atmosphere. It is also important to make sure that the unaccompanied minor is taken care of after the interview.

577. The clinician should be aware of and consider the potential risks and threats to the child, e.g. by the perpetrators of torture. It is strongly recommended that clinicians plan for an evaluation that can be longer than that of adults, considering the time that might be required to establish rapport with a child or allow them the time that might be required to share important and sensitive information.[492] This could mean scheduling the evaluation over several days of meetings and including time for breaks and conversations and activities unrelated to the torture or ill-treatment experience. The level of communication with the child needs to be appropriate to their age, level of development, communication skills and other individual and contextual circumstances.[493] The child should be provided with information and explanations about the evaluation that will enable them to make decisions on whether and how they wish to participate in the procedure in a way that is comprehensible to them and appropriate to their age and level of maturity. Potential and actual risks should be considered with the child. To the degree that it is possible and in the best interests of children, it is a good practice to include their parents or guardians in the assessment process and to arrive at a clear, mutual understanding regarding the nature and degree of their participation and of the information that will be given to them.

578. The establishment of trust can be challenging, as the child may experience the interview situation or conditions as reminiscent of the torture or ill-treatment. Trust may be undermined due to age and power imbalances or if clinicians or interpreters are perceived as representative of the political, ethnic or social group whose authorities executed the torture. These factors may affect the trust and comfort of the parents and guardians with the evaluation as well. It may be impossible to achieve the establishment of trust within the limited time frame of the evaluation. The UNCHR guidelines for interviewing children in the context of applications for asylum in the European Union state that: "Good practice in building trust was evidenced at the beginning of many interviews at which the interviewers introduced the interpreters, explained their role, the meaning of confidentiality, that they would speak in the first person and interpret verbatim."[494]

579. It is recommended to greet the child appropriately and to begin the assessment with neutral subjects on matters related to the child's everyday life, such as school, friendships and favoured activities. Another factor that can potentially facilitate the establishment of trust is a reduction of psychological distance and formality; for example, by using a round or oval table and avoiding having a computer screen in front of the clinician and interpreter. It is recommended that the clinician provide ample opportunity for breaks and notice the child's presentation with special care taken to not overwhelm the child. If there are indications that the child is becoming anxious, dissociated or in notable distress, the evaluator should make note of these clinical indicators and take all steps to relieve the child and/or provide psychosocial support. The evaluation can be recorded with the consent of the child and possibly that of the parent or guardian to enable the interviewers to maintain direct communication with the child without the interruptions of note-taking.[495] If the assessment is recorded, extra caution should be given to keeping the

490 UNHCR, *The Heart of the Matter: Assessing Credibility when Children Apply for Asylum in the European Union* (Brussels, 2014), p. 107.
491 Kathryn Kuehnle and Steven N. Sparta, "Assessing child sexual abuse allegations in a legal context", in *Forensic Mental Health Assessment of Children and Adolescents*, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 129–148.
492 Ibid.
493 UNHCR, *The Heart of the Matter*, p. 107.
494 Ibid., p. 126.
495 Ibid., p. 107.

recording confidential, with limited access given only to the assessment team and to protecting the child's identity. If there are any other local legal requirements regarding data protection, these should be adhered to.

580. It can be useful and provide additional support for the evaluation's conclusions to use assessment instruments. It is recommended that clinicians use instruments the validity and reliability of which have been established for the particular population that is assessed. When such instruments are not available, great caution should be taken in the interpretation of test results. Any adaptation in administration and interpretation procedures should be documented and the potential impact on the findings should be noted.[496]

(c) Clinical considerations

581. An assessment of the psychological effects of torture and ill-treatment on children and young persons should include information regarding the following: (a) the child's age, developmental status, as well as current and past psychological and medical functioning (including cognitive, communication and language abilities, special needs, social and school functioning, behavioural adjustment and emotional disorders); (b) chronological personal and family history of life events, residences etc.; (c) description of the alleged torture or ill-treatment, its frequency and duration; (d) information regarding whether the child witnessed the death and/or torture of others, especially meaningful others, or learned that it had occurred to meaningful others; (e) the alleged torturer's identity and what it represents for the child in their particular social and political context; (f) protective factors and indicators of resilience; (g) the availability of family and other caregivers to provide psychosocial support; (h) the legal status of the child; and (i) the provisions in place for treatment and support.

582. While symptoms may appear in children and can be similar to those observed in adults, manifestation of symptoms can be very different from adults and the clinician must rely more heavily on observations of the child's behaviour than on verbal expression, consider the child's behaviour before the alleged torture or ill-treatment and use developmental milestones to identify any potential impact on normal behaviour.[497] Collecting information from caregivers, teachers or other adults in the child's environment is advised and might be necessary. Research has delineated the effects of trauma on children's mental and physical health. For example, it has been found that trauma significantly compromises cognitive development,[498] and that exposure to traumatic experiences increases the risk of learning and behavioural problems, obesity[499] and psychotic symptoms in childhood.[500] Neurobehavioural development research shows that children's brain development is affected by the environment in which they grow up. Although they may not be able to recall, the memory of torture can have a traumatic effect on babies and toddlers with potential long-term impact on their attachment, regulation and experience of trust.[501] The environment and trauma will influence an adolescent's identity, brain maturation and thought functions, such as abstract thought and the ability to consider multiple perspectives, as well as the regulation of emotions and emotional processing, which are still developing at this age.[502]

583. Symptoms of PTSD may appear in children. The symptoms can be similar to those observed in adults, but the clinician must rely more heavily on observations of the child's behaviour than on verbal expression.[503] For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event and recurrent nightmares that for younger children in particular (e.g. those aged 6 and less) may not have recognizable content. Children may also articulate repetitive concerns that the torture will occur again or

496 Gerald P. Koocher, "Ethical issues in forensic assessment of children and adolescents", in *Forensic Mental Health Assessment of Children and Adolescents*, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 46–63.

497 See Lenore C. Terr, "Childhood traumas: an outline and overview", *American Journal of Psychiatry*, vol. 148, No. 1 (1991), pp. 10–20; Zero to Three, *DC:0–5: Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood*, version 2.0 (Washington, D.C., 2021); Françoise Sironi, "'On torture un enfant', ou les avatars de l'ethnocentrisme psychologique", *Sud/Nord – Folies et Cultures*, No. 4 (Enfances) (1995), pp. 205–215; and Lionel Bailly, *Les catastrophes et leurs conséquences psychotraumatiques chez l'enfant* (Paris, ESF, 1996).

498 Michelle Bosquet Enlow and others, "Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study", *Journal of Epidemiology and Community Health*, vol. 66, No. 11 (2012), pp. 1005–1010.

499 Nadine J. Burke and others, "The impact of adverse childhood experiences on an urban paediatric population", *Child Abuse & Neglect*, vol. 35, No. 6 (2011), pp. 408–413.

500 Louise Arseneault and others, "Childhood trauma and children's emerging psychotic symptoms: a genetically sensitive longitudinal cohort study", *American Journal of Psychiatry*, vol. 168, No. 1 (2011), pp. 65–72.

501 Atilgan Erozkan, "The link between types of attachment and childhood trauma", *Universal Journal of Educational Research*, vol. 4, No. 5 (2016), pp. 1071–1079.

502 UNHCR, *The Heart of the Matter*, pp. 58–60.

503 See Terr, "Childhood traumas"; Zero to Three, *DC:0–5 Diagnostic Classification*; Sironi, "'On torture un enfant'"; and Bailly, *Les catastrophes et leurs conséquences*.

that the perpetrators will hurt them or their loved ones again in spite of reassurances that they are safe. The child may develop bedwetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes towards self and others and feelings that there is no future. The child may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability and significant disturbances in attention and concentration. The child may complain about bodily aches, such as stomach aches, or other physical problems. Fears and aggressive behaviour that were non-existent before the traumatic event may appear as aggressiveness towards peers, adults or animals, fear of the dark, fear of going to the toilet alone and phobias. Children may demonstrate sexual behaviour that is inappropriate for their ages. Post-traumatic behavioural changes can also include risk-taking behaviour, self-harm and suicide attempts. The child may become avoidant and/or clingy around parents or caregivers, exhibit explosive outbursts or tantrums, or exhibit a trance-like state, lapses in attention, confusion, forgetfulness and unresponsiveness. Anxiety symptoms, such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying may appear. Distress can be manifest in other behaviours, such as nail-biting and thumb-sucking, and changes in the use of language. The child may also develop eating problems. Teenagers may present very differently, initially denying any symptoms and insisting that their level of function is good and that they have no need of help. Peer pressure to fit in with others and fear of the stigma of mental illness can be particularly evident. Teenagers may have particular difficulty in managing features of PTSD, such as angry outbursts and irritability, directing violence at others or themselves. The examiner needs to take additional time to build trust and rapport and assess carefully for indirect indicators of mental distress, including, for example, appetite, sleep pattern, ability to form friendships and confide in others, self-harming behaviour, risk-taking behaviour and anger management.

(d) Diagnostic classification

584. When assessing children's mental health, behaviours and emotions that are consistent with a child's developmental age should be differentiated from those that are cause for concern. The same diagnostic categories can be viewed problematic in some ages and be part of normal behaviour in younger ages. Thus, behaviour and symptoms need to be assessed and considered within the expected range in a particular age and developmental stage, as well as within the child's cultural context. Furthermore, torture can worsen pre-existing problems in all domains of functioning and can cause a loss or regression of functioning that has already been attained.

585. The following list complements the information on the diagnostic classification in adults above. It is non-exhaustive and enumerates diagnoses or criteria that are particular to children and adolescents.

(i) Post-traumatic stress disorder

586. Traumatic events that occurred to a caregiver or other trusted adult are often experienced by children as seriously disturbing and distressing, even indirectly when the child hears about the events. Because children need relationships with their parents and caregivers to feel safe, such events may be experienced as a threat to the child's physical and psychological survival.[504] Indeed, criterion A in the DSM-5 diagnosis of PTSD in children aged 6 or younger includes in the definition of trauma witnessing the event(s) as it occurred to others, especially primary caregivers, or learning that the traumatic event has occurred to a parent or caregiver. PTSD can develop at any age after 1 year of age.[505] The diagnosis of PTSD in children younger than 6 excludes symptoms that are dependent on the ability to verbalize cognitive constructs and complex emotional states, such as negative self-belief and blame. Therefore, the threshold of avoidance and negative cognitions symptoms (criterion C) is lowered from three to one symptom.[506]

587. The re-experiencing of trauma can vary according to the child's age. In young children, symptoms are more likely to be expressed through play, and fearful reactions at the time of exposure or re-experiencing of trauma may be lacking. Young children's frightening dreams may not be specific to the trauma. Parents may report a wide range of emotional and behavioural changes, including changes in play.[507]

504 Research Triangle Institute International, *DSM-5 Changes: Implications for Child Serious Emotional Disturbance* (Rockville, Maryland, Substance Abuse and Mental Health Services Administration, 2016).
505 Ibid.
506 Ibid.
507 Ibid.

(ii) Separation anxiety disorder

588. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the child is attached, as evidenced by three of the following: (a) recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures; (b) persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters or death; (c) persistent and excessive worry about experiencing an untoward event (e.g. getting lost, being kidnapped, having an accident or becoming ill) that causes separation from a major attachment figure; (d) persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation; (e) persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings; (f) persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure; (g) repeated nightmares involving the theme of separation; and (h) repeated complaints of physical symptoms (such as headaches, stomach aches, nausea or vomiting) when separation from major attachment figures occurs or is anticipated.

(iii) Specific phobia

589. A marked fear or anxiety about a specific object or situation that is out of proportion to the actual danger posed by the object. The anxiety or fear may be expressed by crying, tantrums, freezing or clinging. The phobic object or situation almost always provokes this reaction, is actively avoided or endured with intense fear.

590. It is considered developmentally appropriate for young children to experience fear of specific objects (real or imaginary) or situations (e.g. animals, witches, monsters or the dark), and commonly these are transient and have only a mildly impairing effect. Therefore, in diagnosing specific phobia, it is important to consider the duration of the fear, anxiety or avoidance, the degree of impairment and the child's developmental stage.

(iv) Disorders of social functioning with onset specific to childhood and adolescence

591. ICD-11 lists disorders of social functioning with onset specific to childhood and adolescence that are associated with gross environmental distortions and privations. Among these are elective mutism, reactive attachment disorder of childhood and disinhibited attachment disorder of childhood. Elective mutism is a condition characterized by a marked, emotionally determined selectivity in speaking and is most frequently manifest in early childhood. Reactive attachment disorder of childhood is characterized by persistent abnormalities in the child's pattern of social relationships and relationships with parents that is reactive to changes in environmental circumstances, before the age of 5. Disinhibited attachment disorder of childhood is characterized by a diffuse attachment at around the age of 2 and a clinging behaviour in infancy, and/or indiscriminately friendly, attention-seeking behaviour in early or middle childhood. This pattern is associated with marked discontinuities in caregivers or multiple changes in family placements.

(v) Conduct disorder

592. The DSM-5 diagnostic criteria for conduct disorder are violation of social norms or rules or the rights of others in a persistent and repetitive manner, including aggression towards people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. There are two specifiers to the diagnosis, regarding onset and degree of social emotionality. It has been suggested that trauma plays a key role in the development and persistence of conduct disorder and it has been found that young persons who are diagnosed with conduct disorder often have an experience of trauma.[508] Environmental risk factors listed in DSM-5 include physical and sexual abuse and environmental exposure to violence. A cautionary note in DSM-5 states that the context of the undesirable behaviours associated with conduct disorder should be considered and that the diagnosis may potentially be misapplied to individuals in settings in which the behaviour is viewed as near normative, such as war zones and threatening and dangerous, high-crime areas.

508 Ricky Greenwald, "The role of trauma in conduct disorder", *Journal of Aggression, Maltreatment & Trauma*, vol. 6, No. 1 (2002), pp. 5–23; Pratibha Reebye and others, "Symptoms of posttraumatic stress disorder in adolescents with conduct disorder: sex differences and onset patterns", *Canadian Journal of Psychiatry*, vol. 45, No. 8 (2000), pp. 746–751.

(vi) Oppositional conduct disorder

593. The diagnostic features of oppositional conduct disorder include a frequent and persistent pattern of angry/irritable mood, argumentative/defiant behaviour or vindictiveness (criterion A). Environmental factors play an important role in causal theories of the disorder. First symptoms usually appear during preschool years and rarely later than early adolescence.

(vii) Disruptive mood dysregulation disorder

594. The diagnostic criteria of disruptive mood dysregulation disorder include severe and recurrent temper outbursts, expressed verbally and/or behaviourally, that are intense and prolonged relative to the situation or provocation. They are inconsistent with the developmental level and occur three or four times a week on average. Between outbursts the mood is persistently irritable most of the day, for at least 12 months, in at least two or three settings (i.e. school, home and with peers). While there is no consensus on the causes of disruptive mood dysregulation disorder, dysregulation in childhood has been linked to interpersonal trauma and abuse.[509] Validity for the diagnosis has been established for children between the ages of 7 and 18 and its use should be restricted to this age group.

(e) Family context

595. Families are profoundly affected by an experience of torture of a child as well as by torture of other family members. Torture of parents, as well as living in social and political contexts of violence and oppression, can have a serious impact on parental functioning and mental health. It is therefore important to consider the environmental and contextual factors that affect the family and the child, such as separation between family members and the circumstances of these separations, communication routes during separation, threats to family members, the circumstances of reunification, stress factors in resettlement processes (such as loss of social and economic status), the impact of acculturation, racism, social supports, and experiences and beliefs related to seeking support (such as fear of bringing the attention of the authorities to the family), to name but a few.

596. As parents, many torture survivors fear that the intensity of their own feelings could overwhelm them and they may feel shame and guilt.[510] Coping with the expressed or unexpressed feelings of their children might also raise difficulties for parents, who may feel guilty about the circumstances their children endured and continue to endure.[511] Parents of children who were tortured may also experience guilt over their inability to protect their children and their parenting may be affected by feelings of helplessness. Parents' experience of helplessness can be reinforced in violent and oppressive environments that expose children and adolescents to multiple risk factors. Such environments may also damage adolescents' perceptions of their parents' authority.

597. The effects of torture on individuals' abilities to function as parents can take on many forms. It is beyond the scope of this chapter to describe these effects, yet it is important to note that these should be considered with regard to the child's age, culture and development. Safeguarding issues related to general considerations of parental functioning, including child neglect and physical, sexual and emotional abuse, should also be considered and addressed within the appropriate local legal and social frameworks.

(f) Role of the family

598. The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviours and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be parentified and expected to care for the parents, which can hamper the development and result in a depressive symptomatology or else in aggressive behaviour. In the frame of post-traumatic disorders, parents may show outbursts of anger and violence against a child, as well as other forms of domestic violence, which the child might experience and witness and process in a traumatic way. When the child is not the direct victim of torture but only indirectly affected, adults often tend to underestimate the impact on the child's psyche and development. When loved ones around children have been persecuted, raped

509 Yael Dvir and others, "Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities", *Harvard Review of Psychiatry*, vol. 22, No. 3 (2014), pp. 149–161.
510 Center for Victims of Torture, *Healing the Hurt: A Guide for Developing Services for Torture Survivors* (Minneapolis, 2005), chap. 2.
511 Ibid.

and tortured or the children have witnessed severe trauma or torture, they may develop dysfunctional beliefs, such as believing that they are responsible for the bad events or that they have to bear the burdens of their parents. This type of belief can lead to long-term problems with guilt, loyalty conflicts, personal development and maturing into an independent adult.

D. Lesbian, gay, bisexual, transgender and intersex persons and torture and ill-treatment

599. Based on their sexual orientation, gender identity, gender expression or sex characteristics, lesbian, gay, bisexual, transgender and intersex persons are frequently stigmatized and dehumanized, leaving them particularly vulnerable to human rights violations, including persecution, criminalization, imprisonment, torture and ill-treatment. Research on lesbian, gay, bisexual and transgender children and young persons shows that they are at risk of experiencing severe and prolonged physical and psychological abuse, with a potentially severe impact on their mental health.[512] Lesbian, gay, bisexual and transgender adult asylum seekers also have particular persecution experiences, with consequences for mental health.[513] Depending on the different levels of stigma and pathologization, lesbian, gay, bisexual, transgender and intersex persons have experienced in their lives, including health care, they can develop great difficulty in revealing their identity, including to the examining clinician.

600. When examining an alleged torture victim from the lesbian, gay, bisexual and transgender community, specific considerations should be taken into account to avoid pathologizing or retraumatizing them. Some of the basic principles and keynotes that should be taken into account by clinicians in order to create a sense of safety and respect and thus help individuals reveal all the aspects of their torture history and help the clinician better understand their current needs (medically, psychosocially and legally) include:

(a) Recognize that diversity in sexual orientation, gender identity, gender expression and sexual characteristics is normal and is not a mental illness;

(b) Understand how the persecution experiences of lesbian, gay, bisexual, transgender and intersex children, youth and adults affect their mental and physical health;[514]

(c) Be familiar with the specific social, cultural and political factors that may have influenced the physical and mental health of lesbian, gay, bisexual, transgender and intersex persons;[515]

(d) Ask about persecution and abuse that target sexual orientation and gender identity during childhood and adolescence;[516]

(e) Create a supportive environment in which lesbian, gay, bisexual, transgender and intersex individuals are able to explore, discuss and reveal their sexual orientation and gender identity as much as possible at the time;

(f) Recognize that lesbian, gay, bisexual and transgender and intersex persons may not have disclosed their sexual orientation, gender identity, sex characteristics, chosen name or gender pronouns in previous interactions with authorities out of fear based on past experience and other factors;

(g) Use whenever possible the proper names and gender pronouns chosen by the individual, compatible with the individual's self-identification;

(h) Be aware of their own attitudes, perceptions and prejudices and how they might affect the quality of interaction with lesbian, gay, bisexual, transgender and intersex persons;

(i) Apply an intersectional, intercultural and interreligious approach and strive to understand the specific barriers that lesbian, gay, bisexual, transgender and intersex persons face when they have additional stigmatized and/or minority identities (e.g. HIV-positive person, refugee, sex worker or person with physical disabilities);

(j) Do not attempt to change the interviewee's sexual orientation or gender identity;

512 Edward J. Alessi, Sarilee Kahn and Sangeeta Chatterji, "'The darkest times of my life': recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity", *Child Abuse & Neglect*, vol. 51 (2016), pp. 93–105.

513 Rebecca A. Hopkinson and others, "Persecution experiences and mental health of LGBT asylum seekers", *Journal of Homosexuality*, vol. 64, No. 12 (2017), pp. 1650–1666.

514 Alessi and others, "'The darkest times of my life'".

515 Ibid.

516 Ibid.

(k) Do not interpret or seek specific elements that "explain" the sexual orientation and gender identity of lesbian, gay, bisexual and transgender persons;

(l) Do not assume a person's sexual orientation and/or gender identity based on appearance or gender expression.

601. Further useful information and references on issues of identity, intervention and assessment can be found in the guidelines of the American Psychological Association[517] and other references.

517 American Psychological Association, *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (2011).


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602. The involvement of health professionals in the investigation and documentation of torture and ill-treatment is not limited to comprehensive clinical evaluations for legal purposes. Torture and ill-treatment may also be discovered by health professionals in non-legal[518] contexts, such as the routine delivery of health care and health inspections or examinations. This chapter seeks to clarify the role of health professionals in both legal and non-legal contexts and provide guidance on the effective investigation and documentation practices[519] in these contexts. While the guidance in this chapter primarily aims to help health professionals working in non-legal contexts fulfil their obligations to investigate and document torture and ill-treatment, it is not intended to serve as comprehensive guidance for clinical evaluations of torture and ill-treatment. Health professionals working in non-legal contexts should be familiar with all the relevant chapters in the Istanbul Protocol and its annexes, particularly chapters II, IV, V and VI and annexes I–IV. This chapter further aims to clarify the role of health professionals in the contexts of monitoring and prevention, in which the primary purpose of clinical encounters is often the prevention of torture and ill-treatment rather than evaluating a specific allegation of abuse or the delivery of health care. The guidance in this chapter is based on a review of relevant considerations, including: relevant State obligations and ethical obligations of health professionals, a review of different documentation contexts and special challenges that health professionals may face in different documentation contexts.

A. State obligations and ethical obligations of health professionals

603. The obligation of health professionals to document and report torture and ill-treatment in all contexts is based on the obligation of States under international law, as well as the ethical obligations of health professionals. As stated in chapters I and III, States have an obligation to respect and protect everyone's right to freedom from torture and ill-treatment. This includes the obligation to prevent, investigate and document incidents of torture and other forms of ill-treatment and to hold perpetrators accountable.[520] States also have a duty to take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.[521] These State obligations are elaborated in international human rights instruments as discussed in chapter I. Furthermore, specific obligations of health professionals working in custodial settings, to document and report torture and ill-treatment, are elaborated in the Nelson Mandela Rules[522] and in regional human rights instruments[523] as discussed in chapter II. The Istanbul Protocol and its Principles provide guidance on how to effectuate State obligations to effectively investigate and document torture and ill-treatment.

604. International associations of health professionals, such as WMA, WPA and ICN, have also established ethical obligations that are intended to elaborate the core universal duties of their respective health professionals to document and report torture and ill-treatment (see paras. 147 and 155 above). As stated in paragraphs 177–182 above, regardless of employer status (State or non-State) or work setting (custodial or non-custodial), all health professionals have an ethical obligation to document and report alleged and suspected cases of torture and ill-treatment. This obligation should be considered in light of other core ethical obligations (do no harm, confidentiality and respect for autonomy) and careful consideration should be given to the conditions necessary to document and report torture and ill-treatment in the absence of consent (see paras. 177–178 above). As stated in paragraph 155 above, when alleged victims provide their informed consent to health professionals for a clinical evaluation and report torture and ill-treatment, the clinician has an unequivocal duty to document and report the torture or ill-treatment, if substantiated – failing

518 The term "non-legal" contexts is used to refer to clinical encounters in which the evaluation of possible torture and ill-treatment are not the expressed or implicit purpose of the patient encounter, even though information collected in such non-legal contexts ultimately may be entered into evidence in legal cases as often happens in cases of domestic violence, sexual assault and child and elder abuse.

519 Investigation and documentation in non-legal settings typically require health professionals to first identify the possibility of torture and/or ill-treatment based on the clinician's observations (e.g. injuries and/or psychological distress) and a history of contact with possible perpetrators, and then to proceed with a clinical evaluation in order to document and subsequently report clinical evidence of torture and/or ill-treatment.

520 Convention against Torture, art. 12.

521 Ibid., art. 2.

522 While the Nelson Mandela Rules are not treaty-based obligations of States, they provide universal guidance for health professionals working with persons deprived of their liberty.

523 European Committee for the Prevention of Torture, *23rd General Report of the CPT* (see chap. III, para. 71 et seq.); Inter-American Commission on Human Rights, Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas; and African Commission on Human and Peoples' Rights, Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa (Robben Island Guidelines).

to do so would, according to WMA, constitute a form of complicity in torture and ill-treatment.[524]

605. In cases in which consent is not obtained and alleged or observed torture may constitute a threat to the person as well as to others, even representing systemic problems, there is a need for health professionals to communicate their concerns and report on such matters in ways that respect medical confidentiality.

B. Contexts in which documentation may be necessary

606. Health professionals may encounter alleged torture and ill-treatment in many different contexts. These contexts include, but are not limited to:

(a) Police and military custody or prison:

(i) Clinical evaluations requested by detainees;

(ii) Mandatory clinical evaluations during detention (e.g. initial screening upon detention and health checks of segregated detainees);

(iii) Examinations or forms of regular screenings, such as health checks;

(iv) General consultations with health professionals;

(v) Monitoring of places of detention and all places of deprivation of liberty (e.g. national preventative mechanism, national human rights institution, Subcommittee on Prevention of Torture, ICRC, European Committee for the Prevention of Torture, the Inter-American Commission on Human Rights, United Nations Special Rapporteurs and NGOs/civil society organizations);

(vi) Different kinds of institutional health inspections;

(b) Immigration contexts (whether deprived of liberty or not):

(i) Clinical screening of asylum seekers;

(ii) General consultations with health professionals;

(iii) Clinical assessment as a preliminary examination;

(c) Health-care, psychiatric and social institutions:

(i) General consultations with health professionals;

(ii) Institutional health inspections;

(iii) Regular health checks;

(d) Ad hoc national and international settings:

(i) Allegations of torture or ill-treatment in the context of human rights fact-finding missions;

(ii) Medical evaluations requested by regional and international courts and tribunals;

(e) Health-care facilities, emergency rooms and urgent care centres:

(i) General consultations with health professionals;

(f) Other contexts:

(i) NGO investigations and individual evaluations of alleged victims;

(ii) Rehabilitation and treatment centres for torture victims.

607. In these contexts, the primary purpose of a clinical encounter may vary. In some encounters, the primary purpose will be to evaluate alleged and suspected cases of torture and ill-treatment and/or delivery of health-care services. Other encounters may have as the primary purpose to monitor conditions of detention and treatment of persons deprived of their liberty with a view to prevent torture and ill-treatment, including monitoring of the delivery of health services. In addition, clinical encounters may occur in both legal and non-legal contexts. Any clinical evaluation of an individual deprived of their liberty should be considered a legal context

524 WMA resolution on the responsibility of physicians.

given their vulnerability and the increased risk of torture and ill-treatment in such settings.

608. Mandatory health examinations include examinations upon detention, periodically during detention, and before transfer to other facilities or release from custody. The purpose of such examinations is both to assess health conditions and to prevent torture and ill-treatment.

C. Challenges

609. Health professionals who evaluate alleged victims of violence, whether as a result of torture, domestic violence, child abuse or other forms of ill-treatment, may experience significant challenges in conducting such evaluations effectively. In order to fulfil their obligation to document and report torture and ill-treatment, health professionals should understand and mitigate such challenges. State-employed health professionals need to understand and mitigate the challenges associated with effective documentation of torture and ill-treatment in order to fulfil their torture prevention and accountability obligations. These challenges are discussed in detail in paragraphs 269–302 above and include essential conditions and interview skills (e.g. safety, security, trust, empathy and privacy), the risk of retraumatization of the interviewee, specific considerations regarding gender and children and the emotional reactions of the interviewee and the health professional that may adversely affect the clinical evaluation and individuals involved in the evaluation. In conducting clinical evaluations of cases in which torture or ill-treatment is alleged or suspected, health professionals should be aware of: procedural safeguards to ensure safe, ethical and effective evaluations that are independent of undue influence (see paras. 312–315 above); communication barriers and the skills and techniques to address them as discussed in paragraph 325 above, including the use of interpreters (see paras. 296–298 above); and how to assess inconsistencies that may result from trauma-related difficulty in recalling and recounting traumatic experiences (see paras. 342–353 above). Chapter IV also provides guidance on how clinicians should interpret their clinical findings and the limitations of such interpretations (see paras. 379–389 above).

610. Health professionals who encounter alleged victims of torture or ill-treatment in the above-mentioned contexts, particularly non-legal contexts, may experience additional challenges. These challenges include, but are not limited to, the issues mentioned below.

1. Fear of reprisals

611. As mentioned previously, since torture is a crime committed by or with the consent or acquiescence of State officials, health professionals may fear reprisals for conducting a clinical evaluation and/or making interpretations that imply that a crime was committed by a State official. Health professionals working under such conditions should understand that they have a professional duty to document and report torture and ill-treatment whenever informed consent is provided and that failing to do so is a form of complicity in such abuses. It should be kept in mind that contexts in which health professionals face the risk of reprisal may be at the same time contexts in which torture and ill-treatment practices are widespread. Therefore, clinical evaluation and documentation is of vital importance. They should be aware of procedural safeguards in conducting their clinical evaluations to minimize the risk of reprisals (see paras. 312–315 above). Also, as discussed in paragraph 179 above, health professionals should seek to work with independent monitoring and investigation bodies, as well as national and international professional organizations, to mitigate any fear of reprisal.

612. In case the clinical examination is conducted outside clinical facilities, for instance inside a prison or even a prison cell, there may be increased risks with regard to security, privacy, reprisals and different forms of pressure that the health professional must be aware of. There is also the risk of false negative reports after such examinations.

2. Lack of training

613. Health professionals should seek to obtain the necessary training on Istanbul Protocol documentation standards, including reading and understanding the Istanbul Protocol and its Principles, participating in training courses and learning from colleagues, when possible in supervised mentoring settings. States should provide such training for their health professionals, and academic institutions should include relevant training on professional curricula, as well as continuing education courses. Such courses and curricula should include relevant topics in the Istanbul Protocol.

614. Health professionals should be aware of their professional ethical obligation to document and

report torture and ill-treatment and obtain the necessary professional knowledge and skills to fulfil these obligations. Lack of necessary training does not in any way diminish the ethical obligations of the health professional to effectively document and report torture and ill-treatment.

3. Lack of time, heavy workload and inadequate number of health professionals

615. Just as in cases of domestic violence, sexual assault, child abuse and other forms of violence, insufficient time is not an acceptable reason not to conduct an evaluation in cases of alleged or suspected torture or ill-treatment. A clinical evaluation may be condensed and still be consistent with the Istanbul Principles. Health professionals should take the necessary time for an effective evaluation and schedule a follow-up appointment or refer to another health professional with adequate knowledge and skills if the evaluation cannot be completed in a single visit.

616. Health professionals should document all the findings and information detected during clinical encounters and clinical evaluations, as well as the conditions, such as examination time and environment, as stated in paragraph 270 above, while respecting confidentiality and privacy.

4. Lack of adequate professional space or conditions

617. Evaluations conditions can be challenging, for example the lack of privacy, the physical conditions of the interview setting and the person being restrained. As mentioned in paragraphs 315 and 354 above and annex I, all evaluations should be conducted in privacy and without limitations or restrictions. If this cannot be achieved, any limitations on privacy should be documented in the clinician's report.

618. In order to fulfil their professional obligation to document and report torture and ill-treatment, health professionals should take steps to request – if possible, in writing – that the authorities provide an appropriate environment and conditions, equipment, time and human resources. In addressing the authorities in these situations, health professionals can refer to international and scientific standards. Keeping a copy of such correspondence is advised.

5. Non-disclosure

619. Victims of torture do not necessarily disclose their torture experiences readily or at a first appointment and circumstances such as the presence of others or fear of reprisals may make them even less likely to do so. The health-care professional should develop skills in facilitating disclosure, pay attention to cues of further torture experiences, especially sexual torture (see paras. 274–276 above), that the person may find difficult to disclose initially, and explore such cues as they present in the review of bodily systems and in the full examination.[525]

6. Vicarious trauma and burnout

620. As discussed in paragraphs 300 and 302 above, health professionals who are unaware of the way in which they indirectly experience the trauma of others may react in a way that is neither healthy for themselves nor effective for the alleged victim. Professional wellness and effective evaluations require knowledge and mitigation of vicarious trauma. This is especially true for clinicians who work alone, with limited collegial support, and are subject to high levels of stress at work and heavy workloads.

D. Implementing ethical obligations

621. As discussed in paragraphs 159–172 above, all health professionals who encounter alleged victims of torture or ill-treatment, regardless of the primary purpose of the contact or the context in which the encounter occurs, must respect their core ethical obligations even in the face of real or perceived obligations to third parties. The non-maleficence obligation may imply in extreme cases that, due to risks for the alleged victim, no further steps regarding identification, documentation, evaluation and reporting should be taken. At the same time, the ethical obligation to document and report is critical in preventing the passive complicity of health professionals in these crimes.

622. The duty to document and report torture and ill-treatment may be particularly challenging in settings in which health professionals are under a real or perceived pressure from third parties, such as a State employer, that conflicts with their ethical duties. In instances in which the alleged torture or ill-treatment

525 Faculty of Forensic and Legal Medicine of the Royal College of Physicians, *Quality Standards for Healthcare Professionals.*

was perpetrated in the institution in which the alleged victim is being held, this may expose the victim to a very high risk. Under such circumstances, the health professional's ethical obligations of acting in the best interests of the individual, not doing harm and respecting autonomy and confidentiality may conflict with the ethical obligation to document and report torture and ill-treatment and to prevent harm to others.

623. Even in such conflicting situations, health professionals should never ignore cases and the suspicions of torture or allegations presented. Health professionals who suspect torture or ill-treatment, regardless of the setting or purpose of a clinical encounter, should always:

(a) Seek to obtain informed consent and disclose any mandatory reporting obligation;

(b) Document and report torture and ill-treatment in accordance with the Istanbul Principles when informed consent for a clinical evaluation and reporting is provided;

(c) Consider, in the absence of informed consent, all ethical obligations and only consider breaches in confidentiality under the conditions provided for in paragraphs 177–178 above;

(d) Document patterns of abuse anonymously and report such patterns of abuse to international and national human rights institutions;

(e) Consider the need for referrals, either for treatment purposes or for further documentation by other clinicians.

1. Real or perceived obligations to third parties

624. As discussed in paragraphs 173–182 above, dilemmas arising from real or perceived obligations to third parties, such as State employers or a military chain of command, may compromise a health professional's respect for core ethical duties. Whatever the circumstances of their employment, health professionals cannot be obliged by contractual or other considerations to compromise their professional ethical obligations or independence.

2. Implicit and explicit bias

625. Explicit biases are conscious thoughts directed towards a specific group of individuals and are easily recognized by the holder of those beliefs or by others during routine interactions.[526] Implicit biases are unconscious thoughts that are directed towards a specific group of individuals. The unconscious nature of implicit bias makes it quite pervasive, even among health-care professionals working with groups such as victims of torture or ill-treatment, particularly those who are in custody. It is important to recognize and mitigate implicit and explicit bias in working with patients, clients and alleged victims, to avoid acting upon such biased conceptions.

3. Limited opportunities for referral

626. Referral options may be limited due to lack of experts to refer to, resistance in the system to refer cases, economic hindrances, as well as problems of access and adequate standards with regard to transfer and examinations in health facilities. This makes the initial documentation of torture or ill-treatment all the more urgent and necessary.

E. Guidance and procedures

627. All clinicians should do their utmost to fulfil their ethical obligation to document and report torture and ill-treatment in all settings. The Istanbul Protocol and its Principles should be considered the principal framework within which to fulfil this obligation.

1. Clinical evaluations in legal contexts

628. Chapters IV, V and VI and annexes I–IV provide detailed guidance on clinical evaluations of torture and ill-treatment in legal contexts. Several key points on this guidance are included here only to highlight differences between clinical evaluations in legal and non-legal contexts. Health professionals should refer to chapters IV, V and VI and annexes I–IV to ensure that their clinical evaluations in legal contexts are consistent with the standards of the Istanbul Protocol.

629. When an individual alleges the crime of torture or ill-treatment, the State has a duty to investigate the

526 Chloë FitzGerald and Samia Hurst, "Implicit bias in healthcare professionals: a systematic review", *BMC Medical Ethics*, vol. 18, No. 1 (2017).

allegations.[527] These investigations should include clinical assessments of both physical and psychological evidence in accordance with the Istanbul Protocol and its Principles. Regardless of the type of legal case (criminal, civil, administrative or other) or the setting in which torture is alleged (custodial or extra-custodial), the State should conduct timely assessments by qualified experts. As stated in chapter IV (see paras. 354–355, 379 and 382 above) and annex I, the Istanbul Principles suggest that health professionals should provide an interpretation of all findings and an opinion on the possibility of torture or ill-treatment.

630. The provisions of the Istanbul Protocol allow for some flexibility with regard to the level of detail provided in a medico-legal report. This means that the content of medico-legal evaluations can vary as long as the evaluations follow the Istanbul Principles. States should establish policies and procedures for State-employed health professionals' use of the Istanbul Protocol, including their obligation to perform evaluations in accordance with the Istanbul Protocol and its Principles. This also includes, but is not limited to, requiring the use of standardized evaluation formats to ensure quality, accuracy and accountability that are consistent with the Istanbul Protocol and its Principles. Non-governmental health professionals, on the other hand, should not be required to use a standardized evaluation form that may be required of State health professionals.

631. In all cases of alleged or suspected torture or ill-treatment, it is the duty of the health professional to carry out this work in accordance with the Istanbul Protocol and its Principles and not accept any limitation to this procedure, given for instance by prosecutors or judges. This means that the duty to examine alleged victims in this way supersedes any limitations that may be imposed by statutory considerations. It should be noted that clinicians who conduct health assessments of persons deprived of their liberty, for example in the case of routine health assessments of detainees, health-care delivery of prisoners and detention monitoring visits, should be trained and have the capacity to conduct clinical evaluations in accordance with the Istanbul Protocol and its Principles given the possibility of torture and ill-treatment in these settings.

632. While non-governmental health professionals do not conduct evaluations on behalf of the State, their evaluations should conform to the minimum standards contained in the Istanbul Principles when they provide a medico-legal opinion on torture or ill-treatment in legal cases.

2. Clinical evaluations in non-legal contexts

633. In non-legal contexts, health professionals may observe injuries and psychological stress in the course of providing health-care services or assessing the health status of victims. When this is the case, the health professional should enquire about the cause of such injuries or psychological stress and related circumstances, including whether the individual has been in the custody of any State officials, including law enforcement. Health professionals should always keep in mind that any person deprived of their liberty faces the risk of torture and other forms of ill-treatment.

634. If the individual alleges or the health professional suspects the possibility of torture or ill-treatment by or with the acquiescence of a State official, the clinician should consider the following guidance in documenting and reporting the torture or ill-treatment (see annex I):

(a) Seek to obtain informed consent, as described in paragraphs 165–171 and 273 above, including disclosure of any mandatory reporting requirements, before proceeding with an evaluation;

(b) Exclude any third parties from the evaluation room to ensure privacy. See paragraphs 312–315 above for additional guidance on the presence of any third party during an evaluation;

(c) Enquire about the cause of any injuries or psychological distress;

(d) Record and evaluate any physical and/or psychological symptoms or disabilities that may be related to the alleged abuse;

(e) Conduct a directed physical examination of all organ systems that may be related to the allegations of abuse, including a brief mental status examination and a risk assessment for harm to self and to and from others;

527 Convention against Torture, art. 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."

(f) Document the presence of all injuries detected, including those that might be associated with alleged or suspected abuse, with body diagrams (see annex III) and photographs if at all possible;

(g) If ill-treatment is alleged or suspected on the basis of clinical observations or clinical findings, and on the condition that informed consent is provided by the alleged victim, the health professional must:

(i) Make appropriate referrals for further consultation, assessment and medico-legal evaluation of the alleged or suspected ill-treatment and also for treatment of medical and mental health conditions;

(ii) Notify the appropriate authorities and inform individuals of their right to clinical evaluations by independent, non-governmental clinical experts and, to the extent possible, make a referral to a specific non-governmental expert;

(h) Clinicians who have knowledge and experience applying the Istanbul Protocol and its Principles may consider providing an interpretation of the level of consistency between clinical findings and the alleged method(s) of injury, as well as an opinion on the possibility of torture or ill-treatment as defined in the Convention against Torture (see paras. 382–385, 424–425 and 546–548 above);

(i) Provide a copy of the documentation/evaluation to the appropriate legal authorities and the patient, if requested, and/or the patient's legal representative but not to law enforcement officials. Health professionals should keep one copy of the evaluation and documentation for themselves in secure medical files;

(j) If the health professional is unable to conduct any or all components of this evaluation, the clinician should indicate the reason(s) for this in the documentation and pursue alternative approaches;

(k) If there is any sign of torture or ill-treatment, the clinician should make every effort possible, and take all measures to avoid that the alleged victim is sent back to the place where the torture or ill-treatment is alleged or suspected to have taken place.

635. When independent, non-governmental health professionals conduct clinical evaluations of alleged or suspected torture or ill-treatment in non-legal settings, they do not have the same formal evidentiary requirements as those conducted in legal settings. In such cases, it would be reasonable for clinicians to follow the Istanbul Principles and note any departures from the required elements of these Principles where applicable. For example, some human rights field investigations may not permit sufficient time to conduct full and detailed psychological evaluations and this, therefore, would need to be noted.

636. Health professionals will need, when assessing the information provided and the clinical findings, to take into account that individuals may not disclose the full extent of their torture or ill-treatment experiences. Experiences of sexual torture, in particular, may not be disclosed as discussed in paragraphs 274–276 above and the ability of individuals to recall fully the details of their experiences may be affected by many factors including the stress of the situation, e.g. if they are in detention (see paras. 342–353 above). Their mental state and reported psychological symptoms are also likely to be different if they are deprived of their liberty. Finally, clinicians who are unfamiliar with recognition and documentation of physical injuries may underreport physical findings compared with more experienced clinicians.

637. Clinical evaluations in non-legal settings should strive to provide all of the information inherent in a full medico-legal evaluation as described elsewhere in the Istanbul Protocol. This includes addressing the relevant clinical history, the allegations or suspicion of abuse, physical and psychological symptoms and the findings emerging from a physical and psychological examination. The conclusion should assess the clinical problems and the treatment needs as well as steps taken to initiate tests and treatment and referrals for further examination and treatment. For legal purposes, case information and the circumstances of the evaluation should be included and the clinician's report should be dated and signed.

F. Reporting and regulation

638. The professional obligation to report torture and ill-treatment is discussed in chapter II (see paras. 148, 155 and 177–182 above), as well as the conditions that may preclude the reporting of torture and ill-treatment when the alleged victim does not provide consent. It is also important to be aware of the national laws and regulations regarding reporting of allegations of torture or ill-treatment. Such laws (e.g. criminal procedure codes and

forensic or health laws) often establish a mandatory reporting requirement for health professionals and may disregard the predicate of informed consent. As stated in paragraph 175 above, health professionals have a duty to abide by their core ethical obligations even if they are in conflict with the law.

639. As discussed in paragraph 315 above, the clinical reports of alleged victims should never be provided to law enforcement officials, but to a judicial or other independent authority separate from the setting in which possible abuse has taken place. The official national human rights institution and the national preventive mechanisms in a State may be effective collaborating mechanisms for clarifying or defining such procedures.

640. Documentation and reporting policies for health professionals should be established by State institutions in consultation with international monitoring and prevention bodies, as well as with national and international associations of health professionals, to ensure respect for all the obligations of health professionals. This may be particularly important for health professionals working in detention settings, who may be clinically isolated from peer support. National associations of health professionals and national human rights institutions should take an active role in identifying documentation and reporting procedures for cases of alleged or suspected torture or ill-treatment, especially when the detaining authorities fail to provide such guidance.

G. Monitoring and ensuring the quality of all official evaluations

641. It is not sufficient for States to simply establish procedures and practices that apply provisions of the Istanbul Protocol and its Principles. As discussed in paragraphs 674–679 below, States need to monitor and ensure the quality of all official evaluations in which torture or ill-treatment is alleged or suspected and take remedial action for non-compliance. In addition, it is of critical importance for States to ensure that appropriate evaluations are conducted by health professionals. Official forensic evaluations must be carried out in accordance with the Istanbul Protocol and its Principles.

642. The Istanbul Protocol was developed to establish specific United Nations standards on how effective legal and clinical investigations into allegations of torture or ill-treatment should be conducted. While the Istanbul Protocol served to bridge the gap between the treaty-based duties of States to investigate torture and ill-treatment and the lack of normative guidance, particularly on medico-legal investigation and documentation of torture and ill-treatment, it did not provide detailed, specific guidance on how States should implement these standards. This chapter seeks to provide guidance to States and members of civil society on the implementation of the Istanbul Protocol based on the extensive practical experience of Istanbul Protocol stakeholders. As human rights duty bearers, States have the obligation to ensure effective torture and ill-treatment prevention, accountability and redress. While the guidance in this chapter is aimed primarily at States in order to fulfil their human rights obligations, it is also relevant to members of civil society for use as a framework for State accountability for effective torture and ill-treatment investigation and documentation practices and to identify specific implementation activities in which civil society may participate.

643. Since 1999, a number of legal and health professionals, and other human rights defenders have worked to implement Istanbul Protocol standards in approximately 40 countries. This extensive practical experience has provided insight into the needs and challenges associated with State implementation of the Istanbul Protocol.[528] In 2012, four partner organizations (Physicians for Human Rights, the International Rehabilitation Council for Torture Victims, the Human Rights Foundation of Turkey and the Redress Trust) developed a series of practical guidelines – known as the "Istanbul Protocol Plan of Action" – for State implementation of the Istanbul Protocol. The Istanbul Protocol Plan of Action was recognized and supported by the United Nations High Commissioner for Human Rights in 2012[529] and the Special Rapporteur on torture in 2014.[530]

644. The guidelines of the Istanbul Protocol Plan of Action have been applied in a number of countries and have been instrumental in improving investigation and documentation practices regarding torture and ill-treatment. The guidance included in this chapter is based on the core elements of the Istanbul Protocol Plan of Action as well as the global, practical experience of those who have prepared and drafted the present edition of the Istanbul Protocol.[531] Such guidance is intended to aid States to implement Istanbul Protocol standards and strengthen the conditions necessary for effective legal and medico-legal investigation and documentation of torture and ill-treatment. This guidance is also intended to serve as a framework for accountability for State implementation of effective investigation and documentation practices.

A. Conditions for effective implementation of the Istanbul Protocol

645. During the past 20 years, those who have worked to implement Istanbul Protocol standards have learned that the effective legal and clinical investigation and documentation of torture and ill-treatment depends on a number of interdependent conditions that require progressive implementation. States should take steps to realize the conditions described below.

1. Official recognition of Istanbul Protocol standards

646. Torture and ill-treatment are violations committed by or at the instigation of or with the acquiescence of State officials. In order to achieve consistent accountability within relevant branches of government, it is essential that States, through legislative and administrative actions, officially recognize and institutionalize Istanbul Protocol standards among relevant departments and personnel, such as, prosecutors, lawyers, including court-appointed lawyers, judges, law enforcement, prison and military personnel, forensic and health professionals, and those responsible for detainee health care.

528 Haar and others, "The Istanbul Protocol: a stakeholder survey" (see footnote 7 in the introduction above), which provides the findings of a survey of 220 Istanbul Protocol stakeholders from 30 countries on the country conditions in which they work and reports of the challenges that they face.

529 Statement by the United Nations High Commissioner for Human Rights, Navanethem Pillay, on 24 February 2012.

530 A/69/387, paras. 56 and 74.

531 Vincent Iacopino and others, "Istanbul Protocol implementation in Central Asia: bending the arc of the moral universe", *Journal of Forensic and Legal Medicine*, vol. 69 (2020).

2. Political will

647. One of the most important conditions for the effective investigation and documentation of torture and ill-treatment is the necessary political will at the national level in all relevant government agencies to eradicate torture and ill-treatment, including commitments from actors within institutions such as law enforcement, security and counter-terrorism forces, forensic and medical services, the judiciary, prisons and government departments to implement administrative, legislative and judicial reform. Political will should be demonstrated through consistent, comprehensive and sustained action. Limited remedial actions, such as training for one or more target groups in the absence of other substantive policy reforms, represents an inadequate commitment on behalf of State actors and may even be a deliberate attempt to placate calls for effective remedial action. Evidence of the political will necessary to end torture practices often includes acknowledgement by the State of the nature and extent of torture and ill-treatment practices, a policy of "zero tolerance" as regards torture and ill-treatment, and a national plan of action that includes implementation of the Istanbul Protocol and is based on a comprehensive assessment of the nature and extent of torture and ill-treatment practices. The implementation guidance elaborated in this chapter may serve as a model for national plans of action. Ultimately, the measure of an effective policy to combat torture and ill-treatment will be the State's ability to prevent such crimes, to hold perpetrators accountable and to afford victims the redress that they deserve.

3. An effective criminal justice system

648. Criminal justice systems often face a wide range of challenges in effectively ensuring, inter alia:

(a) Fundamental safeguards during arrest and detention;

(b) Investigation and prosecution of torture and ill-treatment;

(c) Medico-legal evaluations of alleged victims;

(d) Law enforcement investigations of alleged crimes without relying on recourse to torture or ill-treatment as a means to obtain confessions;

(e) Legal defence of alleged victims;

(f) Prohibition of the use in any proceedings of evidence obtained as a result of torture or ill-treatment;

(g) Sanctions against perpetrators and those who are complicit;

(h) Measures to protect and promote the rights of persons deprived of their liberty with special needs;

(i) Systematic monitoring of practices that may amount to torture or ill-treatment;

(j) Accountability and follow-up by government officials when torture or ill-treatment is alleged;

(k) Procedural safeguards and mechanisms of accountability to address the possibility of reprisals against alleged victims;

(l) Redress, including rehabilitation, for victims of torture or ill-treatment.

649. The ability of a State to conduct effective investigations and documentation of torture and ill-treatment often depends on a functional criminal justice system, including legislation that makes torture and ill-treatment, defined in accordance with the Convention against Torture or other relevant international treaties,[532] a specific criminal offence, the existence of criminal procedure rules and rules of evidence that respect the rights of detained and accused persons, a demonstrated willingness and ability to eradicate corruption and formal and practical separation between law enforcement, medical personnel and judicial personnel. State forensic services should be independent of law enforcement, prosecution and/or military authority. Non-governmental clinicians should be empowered to assess physical and psychological evidence in accordance with Istanbul Protocol standards. The Istanbul Protocol and its Principles provide a normative framework for legal systems, particularly criminal justice systems, aiming at ensuring the prevention of torture and ill-treatment, accountability and redress.

532 States might adopt other definitions that provide more protection than article 1 of the Convention against Torture (e.g. the Inter-American Convention to Prevent and Punish Torture).

4. Adequate financial and human resources

650. States should ensure adequate financial and human resources to maintain progressive implementation of Istanbul Protocol standards and the conditions necessary for effective implementation, including qualified legal and medico-legal personnel and, in particular, an adequate number of health professionals with appropriate clinical qualifications (see paras. 303–308 above), including mental health clinicians, and a commitment to medical ethics. Ensuring such human resources usually requires sustained financial support over a number of years.

5. Good governance

651. The way in which States govern is relevant to achieving meaningful human rights reform. Torture and ill-treatment are acts of violence and represent the antithesis of good governance. According to OHCHR, good governance encompasses: "full respect of human rights, the rule of law, effective participation, multi-actor partnerships, political pluralism, transparent and accountable processes and institutions, an efficient and effective public sector, legitimacy, access to knowledge, information and education, political empowerment of people, equity, sustainability, and attitudes and values that foster responsibility, solidarity and tolerance".[533] In addition, "good governance is the process whereby public institutions conduct public affairs, manage public resources and guarantee the realization of human rights in a manner essentially free of abuse and corruption, and with due regard for the rule of law."[534] Good governance is not only critically important in the process of implementing Istanbul Protocol standards, it often serves as the remedy to the conditions that facilitate torture and ill-treatment. Successful remedial anti-torture actions, including implementation of the Istanbul Protocol, therefore depend on a Government's capacity for transparency, accountability, functional institutions, capacity-building, checks and balance of institutions of control, the rule of law, and active participation of civil society organizations, movements and leaders to engage with State actors.

6. Cooperation

652. Taking action to end torture and ill-treatment practices involves cooperation among national, regional and international institutions, including the United Nations and other multilateral organizations, and NGOs. Such cooperation depends greatly on the extent to which a State demonstrates the sustained political will necessary to end torture and ill-treatment practices. Such cooperation may be facilitated by agreements or conditioned on mutually agreed evidence of political will and sustained progress. Cooperation agreements and partnerships help to establish trust and a common understanding of challenges and the remedial action that needs to be taken. Such cooperation allows for a wide range of technical assistance activities, including identifying practices and policies that facilitate torture or ill-treatment, establishing an official national plan of action for the prevention of torture and ill-treatment, accountability and redress, comprehensive capacity-building of relevant target groups, and monitoring of the effectiveness of implementation efforts, including effective investigation and documentation practices regarding torture and ill-treatment.

7. Active civil society participation

653. Those who have worked to implement Istanbul Protocol standards understand from their collective global experiences that the State crimes of torture and ill-treatment are unlikely to change in the absence of active civil society participation. States that commit torture and ill-treatment often use State power to conceal these crimes and resist reform. States that are committed to ending torture and ill-treatment should welcome and facilitate the active engagement with civil society organizations, movements, professional organizations and leaders on action against torture, including implementation of the Istanbul Protocol. States should also encourage and support a national network of non-governmental clinicians to conduct clinical evaluations of alleged torture, review the quality and accuracy of State evaluations and participate in policy reform, capacity-building and public education activities. States should also ensure that non-State legal and clinical actors have appropriate access to all relevant information, such as case files, investigations and alleged victims, in medico-legal cases of alleged torture or ill-treatment as well as deaths in custody.

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533 See www.ohchr.org/EN/Issues/Development/GoodGovernance/Pages/AboutGoodGovernance.aspx.

534 See the good governance and human rights section of the OHCHR website (www.ohchr.org/en/good-governance). See also United Nations Development Programme, *Towards Human Resilience: Sustaining MDG Progress in an Age of Economic Uncertainty* (New York, 2011), chap. 8 on governance principles; and Council of Europe, "12 principles of good democratic governance" (2018).

B. Towards effective implementation of the Istanbul Protocol

654. Those who have worked to implement Istanbul Protocol standards have found it useful to envisage three complementary activities towards implementation – assessment, capacity-building and policy reform – that are applied in interdependent phases. It is important to note that successful implementation of activities within these phases does not require strict sequential application. Examples of successful implementation of the Istanbul Protocol have included, but are not limited to, the following phases of goals and activities.

1. Phase I

655. In the initial phase, torture prevention stakeholders typically face the challenges of developing a common understanding about the nature and extent of the problem of torture and ill-treatment, the importance of Istanbul Protocol standards and the need to establish functional partnerships. The primary goals of this phase include: (a) assessing prevailing country-specific conditions and challenges; (b) raising awareness about Istanbul Protocol standards among relevant government and civil society stakeholders; and (c) developing partnerships among government stakeholders, civil society and international human rights organizations.

2. Phase II

656. In the second phase, the primary goals involve the transfer of essential knowledge and skills, as well as taking steps to implement policy reforms. The specific goals in phase II include: (a) developing sustained capacity to use Istanbul Protocol standards to investigate and document alleged torture and ill-treatment among relevant target groups (State forensic experts, civil society clinical and forensic experts and other health professionals, prosecutors, lawyers and judges); (b) instituting policy reforms to ensure effective investigation and documentation of torture and ill-treatment; and (c) developing a national anti-torture plan of action that includes implementation of the Istanbul Protocol.

3. Phase III

657. After establishing a framework for sustained capacity-building and identifying the necessary remedial policy reforms, effective implementation usually requires the transfer of implementation activities to local civil society and State actors, institutionalization of Istanbul Protocol standards and practices and monitoring of the outcome of implementation efforts. The specific goals in phase III include: (a) transferring capacity-building and policy reform activities to local civil society and State actors; (b) integrating best practices into government and professional institutions; (c) enhancing regional networking and collaboration; and (d) monitoring the quality and accuracy of forensic and medico-legal evaluations of alleged torture or ill-treatment.

C. Legal, administrative and judicial reforms

658. In many countries, States practice torture and ill-treatment with impunity because legal and judicial systems do not have a normative framework and institutional safeguards in place to prevent violations and guarantee accountability and redress. In some instances, they have provisions that actually facilitate torture and ill-treatment. Criminal justice systems that rely heavily on confessions as primary evidence in court proceedings may intentionally or unintentionally facilitate torture and ill-treatment. In order for the investigation and documentation practices outlined in the Istanbul Protocol to be effective, States might need to carry out legal, administrative and judicial reforms, including defining and criminalizing acts of torture and ill-treatment in accordance with the obligations of the Convention against Torture and other relevant international treaties; ratifying and ensuring effective implementation of the Optional Protocol to the Convention against Torture and the establishment of national preventative mechanisms and other independent and effective monitoring bodies. States should further ensure the appropriate application of criminal statutes on torture and ill-treatment and that their application is not precluded by lesser statutes on the abuse of power by State officials or injuries caused by State officials or by imposition of administrative sanctions. In addition, States should ensure that rules of evidence exclude the admission of statements made under torture and ill-treatment and of all other evidence obtained as a result of such violations. One of the most effective ways to prevent false confessions under torture or ill-treatment is to require that the process of obtaining self-incriminating statements be conducted in the presence of a judge after the detainee has had independent legal counsel.

659. Torture and ill-treatment often occur in custody when States fail to ensure safeguards for persons deprived of their liberty and fail to have effective complaint mechanisms to address alleged abuses. States should take the necessary steps to ensure effective complaint mechanisms for individuals who allege torture or ill-treatment and protection from reprisals and/or intimidation. They should also ensure safeguards for persons deprived of their liberty by:

(a) Abiding by the Nelson Mandela Rules and other relevant United Nations standards;

(b) Informing people deprived of their liberty of their rights in a language that they understand;

(c) Guaranteeing prompt access to a lawyer of one's choice during all interrogations and judicial proceedings;

(d) Allowing prompt contact and visits by relatives and/or friends;

(e) Allowing regular visits by monitoring bodies;

(f) Guaranteeing prompt access to a judge ex officio in criminal proceedings and the right to habeas corpus in all proceedings;

(g) Allowing prompt consular access for those detained in a foreign State (a State that is not their State of nationality);

(h) Ensuring that no one is detained in any unrecognized or secret detention facility;

(i) Maintaining effective and accurate custody records;

(j) Prohibiting incommunicado and indefinite detention, including in unofficial places of detention;

(k) Prohibiting the use in any proceedings of evidence obtained as a result of torture or ill-treatment;

(l) Ensuring that interrogations are consistent with internationally recognized law enforcement practices;

(m) Adopting standard operating procedures for evaluating and reporting alleged torture or ill-treatment in detention, whether in civil or military settings, in accordance with Istanbul Protocol standards;

(n) Ensuring appropriate safeguards for special categories of detainees (women, juveniles, older persons, foreign nationals, ethnic minorities, lesbian, gay, bisexual, transgender and intersex persons, persons who are ill, persons with disabilities, persons with mental health problems or learning disabilities and other groups or individuals who may be particularly vulnerable during detention).

660. As described in paragraph 186 above, States have a duty to conduct prompt, impartial, independent, effective and thorough investigations of all allegations of torture or ill-treatment with the participation of victims during all phases of the investigations. Given the critical importance of medico-legal evidence of torture, States should implement a system of mandatory health evaluations of detained persons, including an initial health examination at the time of detention and every 24 hours thereafter; at the request of the detainee; and before transfers to other places of detention, including judicial remand.[535] Since torture and ill-treatment are crimes committed by or with the acquiescence of State officials, it is essential that States ensure the right of alleged victims to one or more health professionals of the detainee's choice for clinical evaluation at any time during or after being in custody, including in places of detention that require security clearance. Such evaluations by non-governmental clinicians must be admissible in court and given consideration equal to that of governmental medical experts.[536] Clinicians, both governmental and non-governmental, should have prompt access (within less than 24 hours) to alleged victims of torture or ill-treatment to assess physical and psychological evidence in accordance with Istanbul Protocol standards whether or not the individuals are in custody. States should ensure that all Istanbul Protocol procedural safeguards for medico-legal evaluations of alleged torture or ill-treatment are codified into national law, including codes of criminal procedure and forensic and health law (see paras. 312–315 above).

661. States should develop a strong legal framework to provide reparation for torture and ill-treatment, including civil proceedings that are independent of the outcome of any criminal proceedings,

535 As such evaluations are an obligation of States, the cost of mandatory health evaluations should be borne by them.

536 While NGOs, clinicians and health professionals are not obliged under international law to produce evaluations in accordance with the Istanbul Protocol, they are greatly encouraged to do so. In addition, alleged victims reserve the right to decide whether to submit evidence and the types thereof.

and the right of victims to rehabilitation. This should include effective procedural remedies, both judicial and non-judicial, to protect the right of victims to be free from torture and ill-treatment in law and practice and to provide reparation and rehabilitation for torture and ill-treatment committed against them. Domestic law should provide for the different forms of reparation recognized under international law and the reparations afforded should reflect the gravity of the violation(s).

662. States should ensure that all relevant personnel (law enforcement officials, prison officials, State forensic experts and other health professionals, prosecutors, lawyers and judges) receive training on effective legal and clinical investigation and documentation of torture and ill-treatment and that law enforcement personnel receive specific training on internationally accepted interrogation methods and effective measures to prevent torture and ill-treatment. Training of relevant target groups should be included in the relevant professional curricula, as well as specific training courses and continuing education for those already practising in their fields. Lawyers, prosecutors and judges should have specific knowledge and training on the Istanbul Protocol and its Principles, particularly the guidance on legal investigations of torture and ill-treatment and relevant medico-legal issues, such as an understanding of the content of medico-legal evaluations of alleged torture and ill-treatment, as described in chapters IV, V and VI and annexes I and IV, and the qualifications necessary for clinical expert witness testimony (see paras. 303–308). Lawyers, prosecutors and judges should also have specific knowledge and training on the exclusionary rule (see paras. 10 (i), 16 and 264 above) under which evidence obtained as a result of torture or ill-treatment is excluded from use in legal proceedings. In addition, government officials should be trained to recognize and respond appropriately to allegations of torture or ill-treatment. Those who have worked to implement Istanbul Protocol standards have developed a number of general and specific training materials for relevant legal and clinical professionals.

663. States should also ensure respect for legal and medical ethical duties as described in chapter II. These include, among others, non-participation by health professionals in any form of interrogation practices and compulsory documentation and reporting requirements when torture or ill-treatment is alleged or suspected. Health professionals are also prohibited from having any role in the imposition of disciplinary sanctions or other restrictive measures.

D. State forensic and health profession reform

664. The obligations of States under international law to effectively investigate allegations of torture or ill-treatment require States to ensure effective policies, practices and capacities for the effective investigation and documentation of torture and ill-treatment by State-employed forensic experts and clinicians. This State obligation also extends to the support of non-governmental clinicians given the critical importance of independence and impartiality in achieving accountability for State crimes, such as torture and ill-treatment. In addition, victims of torture have the right to have access to independent health professionals and clinical experts and may not trust or wish to avail themselves of State services since torture is a crime committed by the State.

665. State-employed forensic experts and clinicians may encounter victims of torture or ill-treatment in medico-legal and other clinical or institutional settings. In all settings, they have a duty to effectively investigate and document clinical evidence of torture or ill-treatment in accordance with Istanbul Protocol standards. State forensic institutions and health agencies need to review and reform policies and practices that are not consistent with Istanbul Protocol standards, ensure safeguards for effective evaluations, provide adequate training and support to all relevant health professionals and ensure respect for relevant ethical principles.

666. One of the most significant problems in implementing Istanbul Protocol standards is the lack of independence of State-employed health professionals. Since torture and ill-treatment are State crimes and State-employed forensic experts and clinicians are under the authority of State officials, these health professionals may experience and/or perceive pressure to ignore or misrepresent clinical evidence of torture or ill-treatment. This should never be tolerated by forensic institutions and health agencies as the failure to document and denounce torture and ill-treatment is considered a form of complicity by WMA (see para. 155 above). States, particularly their forensic institutions and health agencies, are responsible for ensuring an environment wherein all forensic evaluations can be conducted independently, scientifically and ethically. In order for States to meet

their obligation to effectively investigate allegations of torture or ill-treatment, forensic and clinical services must be independent of law enforcement, prosecution and/or military authority. While this may require significant administrative changes, the importance of clinical independence cannot be overstated.

667. Independent State forensic institutions and health agencies should be vested with the authority and funds to train and oversee provision of medico-legal and other relevant clinical evaluations and have adequate financial and human resources to conduct effective medico-legal evaluations of alleged torture or ill-treatment, including: qualified personnel/consultants; professional interpreters; medical and photographic equipment; access to diagnostic imaging and laboratory tests; and adequate time to conduct their evaluations. States should not prohibit or obstruct the establishment of non-governmental forensic or medico-legal services; nor should they have the authority to qualify or disqualify non-governmental forensic experts or clinicians.

668. State forensic institutions and health agencies should ensure that medico-legal evaluations of alleged torture and ill-treatment are conducted promptly (immediately and not later than 48 hours from the time that torture or ill-treatment is alleged or documented in an initial clinical evaluation)[537] and objectively by qualified, independent governmental experts to assess physical and psychological evidence in accordance with Istanbul Protocol standards. They should require their forensic experts and health professionals to investigate all allegations of torture or ill-treatment and cases in which torture or ill-treatment is suspected, even in the absence of a specific legal complaint or request. State forensic institutions and health agencies should ensure that forensic and clinical evaluations of alleged victims of torture or ill-treatment are conducted in accordance with the Istanbul Protocol and its Principles. In order to ensure compliance with Istanbul Protocol standards, States should consider requiring the use of standardized evaluation report forms that are based on the Istanbul Protocol and its Principles.

669. State forensic agencies and health agencies should ensure that procedural safeguards for the effective medico-legal documentation of alleged torture and ill-treatment are included in domestic law, relevant regulations and standard operating procedures for all health personnel who evaluate or may encounter alleged victims of torture or ill-treatment.

670. State forensic institutions and health agencies should respect and facilitate the right of individuals to be evaluated by one or more non-governmental health professional(s) of their choosing anytime during or after being in custody. States must inform an alleged victim of this right and provide referral information to other health professionals if requested to do so by the alleged victim.

671. States should provide training on the effective investigation and documentation of torture and ill-treatment. State forensic institutions and health agencies should ensure that all relevant personnel receive training on the Istanbul Protocol and its Principles. This not only includes State forensic experts, but all clinicians who may encounter alleged victims of torture or ill-treatment. As noted in chapters IV and VII, health professionals may encounter victims of torture or ill-treatment in non-medico-legal contexts in which the primary purpose of the evaluation is related to health status or health care. Training on the Istanbul Protocol for health professionals should be comprehensive and include all aspects of clinical evaluations, in particular: essential interview conditions and skills; clinical qualifications; procedural safeguards for such evaluations; the content of a complete evaluation, including physical and psychological evidence; guidance on the interpretation of findings and conclusions; and limitations of the Istanbul Protocol and potential misuse. In addition, forensic experts and clinicians should receive specific training on relevant ethical obligations, including resisting institutional pressures that conflict with their ethical obligations to patients and alleged victims of torture or ill-treatment. State institutions should also ensure support systems for clinicians to follow their ethical obligations and pathways for them to report concerns.

672. Effective training of health professional groups can be achieved through interactive classroom training, usually under the leadership of highly experienced, independent national or international trainers, followed by individual mentoring and supervision of forensic experts and clinicians in real-life settings. This approach is typically enhanced by implementing extended "training of trainers" courses to amplify the initial training efforts. The effectiveness of training on the Istanbul Protocol is also enhanced by

537 This time frame is based on the necessity of identifying and preserving clinical evidence of torture or ill-treatment, particularly physical evidence, which may resolve over time.

training health and legal professionals together – as interactions among different target groups (State forensic experts, other health and mental health professionals, prosecutors, lawyers and judges) aids in the development of a common understanding of investigation and documentation norms and procedures, and the respective roles and challenges that each group experiences. Furthermore, the participation of health and legal professionals from civil society in the training of State officials often enriches the training experience and enables such officials and members of civil society to work towards common goals.

673. Independent, non-governmental clinicians play a critical role in the effective investigation and documentation of torture and ill-treatment. While they do not act on behalf of the State, their capacity to independently and impartially document torture and ill-treatment is often essential to the State in fulfilling its obligation to ensure the effective investigation and documentation of torture and ill-treatment and its prevention, accountability and redress and rehabilitation. States can and should support non-governmental clinicians as much as possible, including by ensuring training, facilitating evaluations of alleged torture and ill-treatment by non-governmental clinicians, ensuring that equal weight is given to their medico-legal evaluations in judicial proceedings and supporting relevant capacity-building and networking efforts.

E. Implementation of the Istanbul Protocol: monitoring and accountability

674. It is essential to monitor implementation efforts and measure meaningful outcomes in order to evaluate the effectiveness of efforts to eradicate torture and ill-treatment, or the lack thereof. State monitoring of State officials' conduct is often ineffective and, in some countries, used as a means of concealing torture and ill-treatment practices. For this reason, it is essential that independent bodies monitor implementation of the Istanbul Protocol and the findings of monitoring activities should be publicly reported to ensure accountability for State crimes. States should mandate and support an independent monitoring body to monitor the implementation of Istanbul Protocol standards and the conditions necessary for effective investigation and documentation of torture and ill-treatment.

675. The organizational structure of an independent monitoring body may be informed by the guidelines on national preventive mechanisms.[538] Presently, existing independent bodies may already have a role in monitoring progress in using the Istanbul Protocol standards in domestic contexts. Regardless of the organizational structure, the establishment of an independent monitoring body should follow the Paris Principles to ensure the independence, legitimacy and credibility of the monitoring body. Whether monitoring functions are conducted by or within existing national human rights institutions (such as a national commission on human rights, ombudsperson's office or other similar institutions) or a new and separate body, the participation of civil society is essential, and the selection of civil society representatives should be inclusive and transparent.

676. Monitoring functions should include but are not limited to: compliance with conditions for effective implementation of the Istanbul Protocol (see paras. 645–653 above), development of standards, procedures and structures for legal and health professions and training of relevant legal and health professionals. The independent monitoring body should also monitor ongoing functioning of the national documentation system, including overall performance of the documentation system, individual access to prompt, independent, impartial and effective investigation and documentation of allegations of torture or ill-treatment, and torture and ill-treatment practices based on disaggregated data collected in a national documentation system. An independent monitoring body may consider establishing subsidiary medical and legal advisory committees composed of independent experts to provide technical assistance to the independent monitoring body in executing monitoring activities and providing opinions and recommendations for action.

677. An independent monitoring body should seek to provide systematic accountability for torture and ill-treatment in the form of recommendations and guidance on specific issues of concern to professional groups and subgroups, such as capacity-building and policy reforms. Such an independent monitoring body should seek to ensure individual, professional

538 CAT/OP/12/5; and Association for the Prevention of Torture and the Inter-American Institute for Human Rights, *Optional Protocol to the UN Convention against Torture: Implementation Manual*, revised ed. (Geneva, 2010), pp. 85–103.

accountability through professional accountability proceedings initiated against individuals by the relevant professional bodies, such as bar associations, national medical and psychological associations, and judges' associations. In situations in which an independent monitoring body finds that individuals have performed their duties in violation of national criminal law or other relevant legislation (in either case where such legislation is consistent with international legal standards), or ethical or professional rules, recommendations for disciplinary or criminal investigations or proceedings should be initiated by the relevant authorities and professional bodies and licensing agencies.

678. States should encourage and support the monitoring activities of United Nations anti-torture and other human rights bodies, regional anti-torture and human rights bodies and international and domestic human rights organizations in order to effectively monitor and hold State officials accountable for torture and ill-treatment practices.

679. States should ensure that their whistle-blower protection policies cover medico-legal and health personnel who report the findings of their evaluations of alleged torture and ill-treatment. States should also ensure the protection of witnesses and of any official or individual who reports a case of alleged torture or ill-treatment and sanction non-reporting of torture or ill-treatment by officials in situations in which confidential channels of reporting exist.

F. Cooperation, coordination and technical assistance

680. State cooperation, coordination and technical assistance with external actors is critical to the successful implementation of Istanbul Protocol standards and relevant conditions given the responsibility of State actors for crimes of torture and ill-treatment. States should coordinate activities to implement the Istanbul Protocol in cooperation with the assistance of multilateral institutions – such as the United Nations, particularly OHCHR, the Committee against Torture, the Special Rapporteur on torture, the Subcommittee on Prevention of Torture, the Special Rapporteur on violence against women, ICRC, regional human rights bodies, such as the European Committee for the Prevention of Torture and the Organization for Security and Cooperation in Europe – and with experienced NGOs and other States.

681. States should also provide foreign assistance for implementation of the Istanbul Protocol on the basis of support for development, the rule of law, security, cooperation, democratization and nation-building, particularly in emerging democracies and in the aftermath of long-standing torture and ill-treatment practices.

G. Civil society

682. While States have the primary responsibility for implementing Istanbul Protocol standards and the conditions necessary for the effective investigation and documentation of torture and ill-treatment, civil society often plays the most critical role in facilitating implementation of the Istanbul Protocol. During the past 20 years, members of civil society have played a key role in the implementation of Istanbul Protocol standards. In a recent survey[539] of 220 Istanbul Protocol stakeholders from 30 countries, participants reported using the Istanbul Protocol in a broad range of activities related to the investigation and documentation of torture and ill-treatment and its prevention, accountability, and redress and rehabilitation, as well as awareness-raising and advocacy. Most respondents utilized the Istanbul Protocol for advancing public knowledge, compelling investigations, promoting the Istanbul Protocol in national laws and policy reform, campaigning and awareness-raising, and in legal investigations and medico-legal evaluations of alleged torture or ill-treatment. The Istanbul Protocol was also used as an intake tool for medical and mental health treatment and rehabilitation. Other uses included research, education and screening or documenting other traumatic experiences, such as child abuse or domestic violence. Members of civil society have also played a key role in monitoring and promoting implementation of the Istanbul Protocol and in training State institutions, and worked to ensure that capacity-building efforts also include and benefit civil society, that clinicians in civil society conduct clinical evaluations of alleged torture or ill-treatment and that clinical evidence

539 Rohini Haar and others, "The Istanbul Protocol: a global stakeholder survey on past experiences, current practices and additional norm setting", *Torture*, vol. 29, No. 1 (2019), pp. 70–84.

documented by independent, non-governmental clinicians is accepted in judicial proceedings.

683. As previously stated, States can and should encourage and support collaboration with civil society in their remedial anti-torture actions, but members of civil society should not only rely on State initiatives to take independent remedial action. Members of civil society, including human rights experts, lawyers and health professionals, should organize and work together with international and regional human rights bodies and organizations to develop the necessary capacities within civil society to implement Istanbul Protocol standards and other anti-torture activities. This includes applying the Istanbul Protocol and its Principles in legal and medico-legal investigation and documentation of alleged torture and ill-treatment in individual cases; using Istanbul Protocol standards as a framework to hold States accountable for effective investigation and documentation practices, including establishing the conditions necessary for implementation of the Istanbul Protocol; carrying out effective legal, judicial and administrative reforms; ensuring the independence of State forensic institutions and health agencies; establishing effective monitoring activities; and facilitating cooperation, coordination and technical assistance between States and external actors. Special attention should be given to developing relevant psychological expertise that may be lacking in civil society. In States in which torture and ill-treatment are practised with impunity, the provision of rehabilitation services typically falls on civil society organizations given the lack of trust in government institutions. Rehabilitation services in many countries serve as focal points for a wide range of anti-torture activities and should be supported for the key role that they play in the investigation and documentation of torture and ill-treatment and its prevention, accountability and redress.

GLOSSARY

ABUSE	any form of physical or psychological ill-treatment.
ALLEGED VICTIM	an individual who claims and/or is suspected to have been harmed by a wrongful act.
CHAIN OF CUSTODY (OF AN EXHIBIT)	a process enabling the complete history of the custody of an exhibit to be tracked and recreated from the time that it was first secured until the present time.
CLINICIAN	a health professional who provides health-care services and/or conducts clinical evaluations of alleged torture and ill-treatment.
CLINICAL EVALUATION	an assessment of physical and/or psychological evidence of alleged torture and/or ill-treatment by a clinician.
CLINICAL EVIDENCE	physical and/or psychological findings relevant to cases of alleged or suspected torture and/or ill-treatment.
CLINICAL FINDINGS	information collected in clinical evaluations of physical and/or psychological evaluations relevant to alleged torture and ill-treatment.
DETAINEE	any person deprived of liberty except as a result of conviction.
DSM	*Diagnostic and Statistical Manual of Mental Disorders*.
FORENSIC	relating to or dealing with the application of scientific and clinical knowledge to legal issues or the law.
FORENSIC DOCTOR/ PHYSICIAN/EXPERT	for the purposes of this document, a medical doctor/expert who applies scientific and clinical knowledge to legal issues or the law.
HEALTH PROFESSIONAL	any person who has completed a course of study in a field of health. The person is usually licensed by a government agency and/or certified by a professional organization.
ICD	International Classification of Diseases and Related Health Problems.
ILL-TREATMENT	as defined by the Convention against Torture, any form of cruel, inhuman or degrading treatment or punishment.
IMPLEMENTATION OF THE ISTANBUL PROTOCOL	refers to the process of establishing the conditions necessary for effective investigation and documentation of torture and ill-treatment.
INFORMED CONSENT	the process by which an individual learns about and understands the purpose, benefits and potential risks of a (clinical) procedure, including clinical evaluations of alleged torture or ill-treatment, and then agrees to the procedure.
ISTANBUL PRINCIPLES	provisions articulated in annex I of the Istanbul Protocol on the effective investigation and documentation of torture and ill-treatment.
ISTANBUL PROTOCOL STAKEHOLDERS	refers to individuals, groups, organizations and institutions involved in or affected by the effective investigation and documentation of torture and ill-treatment.
MEDICAL	of or relating to the science or practice of medicine, including physical and psychological aspects of medical practice.
MEDICAL/CLINICAL EXPERT WITNESSES	health professionals who serve as expert witnesses in legal proceedings on the basis of professional knowledge and skill and their capacity to apply the Istanbul Principles and guidelines in clinical evaluations of alleged torture and ill-treatment.
MEDICO-LEGAL	relating to that branch of medicine that relates to the law or legal contexts.

MEDICO-LEGAL EVALUATION	a clinical evaluation of possible physical and psychological evidence of torture and/or ill-treatment in legal contexts. Such evaluations may be conducted both by clinicians that are employed within or outside of State institutions.
MEDICO-LEGAL REPORT	a report of the physical and/or psychological findings of a medico-legal evaluation.
MENTAL HEALTH CLINICIANS	health professionals with specific mental health training and/or certification, such as psychologists, psychiatrists, social workers, psychiatric nurses and mental health counsellors.
NGO	non-governmental organization.
OHCHR	Office of the United Nations High Commissioner for Human Rights.
PERSONS DEPRIVED OF THEIR LIBERTY	persons who have been arrested or are in detention or imprisonment or any other custodial setting that they are not permitted to leave at will.
PRISONER	The term used in the context of the Nelson Mandela Rules to refer broadly to persons deprived of their liberty in penal institutions whether criminal or civil, untried or convicted, including those subject to "security measures" ordered by a judge.
PROFESSIONAL ETHICS	moral principles that govern the behaviour and activities of members of a particular profession.
PSYCHOLOGICAL (OR PSYCHIATRIC) EVALUATION	a clinical assessment of possible psychological consequences of torture or ill-treatment.
PHYSICAL FINDINGS	information that is derived from the clinical evaluation of an alleged victim of torture or ill-treatment, which typically includes relevant symptoms and disabilities, signs and symptoms noted on physical examination, diagnostic test results, photographic evidence, and relevant medical reports, among others.
RETRAUMATIZATION	refers to traumatic stress reactions (emotional and/or physical) triggered by exposure to memories or reminders of past traumatic events.
SEQUELA (PLURAL, SEQUELAE)	conditions (findings and/or symptoms) that are the consequence of a previous disease or injury.
TORTURE	as defined in article 1 of the Convention against Torture, "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."
TORTURE AND ILL-TREATMENT	refers to torture and other cruel, inhuman or degrading treatment or punishment.
VICARIOUS (OR SECONDARY) TRAUMA	psychological impact in the self of an individual working with victims of trauma that results from empathic engagement with traumatized clients and their reports of traumatic experiences.
VICTIM (OR SURVIVOR) OF TORTURE AND/OR ILL-TREATMENT	an individual who has experienced physical and/or mental harm through acts or omissions that amount to torture and/or ill-treatment.

ANNEX I

Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[1]

1 The Commission on Human Rights, in its resolution 2000/43, and the General Assembly, in its resolution 55/89, drew the attention of Governments to the Istanbul Principles and strongly encouraged them to reflect thereupon as a useful tool in efforts to combat torture.

1. The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter "torture or other ill-treatment") include the following:

(a) Clarification of the facts and establishment and acknowledgement of individual and State responsibility for victims and their families;

(b) Identification of measures needed to prevent recurrence;

(c) Facilitation of prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2. States shall ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation shall be undertaken if there are other indications that torture or ill-treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission investigations by, impartial clinical or other experts. The methods used to carry out such investigations shall meet the highest professional standards and the findings shall be made public.

3. **(a)** The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.[2] The persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence.

(b) Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as those conducting the investigation.

4. Alleged victims of torture or ill-treatment and their legal representatives shall be informed of, and have access to, any hearing, as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5. **(a)** In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse or for other substantial reasons, States shall ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles.[3]

(b) A written report, made within a reasonable time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. Upon completion, the report shall be made public. It shall also describe in detail specific events that were found to have occurred and the evidence upon which such findings were based and list the names of witnesses who testified, with the exception of those whose identities have been withheld for their own protection. The State shall, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

6. **(a)** Clinical experts involved in the investigation of torture or ill-treatment shall behave at all times in conformity with the highest ethical standards and, in particular, shall obtain informed consent before any examination is undertaken. The examination must conform to established standards

2 Under certain circumstances, professional ethics may require information to be kept confidential. These requirements should be respected.
3 Under certain circumstances, professional ethics may require information to be kept confidential. These requirements should be respected.

of clinical practice. In particular, examinations shall be conducted in private under the control of the clinical expert and outside the presence of security agents and other government officials.

(b) The clinical expert shall promptly prepare an accurate written report, which shall include at least the following:

(i) Circumstances of the interview: name of the subject and name and affiliation of those present at the examination; exact time and date; location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g., detention centre, clinic or house); circumstances of the subject at the time of the examination (e.g., nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner or threatening statements to the examiner); and any other relevant factors;

(ii) History: detailed record of the subject's account of events as given during the interview, including alleged methods of torture or ill-treatment, times when torture or ill-treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

(iii) Physical and psychological examination: record of all physical and psychological findings on clinical examination, including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(iv) Opinion: interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment and/or further examination shall be given;

(v) Authorship: the report shall clearly identify those carrying out the examination and shall be signed.

(c) The report shall be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process shall be solicited and recorded in the report. It shall also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report shall not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such a transfer.

ANNEXE II

Guidelines for documenting torture and ill-treatment of children

While the Istanbul Protocol and its Principles apply to children, there are additional considerations to be aware of and practice guidelines that should be implemented to ensure that investigation and documentation of torture and ill-treatment of children is done effectively. This edition of the Istanbul Protocol includes additional updates and clarifications on the documentation of torture and ill-treatment of children in each chapter. This annex serves as a summary of that chapter-based content, but not as comprehensive guidance for such evaluations.

I. Considerations for documenting torture and ill-treatment of children

A. Definition

Article 1 of the Convention on the Rights of the Child defines a child as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". The Office of the United Nations High Commissioner for Refugees (UNHCR) also understands that the definition of "child" includes a wide range of developmental stages and levels of maturity.[1] Despite their special place in most societies and universally recognized vulnerable status, children around the world experience or witness torture and ill-treatment.

B. Legal considerations

The Convention on the Rights of the Child states that: "No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment."[2] Several other United Nations treaties and regional human rights systems address children and their rights. United Nations treaties include the International Covenant on Civil and Political Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (art. 10); and the Convention on the Rights of Persons with Disabilities (art. 15). Regional treaties include the Convention for the Protection of Human Rights and Fundamental Freedoms; the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (art. 3); the American Convention on Human Rights (art. 5 (2)); and the African Charter on Human and Peoples' Rights (art. 5). In a report to the Human Rights Council, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, stated that when considering torture and ill-treatment of children separately from adults, "the threshold at which treatment or punishment may be classified as torture or ill-treatment is therefore lower in the case of children", especially in cases in which they are deprived of their liberty or are unaccompanied[3] (see para. 382 above). In addition to international treaties and customary international law governing the rights of the child, there are often country-specific legal frameworks and rules regarding child protection and safeguarding that must be considered in conducting clinical evaluations.

C. Psychological considerations

The effects of torture and ill-treatment need to be considered in the context of the psychological and physical developmental stages of children and adolescents. While torture and ill-treatment have both physical and psychological consequences on all individuals, the effects on children and adolescents can potentially lead to more long-term and far-reaching changes in the course of their psychological and physical development.

Developmental factors should always be considered in clinical evaluations of torture and ill-treatment of children. Estimates of the age at which children become capable of accurate recall of events vary greatly, and range between the ages of 3–6 and 14–15.[4] Furthermore, the ability of children to recount events and establish coherent narratives is affected by cognitive and language abilities, and social and cultural contexts (see paras. 284–293 above). Nonetheless, information that is valuable and truthful can be obtained from children of varying ages.

The younger the children, the more their experiences and understanding of the traumatic events will be influenced by the immediate reactions and attitudes

1 UNHCR, *The Heart of the Matter, Assessing Credibility when Children Apply for Asylum in the European Union* (Brussels, 2014), p. 21.
2 Convention on the Rights of the Child, art. 37 (a).
3 A/HRC/28/68, para. 33. See also, ibid., para. 17.
4 Linda Sayer Gudas and Jerome M. Sattler, "Forensic interviewing of children and adolescents", *Forensic Mental Health Assessment of Children and Adolescents*, Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 115–128.

of caregivers.[5] For children under the age of 3 who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.[6] Children older than 3 but less than 8 often tend to withdraw and find it impossible to speak directly about traumatic experiences. The ability for verbal expression increases during development with a marked increase around 8 to 9 years old. At this time and even before, concrete operations and temporal and spatial capacities develop.[7] Adolescence is a volatile developmental period when the effects of torture and ill-treatment can vary widely and may cause profound behavioural changes, including erratic reactions similar to those seen in younger children as well as those seen in adults, for example anger, depression and painful memories (see paras. 575 and 584–594 above).

Children's ages and development – as well as the repeated traumas that they experience, separation from the family at a young age or the family's attitude about sharing the experiences, mental health and pre-existing difficulties, such as learning disabilities – can affect children's understanding of events and their ability to recall events and communicate experiences.

D. Family considerations

It is important to consider factors that affect the family and the child (e.g. physical separation between family members, threats to family members, bereavement, witnessing the torture or death of family members, loss of social and economic status, discrimination, forced displacement, racism, and experiences and beliefs related to seeking support) and the social and political contexts. Parents who are torture survivors may experience shame and guilt, fearing that the intensity of their own feelings about their trauma could overwhelm their children.[8]

Parents of children who were tortured may also experience guilt over their inability to protect their children, and their parenting may be affected by feelings of helplessness, which can be reinforced in violent and oppressive environments. Such environments may also damage adolescents' perception of their parents' authority. Furthermore, in order to preserve cohesion in the family, a child may be overly protected or important facts about the trauma may be hidden.

E. Ethical issues

1. Safeguarding children and duty of care

When working with children and young persons it is important to remember that: "Organisations have a duty of care to children with whom they work, are in contact with, or who are affected by their work and operations."[9] The principle of safeguarding children includes ensuring that children are protected from harm and that any risk of harm is identified and addressed immediately. Safeguarding includes the prevention of further torture or ill-treatment, recommendations for recovery and reintegration, reduction of exposure to experiencing or witnessing violence, and access to appropriate and confidential medical and psychological follow-up care.[10] If the assessment is recorded, particular caution should be given to keeping the recording confidential, with limited access given only to the assessment team, and to protecting the child's identity. Local legal data protection requirements should be adhered to.

2. Informed consent

Children should be provided in advance with full information about any assessment or procedure. Information on procedures needs to be tailored to children and their developmental stages and communicated in ways that they can understand. Children should be given the opportunity to consent or assent to any evaluation or procedure. In younger children, this process will also normally involve seeking consent from their parents or legal guardians; however, in all cases, consideration for safeguarding the child's best interests should be paramount and include deliberation on the possibility of harm by family members. The age at which children can provide independent consent without the need to inform their parents or legal guardians varies across countries and jurisdictions and so local legal and ethical guidelines should be considered before seeking independent

5 Saskia von Overbeck Ottino, "Familles victimes de violences collectives et en exil: quelle urgence, quel modèle de soins? Le point de vue d'une pédopsychiatre", *Revue française de psychiatrie et de psychologie médicale*, vol. 14 (1998), pp. 35–39.

6 Michel Grappe, "La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés", in *Psychiatrie humanitaire en ex-Yougoslavie et en Arménie: face au traumatisme*, Marie Rose Moro and Serge Lebovici, eds. (Paris, Presses universitaires de France, 1995), pp. 89–106.

7 Jean Piaget, *La naissance de l'intelligence chez l'enfant*, 9th ed. (Neuchâtel, Delachaux et Niestlé, 1977).

8 Center for Victims of Torture, *Healing the Hurt: A Guide for Developing Services for Torture Survivors* (Minneapolis, 2005), chap. 2.

9 Keeping Children Safe, *Child Safeguarding Standards and How to Implement Them* (2014), p. 10.

10 Convention on the Rights of the Child, art. 39.

informed consent (see paras. 165–171 and 273). Clinicians should also take into consideration possible obligations to report to the relevant authorities when a child is in danger or has been exposed to violence or abuse of any kind and that the failure to do so, by the health professional or others who observe or are informed of such violence or abuse, may lead to criminal investigation and/or sanctions by professional associations or licensing agencies.

II. Interviewing and evaluation process

A. Training

Appropriate training on interviewing and examining children who were tortured or ill-treated is important and ideally should be completed by anyone who will be involved in evaluating and documenting children's experiences. The training should cover specific interview techniques and procedures that safeguard children's well-being and protect them from retraumatization, and provide guidance on how to collect information from children reliably based on their developmental stage. There are several national and international guidelines and training protocols in this area, including those drawn up by the National Institute of Child Health and Human Development,[11] UNHCR,[12] Defence for Children International[13] and the American Professional Society on the Abuse of Children.[14]

B. Setting

1. Time

A single lengthy interview may be overly exhausting for children and as their attention spans can be quite short (depending on their developmental stage, level of trauma and co-morbid conditions), it may be necessary to take breaks during the interview or conduct it over multiple sessions.

2. Presence of trusted adults and support during assessment

Children should be supported by persons whom they trust whenever possible and fear of contaminating witness evidence should not be a reason for isolating children from positive and supportive adult contact; the child's well-being and best interests must be paramount at all times. The presence of parents/legal guardians or other supportive adults in the assessment should be considered, unless they are not available or are themselves not representing the child's best interests. The presence of adults who are meaningful to the child and represent the child's best interests will provide comfort to an anxious child and also allow the adult to tacitly endorse the child's cooperation. In some cases, such as those involving sexual violence, domestic violence or issues arising from perceived sexual orientation and/or gender identity or expression, the presence of family members might make it more difficult for children to disclose these experiences for fear of bringing shame, stigmatization or further ill-treatment or punishment on themselves or their families. Children may not disclose in the presence of a parent due to their concern that the disclosure will distress their parents or add to their guilt or shame. Clinicians must exercise judgment and patience in making the child comfortable and support them when being interviewed alone. Clinicians may need to consider children's wishes to keep information that they disclose confidential from their parents and how to address this ethically. In circumstances in which children or teenagers are interviewed in the absence of their parents or guardians, care must be taken to ensure their understanding of, and consent to, the interview. Particular attention must be given to providing support, such as taking time to build rapport, using clear and age-appropriate language throughout and providing breaks and opportunities to ask questions.

C. Collecting information

1. Building rapport and establishing trust

Taking time to build trust and rapport will make it easier for interviewees of all ages, including children, to talk about difficult topics. However, the

11 United States of America, National Institute of Child Health and Human Development, "Revised NICHD Protocol: interview guide" (2014).
12 UNHCR, *Guidelines for Interviewing Unaccompanied Minors and Preparing Social Histories* (1985).
13 Defence for Children International – Belgium, *Practical Guide: Monitoring Places Where Children are Deprived of Liberty* (Brussels, 2006).
14 American Professional Society on the Abuse of Children Taskforce, "Practice guidelines: forensic interviewing in cases of suspected child abuse" (Columbus, 2012).

establishment of trust can be challenging, as the child may experience the interview situation or elements of it as reminiscent of the torture or ill-treatment. Trust may be undermined or lacking if evaluators or interpreters are perceived as representing the political, ethnic or social groups whose authorities have initiated or participated in the torture or ill-treatment. These factors may affect the trust of parents and guardians as well. Trust can be enhanced or established if interviewers or interpreters come from the child's own culture or ethnic group.[15] Age-related developmental factors, such as an adolescent's self-assertion, should be considered in the establishment of trust as well. Some techniques that can facilitate initial positive rapport include informal and comfortable room settings (e.g. lighting, child-friendly design, temperature, age-appropriate seating and background noises) and explaining the setting and process (e.g. how long will the interview take, noting that breaks are allowed). As mentioned in paragraph 272 above, open body language, attentiveness, active listening and empathy are all important in building and maintaining trust and rapport. As is the case with adults, it is important for examiners to ask directly about issues a child or an adolescent may not otherwise feel safe to disclose, e.g. sexual or domestic violence, suicidal impulses, perceived or actual gender identity or expression or sexual orientation. It is important to remember that in all cultures the development of self-awareness of one's own sexual orientation and gender identity takes place over time, often years or decades and that, in areas in which minority sexual and gender identities are met with violent repression, such self-awareness may have been suppressed. Some interviewees who are very young may be puzzled about why they have been ill-treated in the first place. Language and vocabulary are also important, especially when discussing issues related to sexuality and gender expression. Examiners and interpreters should be sensitive to the lack of neutral or positive names for descriptions of diverse sexual and gender presentations and behaviours in many cultures and languages. They should be knowledgeable of and take steps to mitigate internalized homophobia and transphobia in interviewees and in themselves.

Building rapport with children can be facilitated by taking measures to ensure that the environment and tone of the interview is non-threatening and as informal as possible. Interviewers should use child-appropriate language and adapt their communication style to match local terminology and cultural norms to help the child feel at ease and engage in the interview process. Starting interviews by encouraging children to talk about a neutral topic can create opportunities to build rapport and convey a sense of safety and security, and enable interviewers to get to know the children, their verbal abilities, and their degree of relational (un)ease.[16] After explaining the purpose and content of the evaluation and only when the child is talking at ease should the interview progress to more sensitive topics, and interviewers should understand that it may take some time for children to become sufficiently comfortable talking.[17]

2. Communication and techniques

Open questions should be used where possible, as these allow individuals of all ages to respond in their own words. However, children tend to provide less information than adults and so probing questions can be helpful. Children are particularly susceptible to leading questions that suggest a desirable response and so leading questions and closed-ended questions should be avoided wherever possible. Letting children know that it is acceptable to say "I do not know" to indicate when they do not understand a question will also help improve accuracy.

Children typically provide less information than adults. This is partly because they are less capable of, and less skilled at, generating retrieval cues independently. Techniques such as drawing, body diagrams and the use of timelines can all help children generate memory cues that, in turn, should help them remember additional details. Caution should be employed when interpreting children's non-verbal communication such as play, as this is not necessarily a literal account of events and may include elements of imagination and their inner world. See paragraphs 284–293 above for additional information on interviewing children.

3. Additional sources of information

Since the degree to which children express their thoughts and emotions regarding trauma verbally

15 UNHCR, *The Heart of the Matter*, p. 126.

16 Michael E. Lamb and others. "Structured forensic interview protocols improve the quality and informativeness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol", *Child Abuse & Neglect*, vol. 31, No. 11–12 (2007), pp. 1201–1231.

17 Defence for Children International – Belgium, *Practical Guide*.

rather than behaviourally depends on the child's age, developmental level and other factors, such as family dynamics, personality characteristics, cultural norms and psychosocial context, it is sometimes useful to include other sources of information in the assessment in order to assess and record potential impact including:

(a) Children's behaviour during assessments: the evaluator can comment on the level of activity, the nature of the interactions and relationships with others, affect and state of regulation, general mood and involvement in play;

(b) External reports: wherever possible, it is recommended to gather information from parents, teachers and others about children's developmental history, special needs, psychiatric and medical history, social and school functioning, and behavioural adjustment, before and after the alleged traumatic events and changes in patterns of behaviours;[18]

(c) Diagnostic scale and measures: in order to assess symptoms, additional instruments, such as scales and checklists, can be considered. It is desirable as long as the validity and reliability of these instruments have been established for the particular population that is being evaluated, or for similar populations. If these do not exist, data from dissimilar cultural populations may be consulted but need to be used with care.

D. Special consideration for assessment of sexual assault in children

Investigators should be sensitive to the fact that children and young persons might not comprehend the concept of sexual assault or be able to identify it. In such cases there may often be a fear of bringing shame or stigmatization on themselves or their families, which may also affect their ability to disclose their experiences. It is important, if at all possible, that in such circumstances the child be seen by an expert in child abuse.[19] The evaluator should be aware that an examination may be reminiscent of the original assault and should therefore be carried out sensitively with appropriate explanations to the child and the child's accompanying guardian or caregiver.

III. Medical evaluation

Medical examinations should be carried out in a child friendly setting by trained clinicians with experience in assessing and documenting physical injury (including those resulting from sexual assault) in infants, children and young persons. Consent for examinations should be obtained from the children's caregivers and, in situations in which they are able to give consent themselves, from children or young persons. Ideally, clinicians should have access to additional diagnostic facilities, for example X-rays and other imagining, haematological testing and further specialist advice as needed. In interpreting their findings, clinicians usually need to seek additional information from children, young persons and their caregivers over and above that available from non-medical interviews. Clinicians should be able to document their findings using the agreed international format.

Children who have endured torture or ill-treatment must have access to trained, competent paediatric examiners, wherever possible, who can provide medical assessments and recommendations for care. In children, part of the evaluation must include safeguarding for the prevention of further torture and ill-treatment, recommendations for recovery and reintegration, and reduction of exposure to experiencing or witnessing violence. Access to appropriate and confidential medical and psychological follow-up care is an entitlement for children.[20]

A child who has, or is thought to have, suffered sexual torture should wherever possible be examined by a paediatrician with specialist expertise in examining victims of sexual abuse.

IV. Psychological impact of trauma

Childhood traumas have been associated with a wide range of social, health and mental health problems. Cumulative adverse childhood experiences increase the risk of social, behavioural, health and mental health problems in a strong and graded manner.[21] Research has demonstrated that trauma may significantly compromise cognitive development[22]

18 Kathryn Kuehnle and Steven N. Sparta, "Assessing child sexual abuse allegations in a legal context", in *Forensic Mental Health Assessment of Children and Adolescents,* Steven N. Sparta and Gerald P. Koocher, eds. (New York, Oxford University Press, 2006), pp. 129–148.

19 Royal College of Paediatrics and Child Health, *The Physical Signs of Child Sexual Abuse: An Evidence-Based Review and Guidance for Best Practice* (Lavenham, United Kingdom, Lavenham Press, 2015). See also Astrid Heger, S. Jean Means and David Muram, eds., *Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas,* 2nd ed. (New York, Oxford University Press, 2000), pp. 229.

20 Convention on the Rights of the Child, art. 39.

21 Nadine J. Burke and others, "The impact of adverse childhood experiences on an urban paediatric population", *Child Abuse & Neglect,* vol. 35, No. 6 (2011), pp. 408–413.

22 Michelle Bosquet Enlow and others, "Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study", *Journal of Epidemiology and Community Health,* vol. 66, No. 11 (2012), pp. 1005–1010.

and that exposure to traumatic experiences increases the risk of learning and behavioural problems, obesity[23] and psychotic symptoms in childhood and beyond.[24] Neurobehavioural developmental research also indicates the long-lasting neurological impact of traumatic experiences on children at various ages from pre-verbal stages to late adolescence. In terms of psychological conditions and diagnoses, some are similar to those used in adults, such as post-traumatic stress disorder, depression, anxiety and phobias, while others are specific to children, such as elective mutism, reactive attachment disorder of childhood and disinhibited attachment disorder of childhood, conduct disorder, oppositional conduct disorder and disruptive mood dysregulation disorder. See paragraphs 581–594 above for a detailed account of conditions and diagnoses that may be observed in children who have been tortured or ill-treated.

It should be noted that, while the same diagnoses can be found in both children and adults, children manifest symptoms differently and clinicians need to rely more on observing the child's behaviour (e.g. monotonous, repetitive play) and somatic reactions (e.g. loss of control of bowel movements), and consider the use of appropriate questionnaires in order to make accurate diagnoses. The clinician therefore may need to rely on a child's behaviour and reports from others rather than predominantly on narratives provided by the child. A range of psychological diagnostic techniques may be required as children, especially teenagers, may present themselves as having no difficulties in their lives until more specific questions are asked.

It should also be noted that, when diagnosing children's mental health, it is important to differentiate between behaviour, cognition and emotion that are typical to the child's developmental stage and age and those that are cause for concern. Furthermore, behaviour and other indicators need to be considered within the child's cultural and psychosocial context.

V. Lesbian, gay, bisexual and transgender children and young persons

Lesbian, gay, bisexual and transgender children and young persons are likely to experience abuse by adults and peers, and the risk increases with the decrease or absence of social and legal protections.[25] Research demonstrates that experiences of persecution and abuse may severely affect their mental health.[26] When documenting torture in lesbian, gay, bisexual and transgender children and young persons, it is important to consider the specific risk factors and acknowledge their potential impact. As for adults, it is essential to provide a safe and respectful setting and not to pathologize gender identities and sexual orientations (see paras. 599–601 above).

23 Burke and others, "The Impact of adverse childhood experiences".

24 Louise Arseneault and others, "Childhood trauma and children's emerging psychotic symptoms: a genetically sensitive longitudinal cohort study", *American Journal of Psychiatry*, vol. 168, No. 1 (2011), pp. 65–72.

25 Edward J. Alessi, Sarilee Kahn and Sangeeta Chatterji, "'The darkest times of my life': recollections of child abuse among forced migrants persecuted because of their sexual orientation and gender identity", *Child Abuse & Neglect*, vol. 51 (2016), pp. 93–105.

26 Ibid.; and Rebecca A. Hopkinson and others, "Persecution experiences and mental health of LGBT asylum seekers", *Journal of Homosexuality*, vol. 64, No. 12 (2017), pp. 1650–1666.

ANNEXE III

Anatomical drawings for the documentation of torture and ill-treatment

Subject Name .....

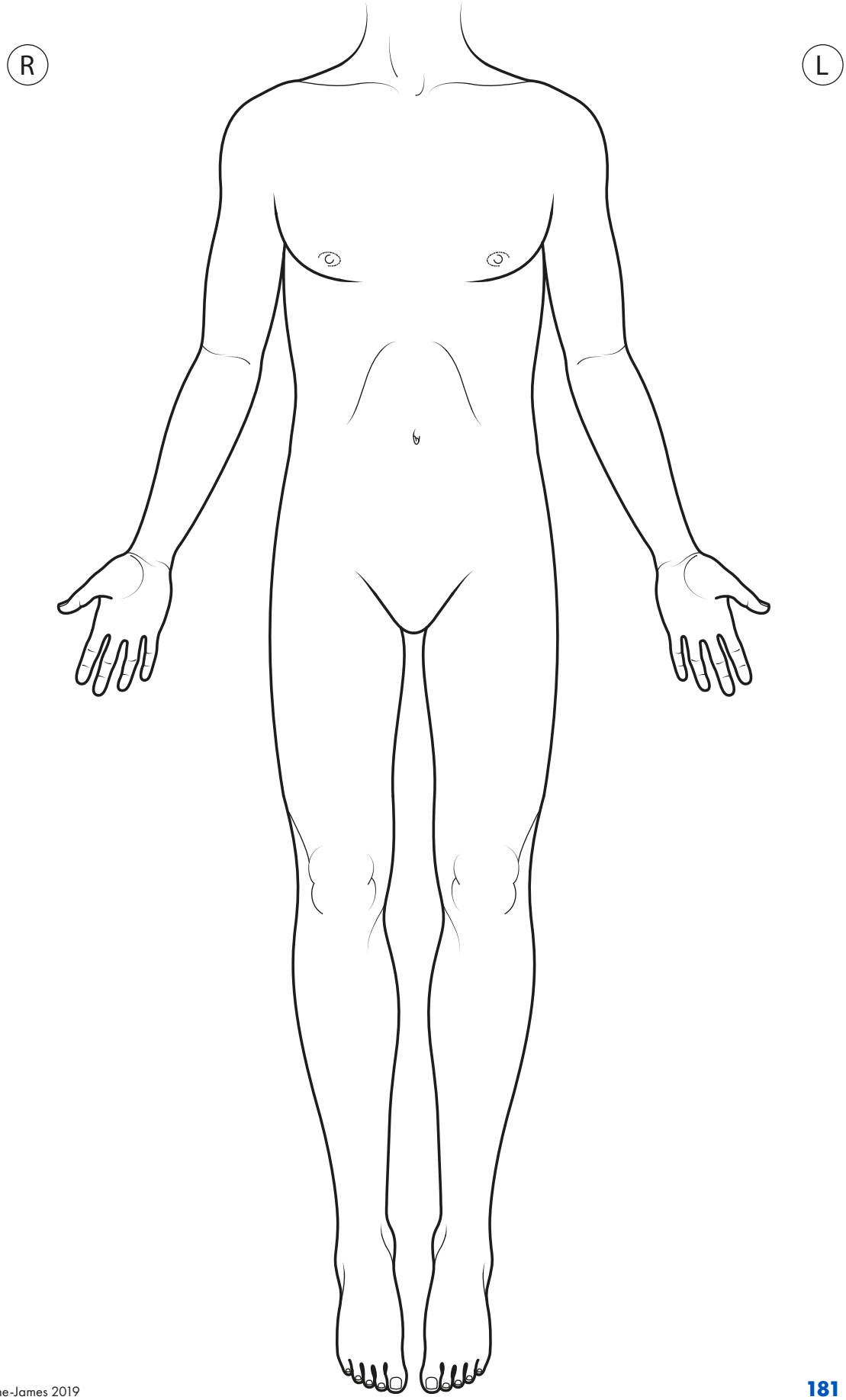
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Gender-Neutral Full Body – Anterior View



Subject Name .....

Examiner Name .....

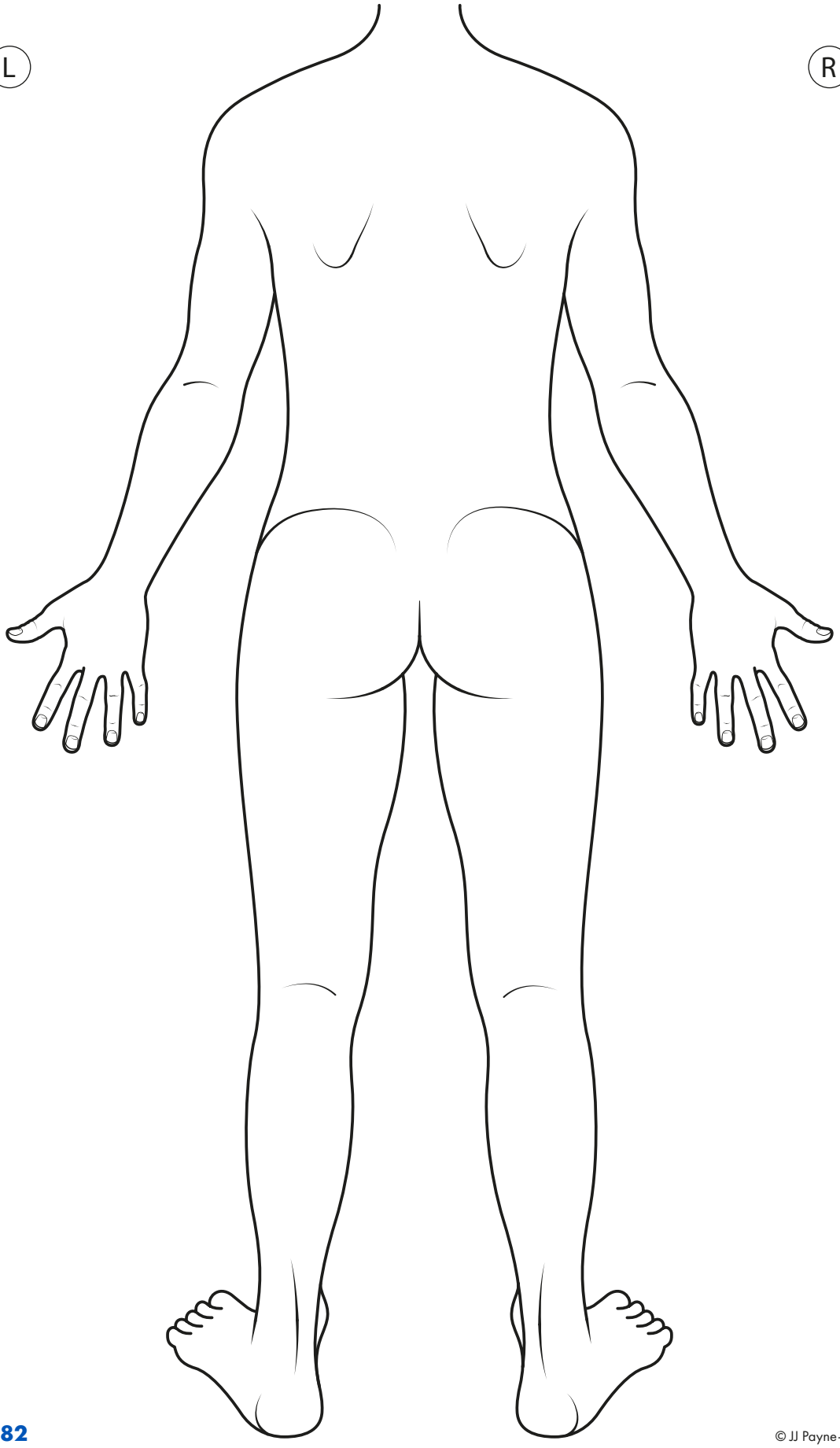
Date of Examination .....

Time of Examination .....

Reference Number.....

L

R



Gender-Neutral Full Body – Posterior View

Subject Name .....

Examiner Name .....

Date of Examination .....

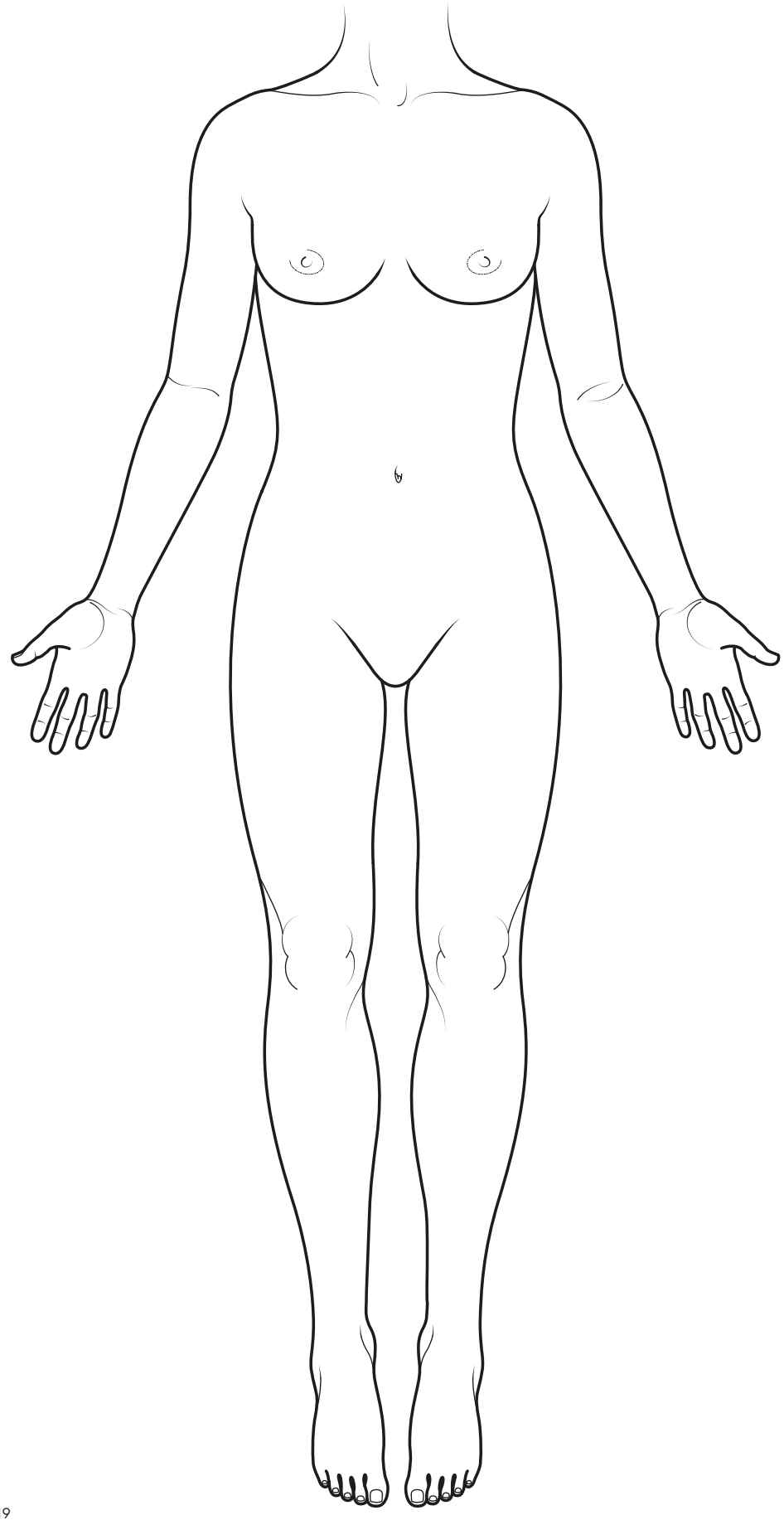
Time of Examination .....

Reference Number.....

Female Full Body – Anterior View

R

L



Subject Name .....

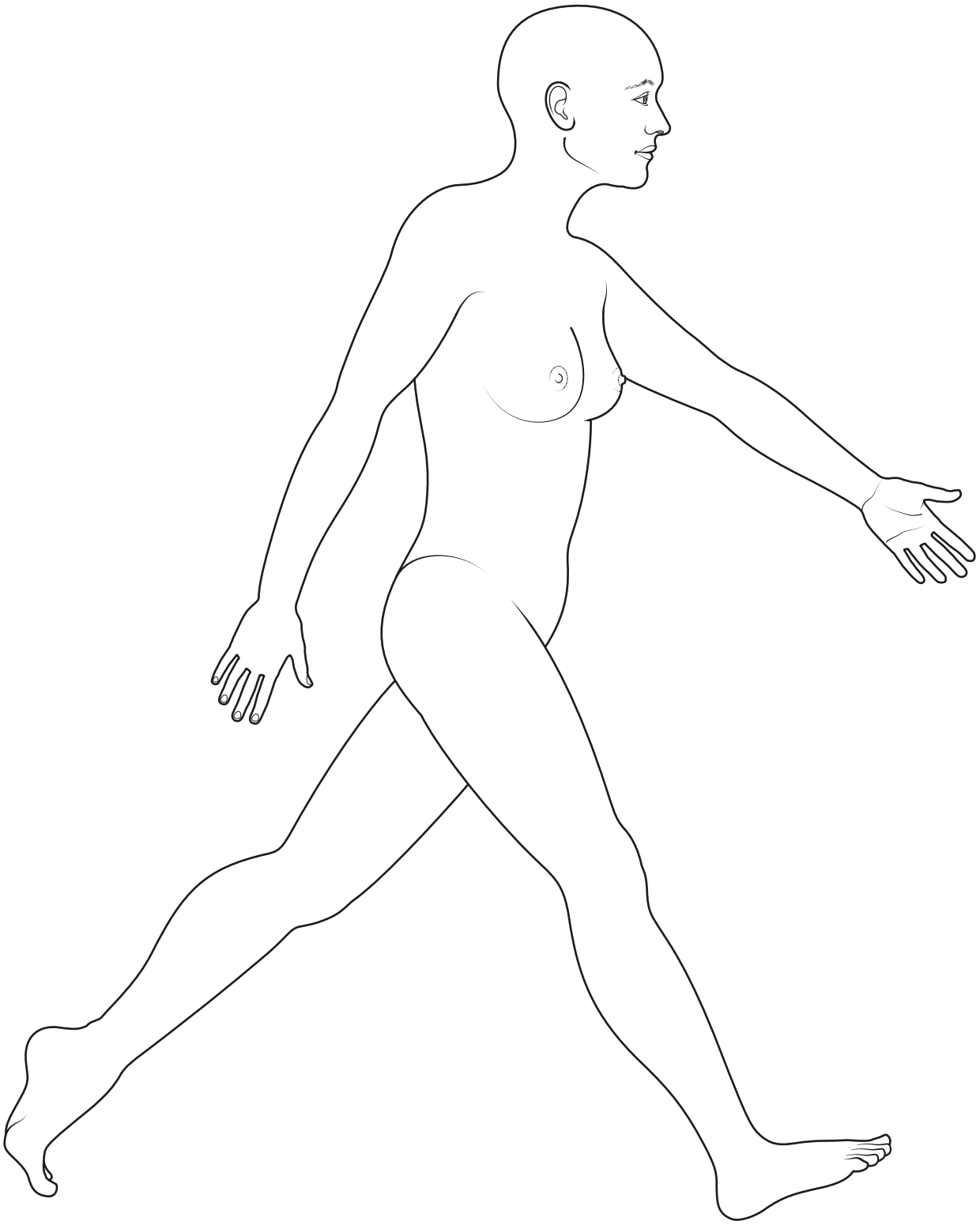
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

R



Female Full Body – Right Lateral View

Subject Name .....

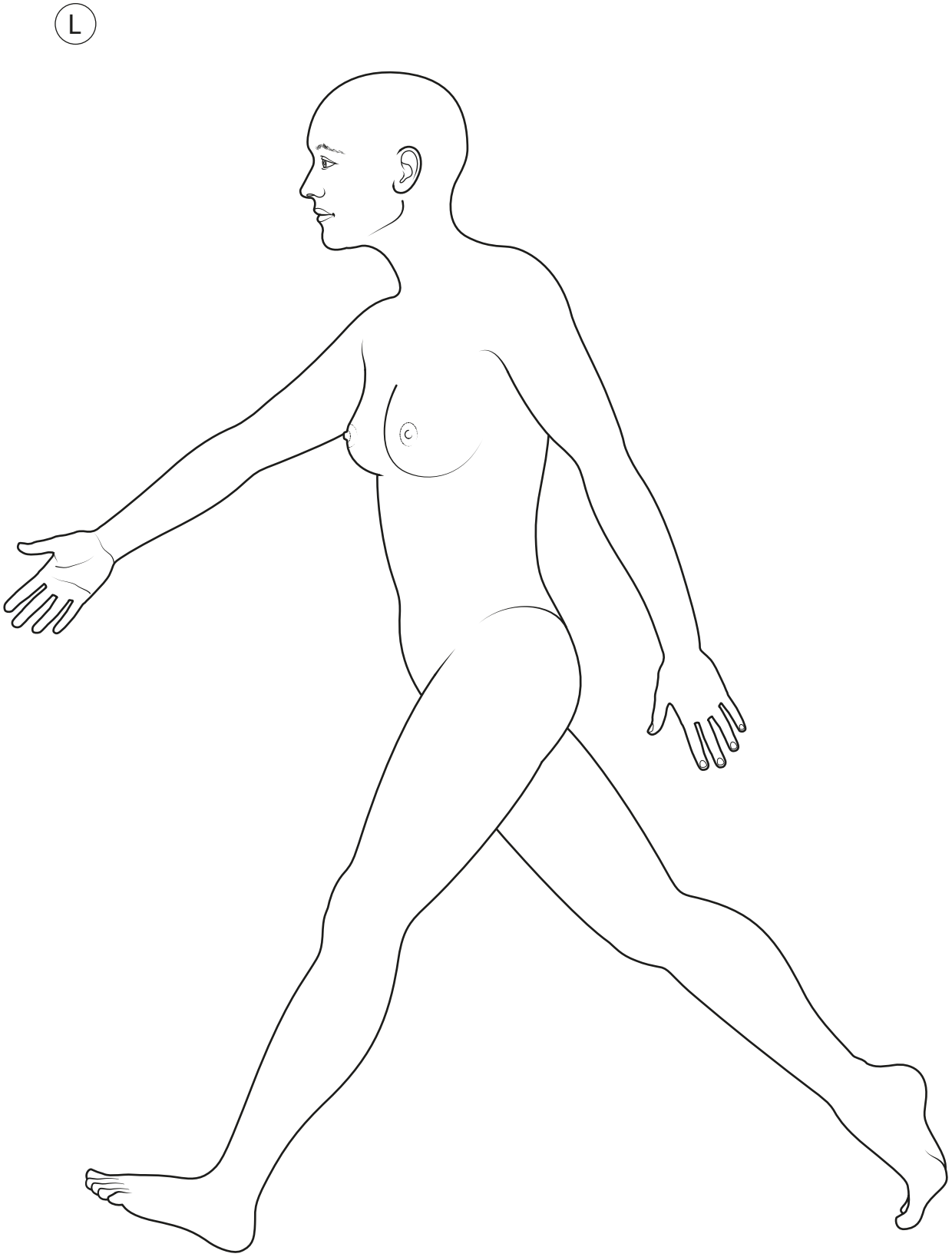
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Female Full Body – Left Lateral View



Subject Name .....

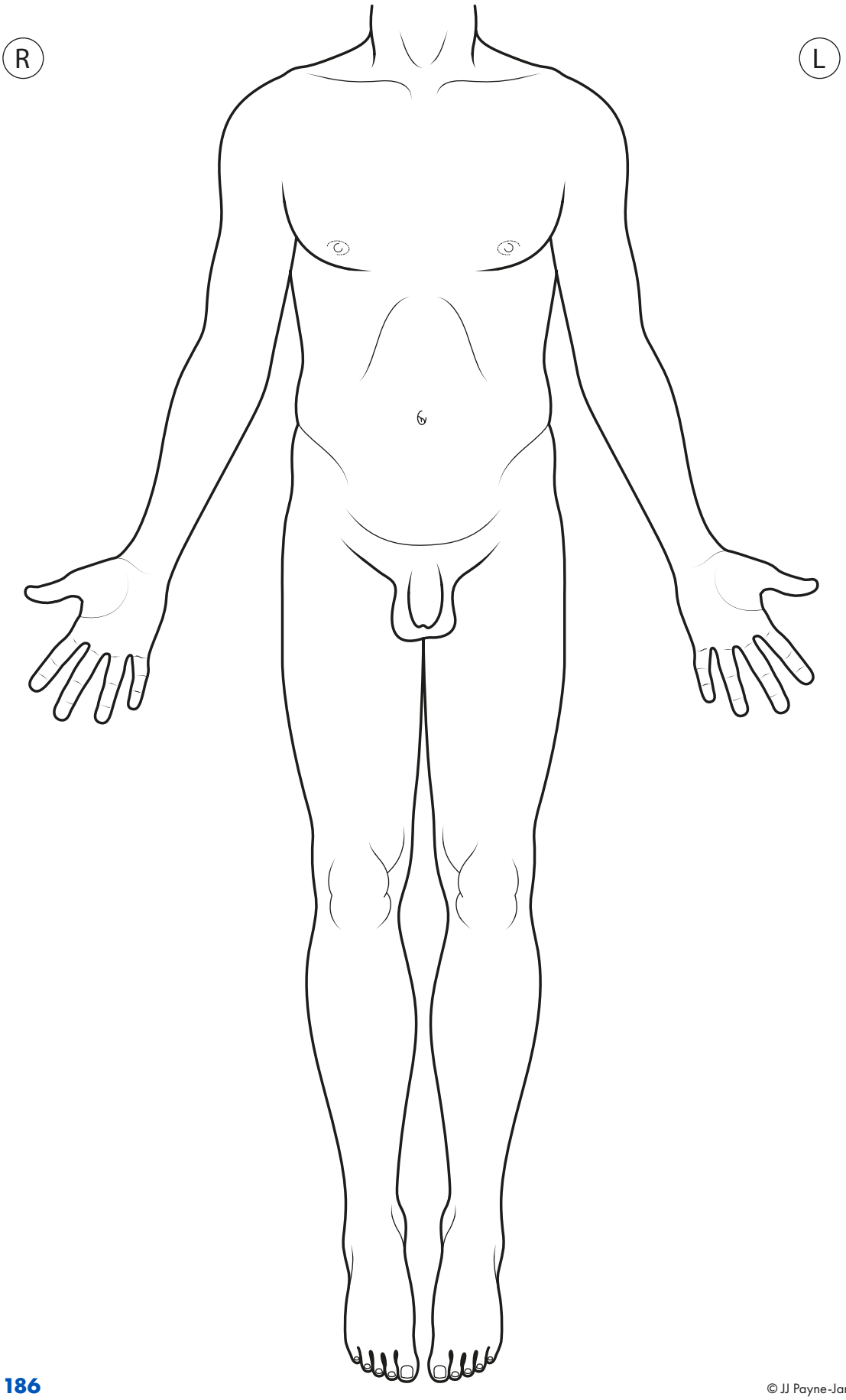
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Male Full Body – Anterior View



Subject Name .....

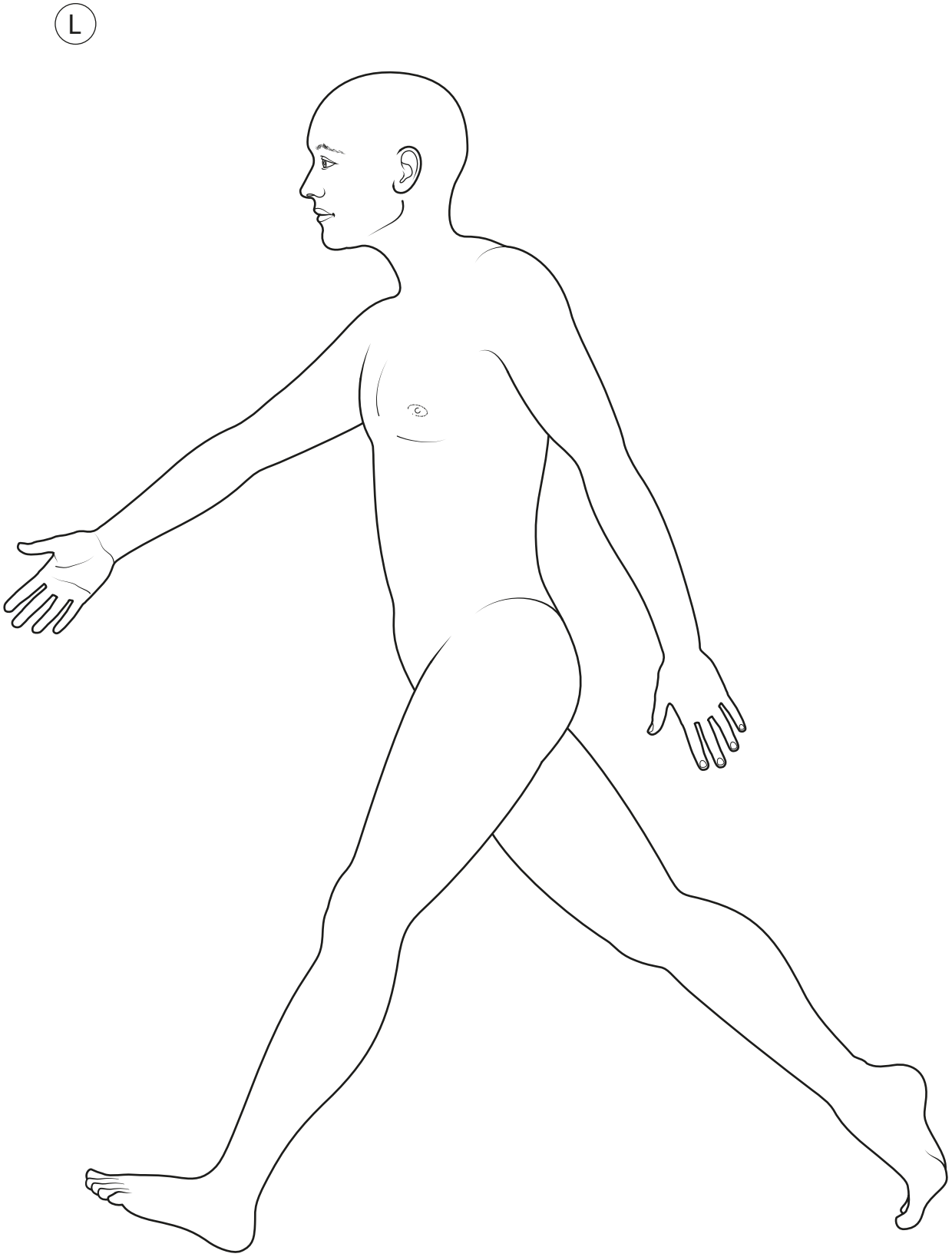
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Male Full Body – Left Lateral View



Subject Name .....

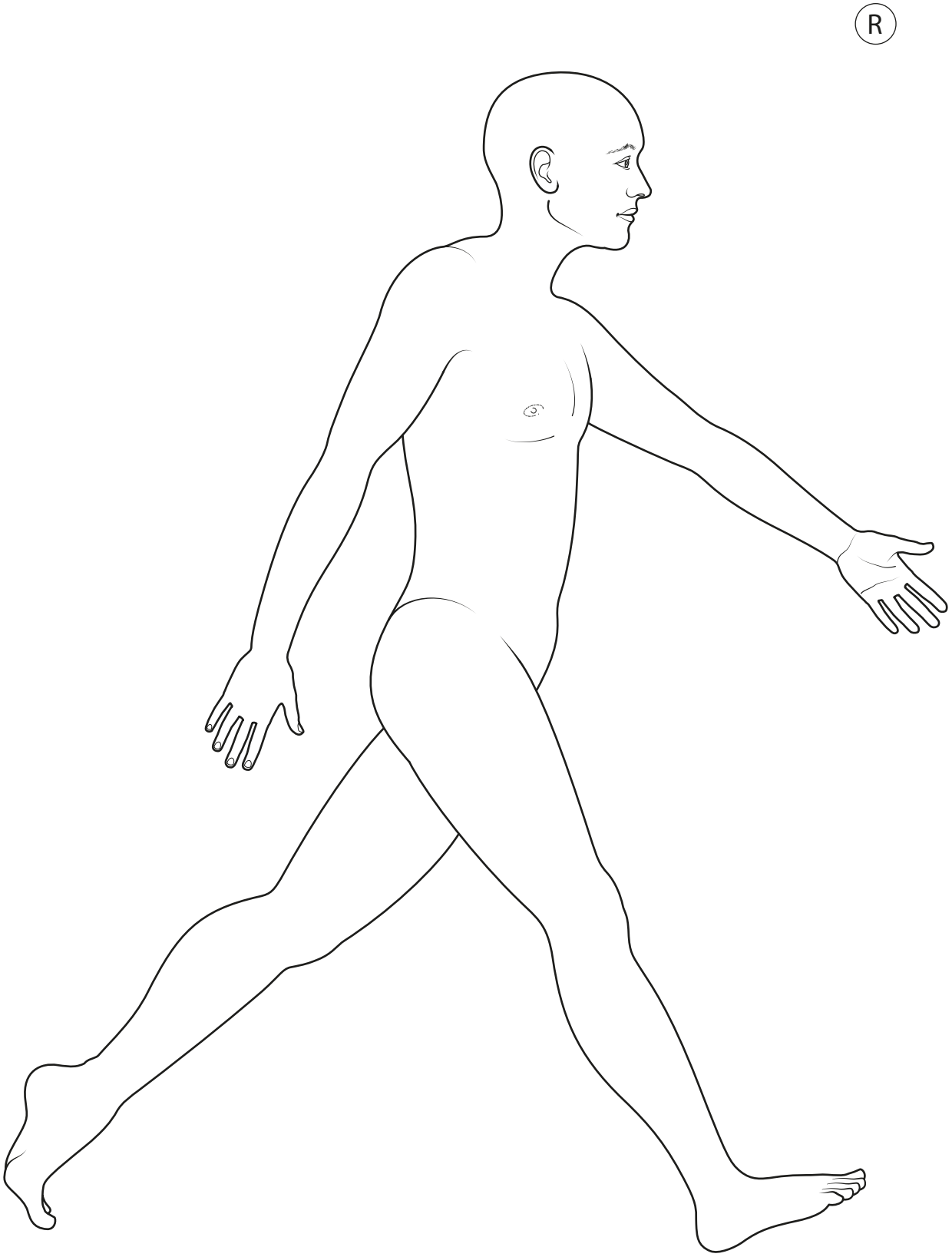
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Male Full Body – Right Lateral View



Subject Name .....

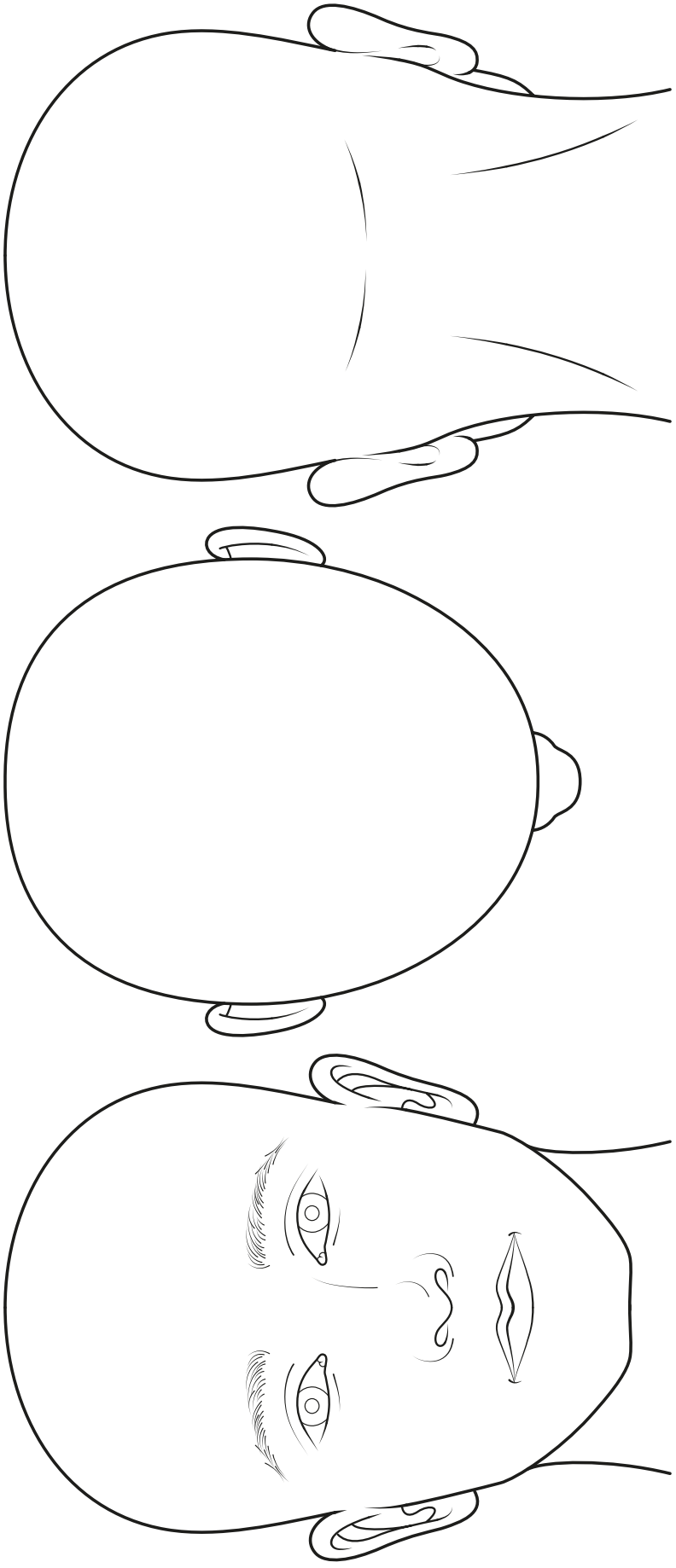
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Head – Anterior, Superior and Posterior Views



Subject Name .....

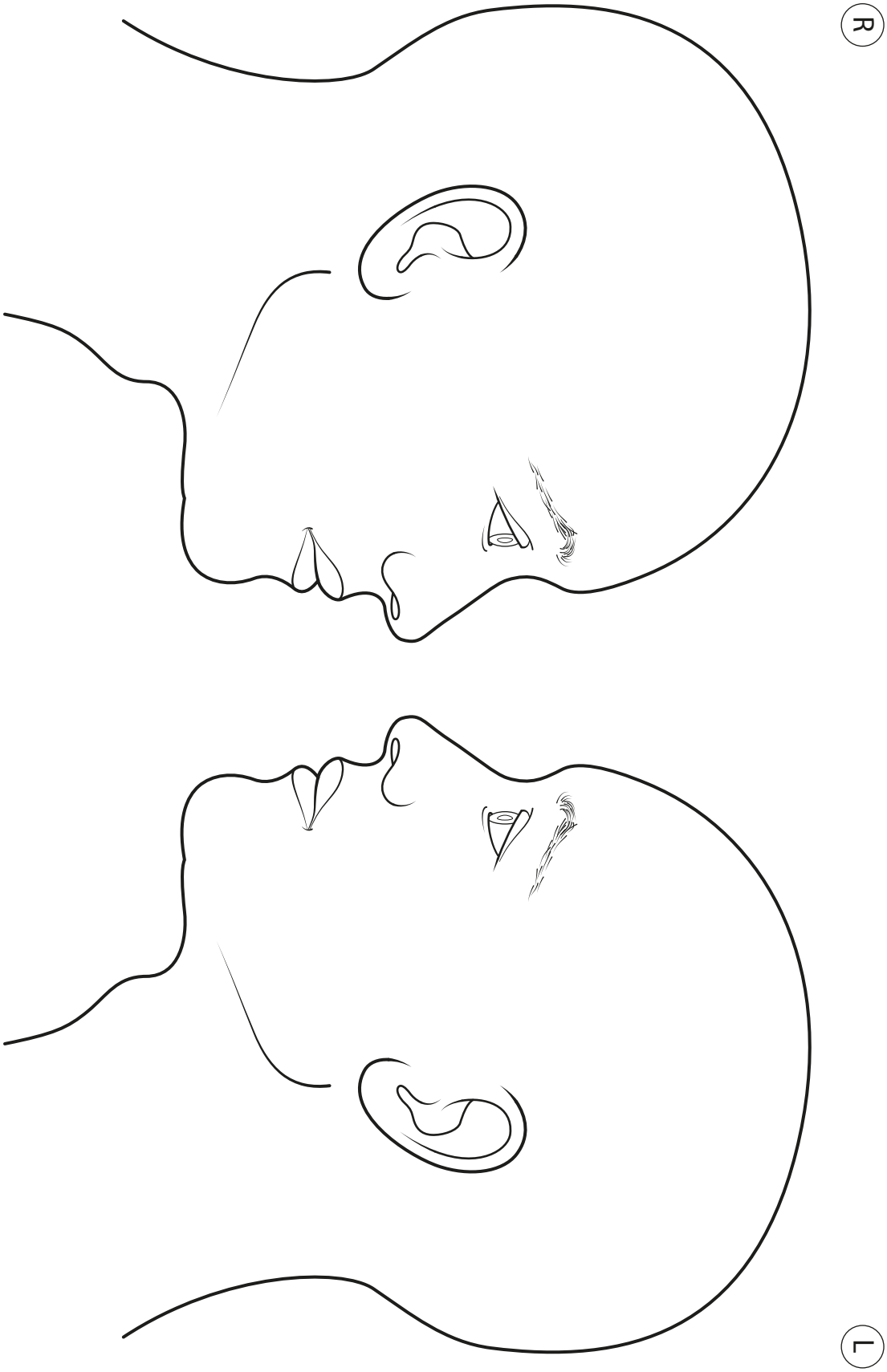
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Head – Left and Right Lateral Views



Subject Name .....

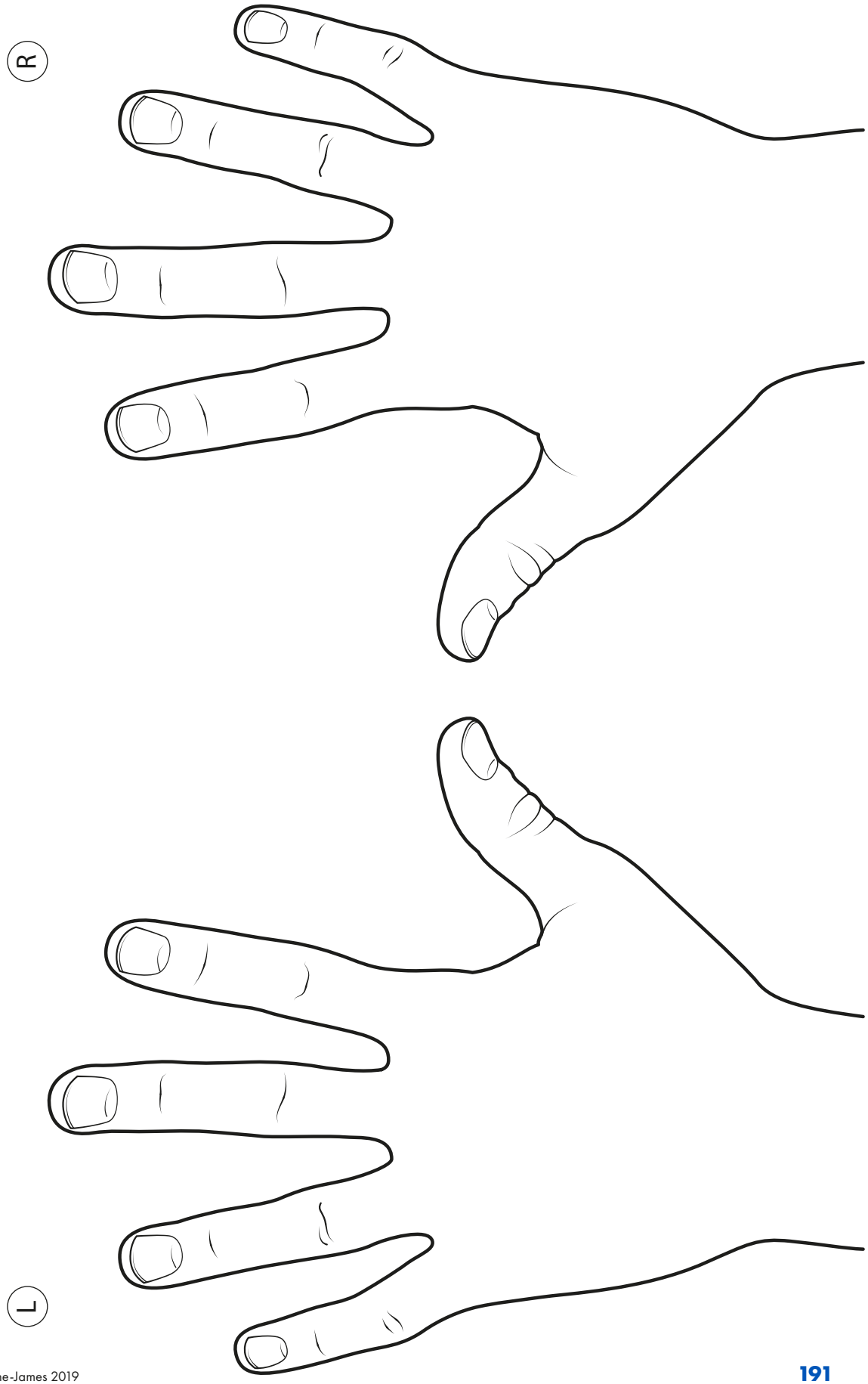
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Hands – Dorsal View



Subject Name .....

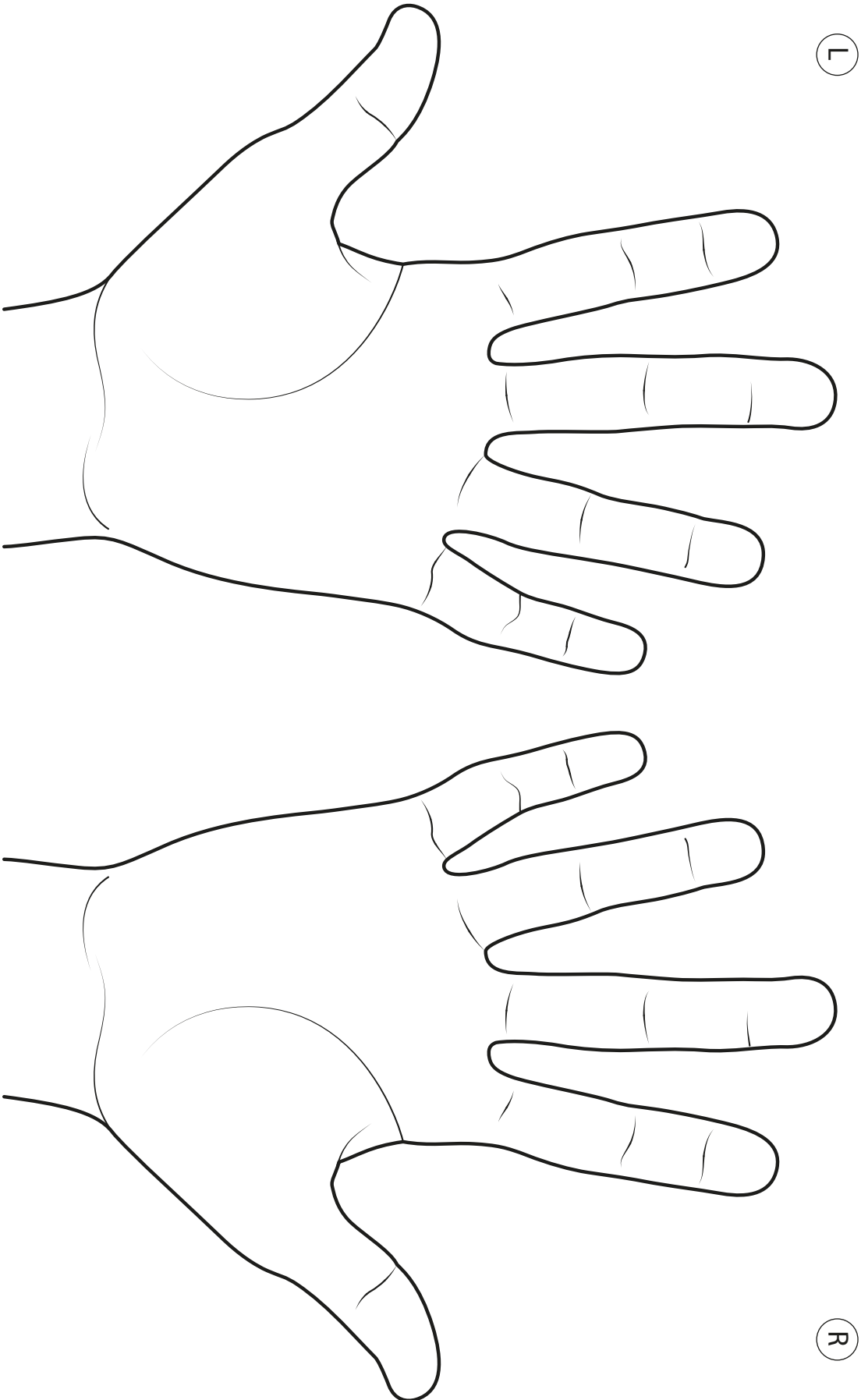
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Hands – Palmar View



Subject Name .....

Examiner Name .....

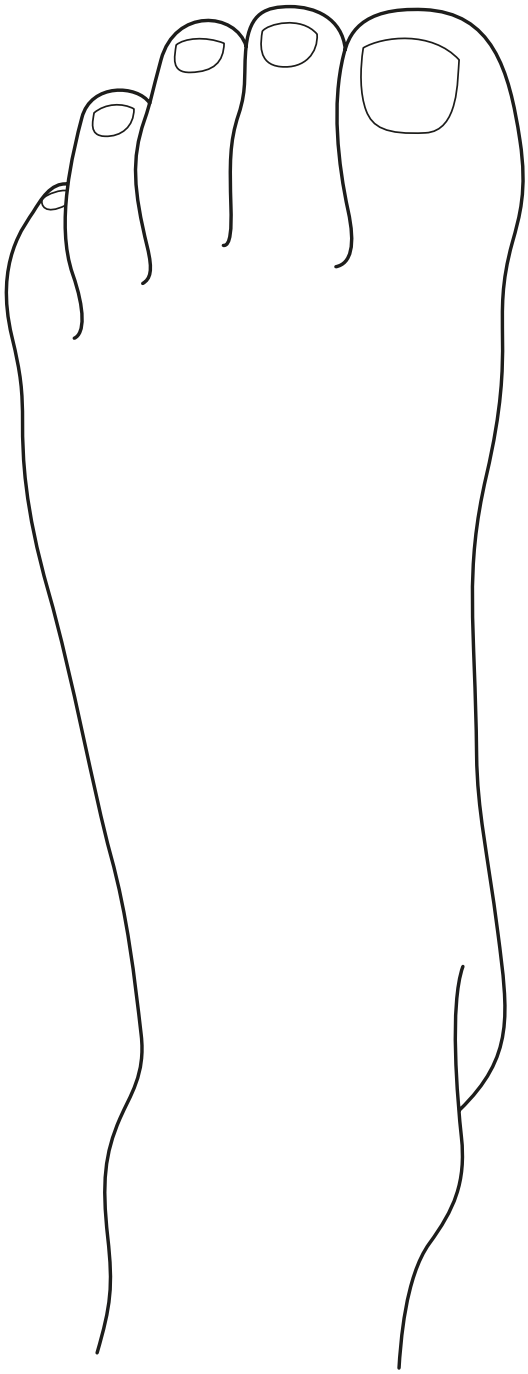
Date of Examination .....

Time of Examination .....

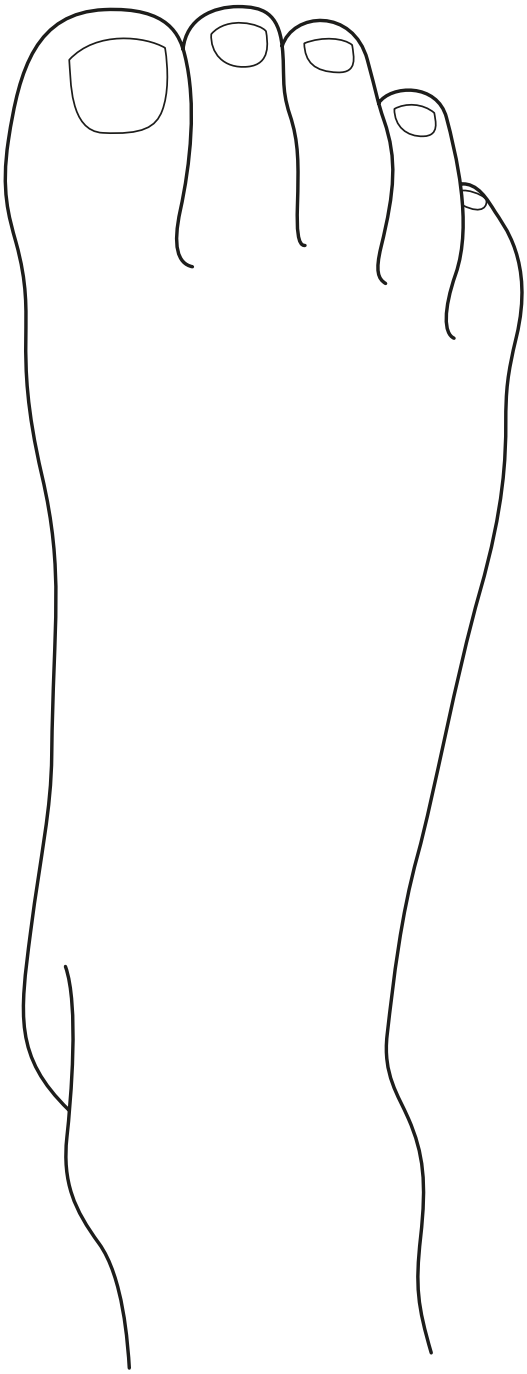
Reference Number.....

Feet – Dorsal View

L



R



Subject Name .....

Examiner Name .....

Date of Examination .....

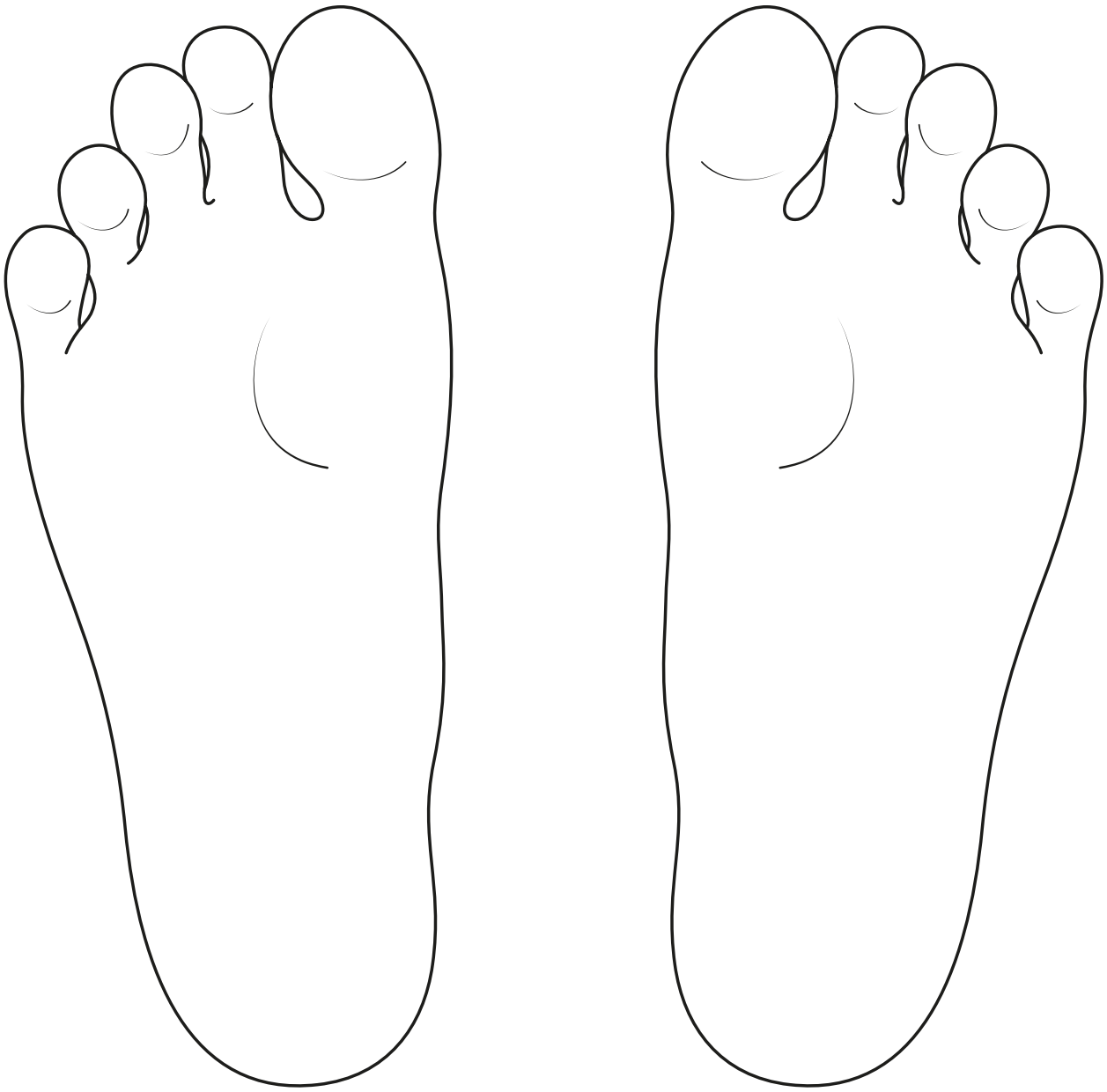
Time of Examination .....

Reference Number.....

Feet – Plantar View

R

L



Subject Name .....

Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Axilla

Subject Name .....

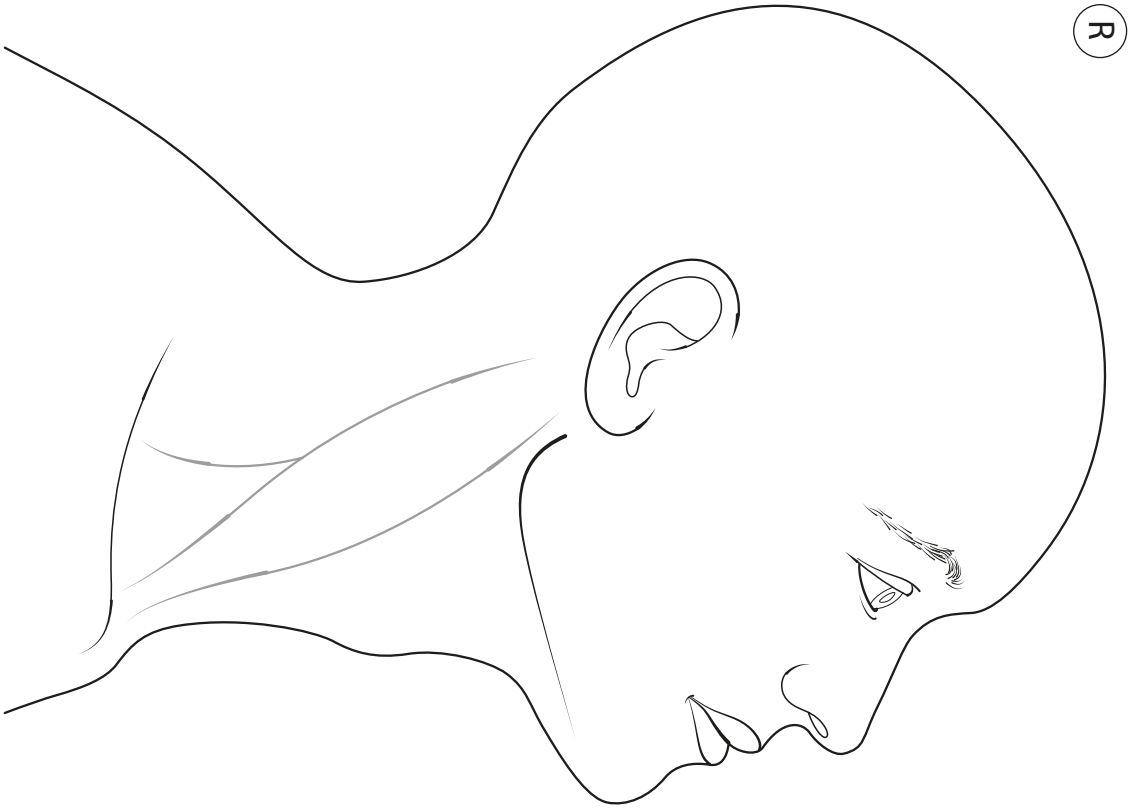
Examiner Name .....

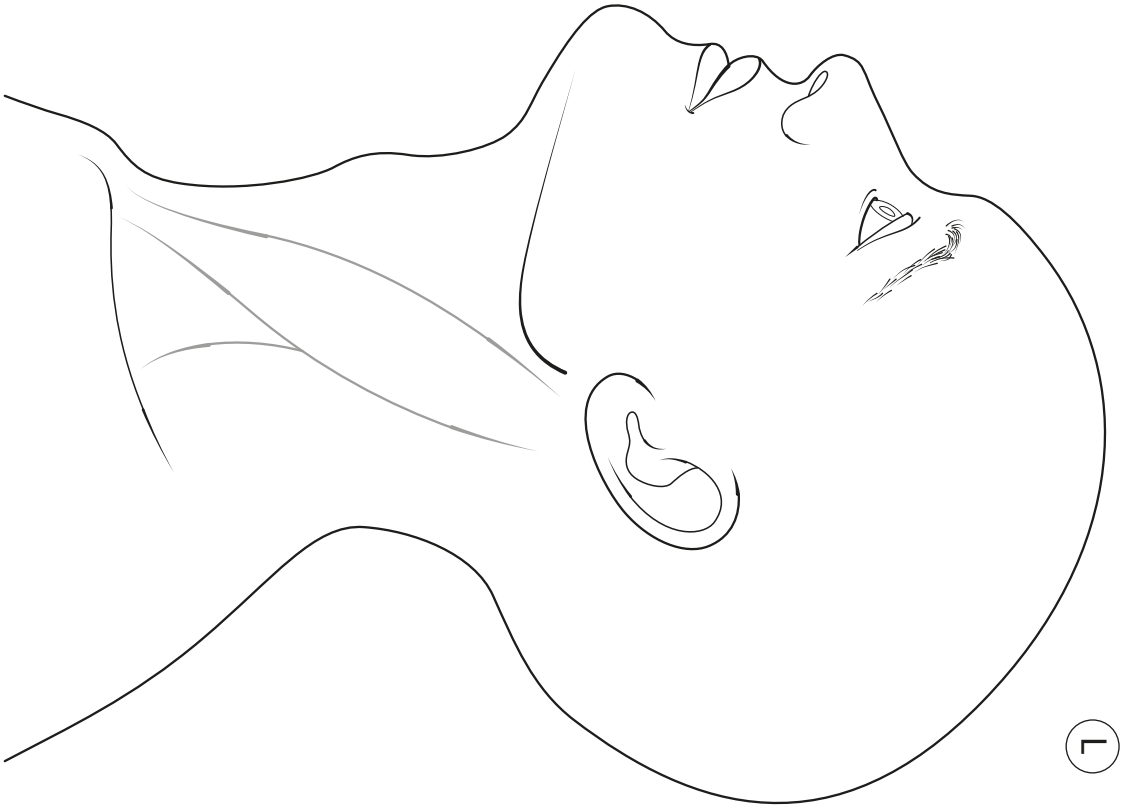
Date of Examination .....

Time of Examination .....

Reference Number.....

Neck Extended – Left and Right Lateral Views





Subject Name .....

Examiner Name .....

Date of Examination .....

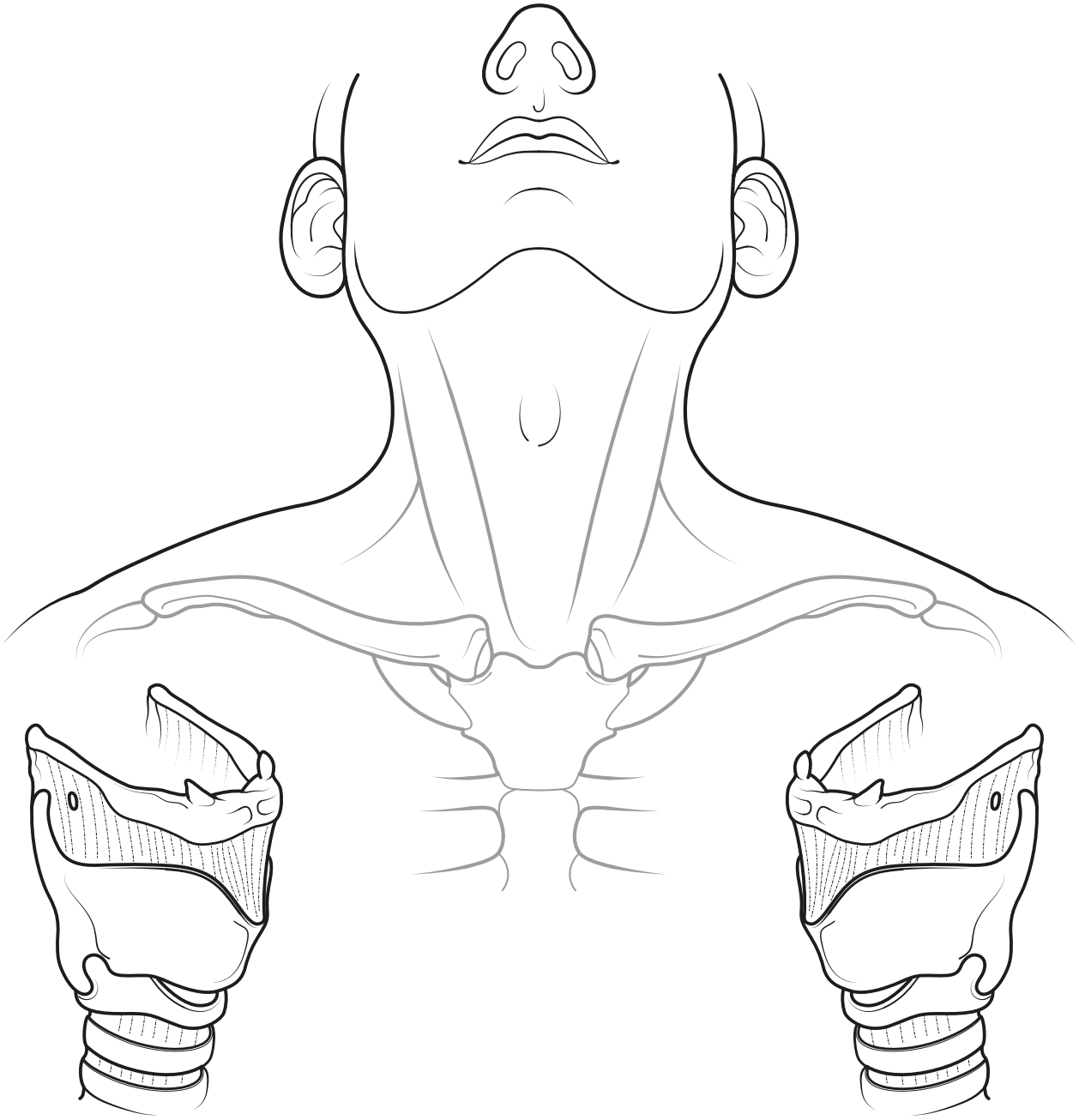
Time of Examination .....

Reference Number.....

Neck Anterior Extended and Larynx

R

L



Subject Name .....

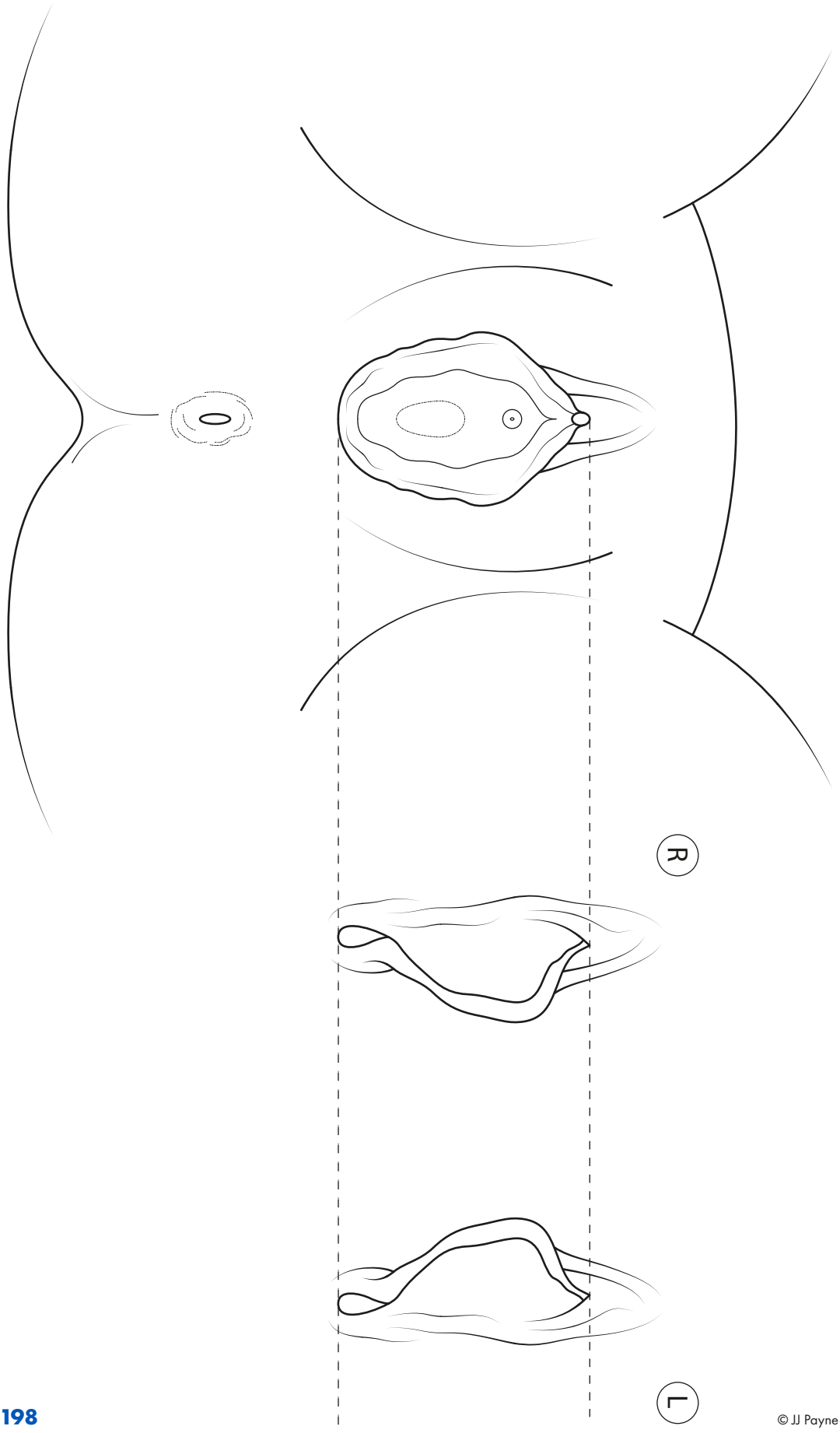
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Female Genitalia



Subject Name .....

Examiner Name .....

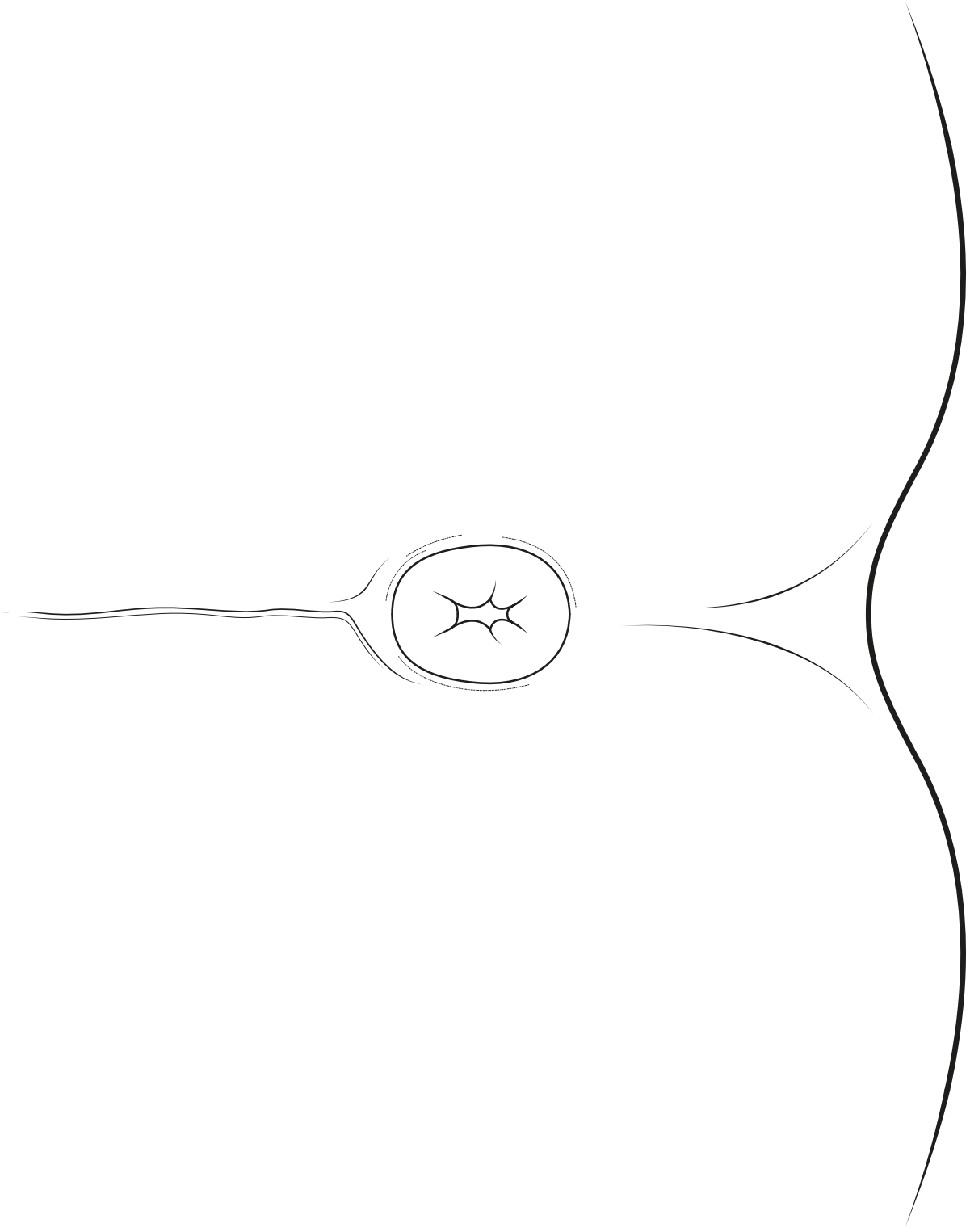
Date of Examination .....

Time of Examination .....

Reference Number.....

Gender-neutral Anus

L



R

Subject Name .....

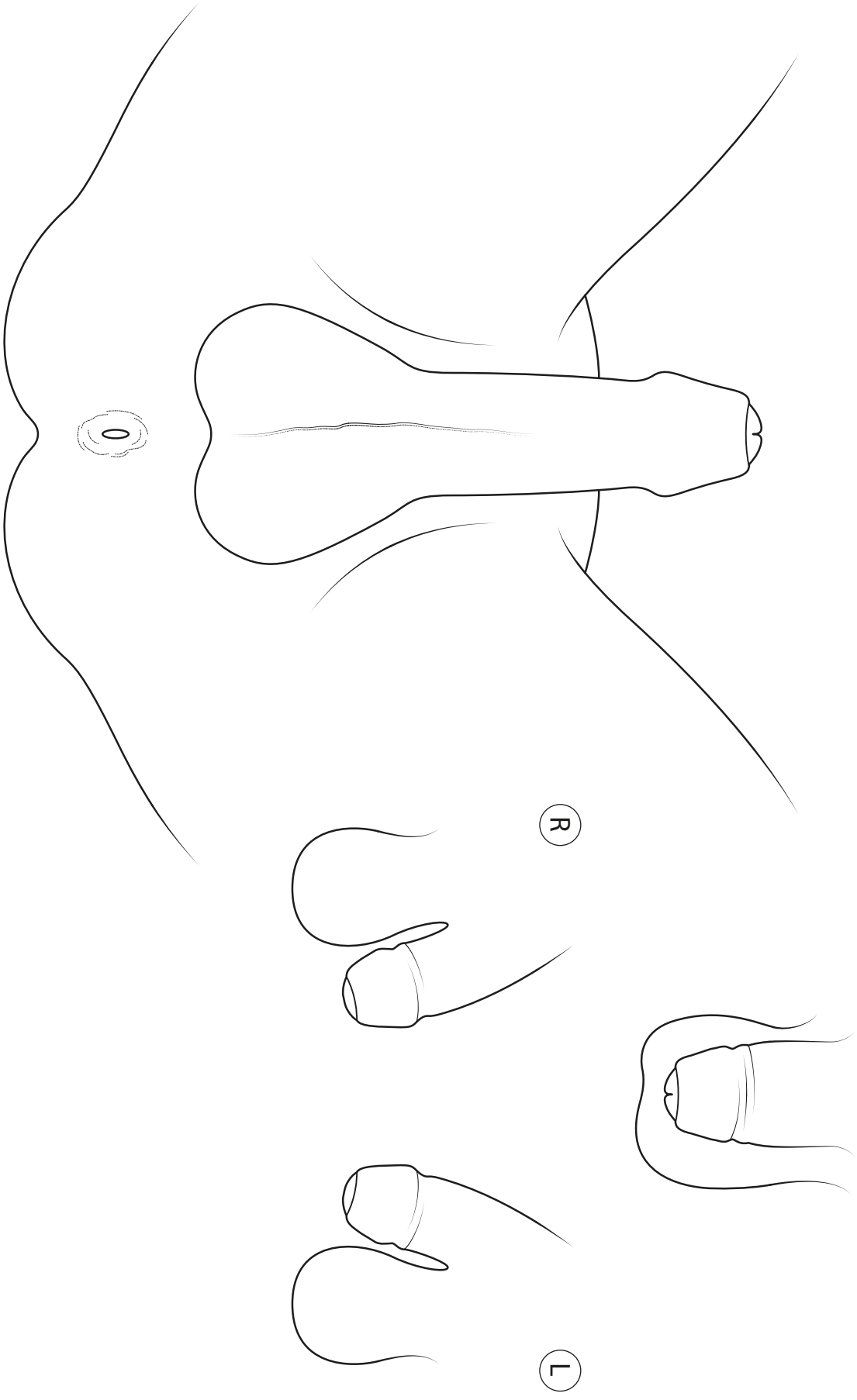
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Male Genitalia Uncircumcised



Subject Name .....

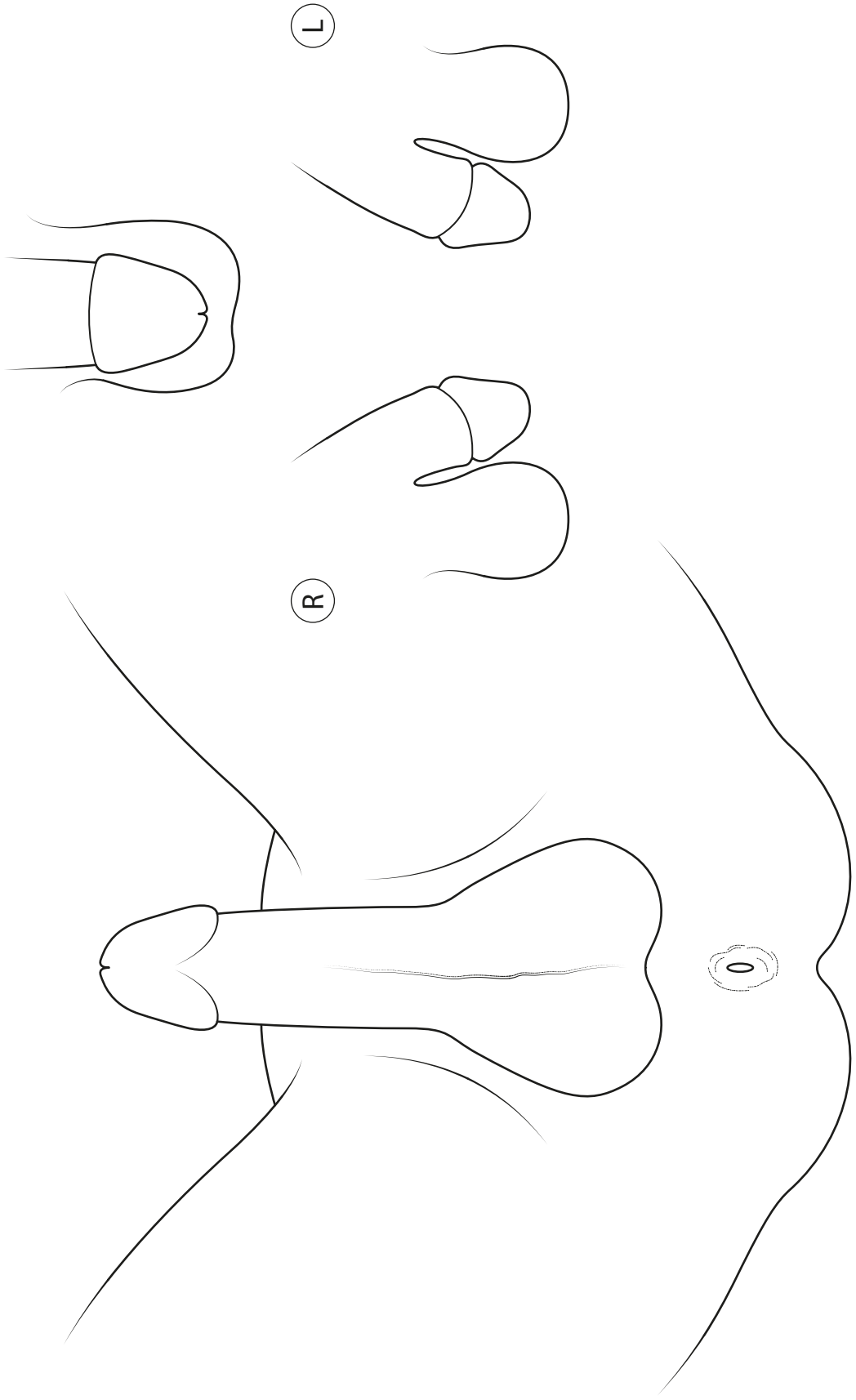
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Male Genitalia Circumcised



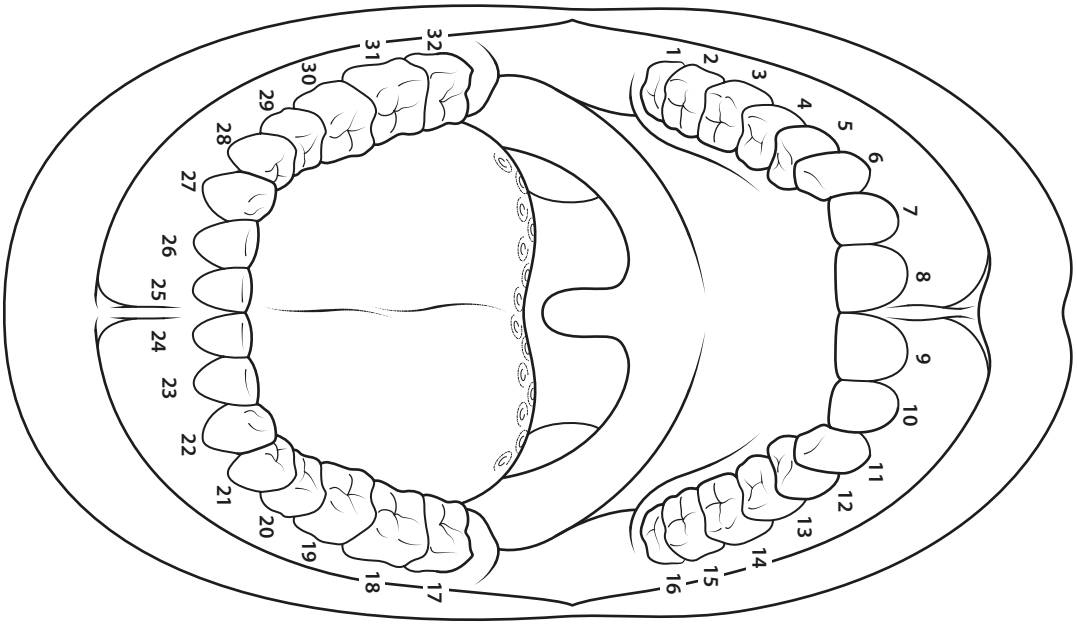
Subject Name .....

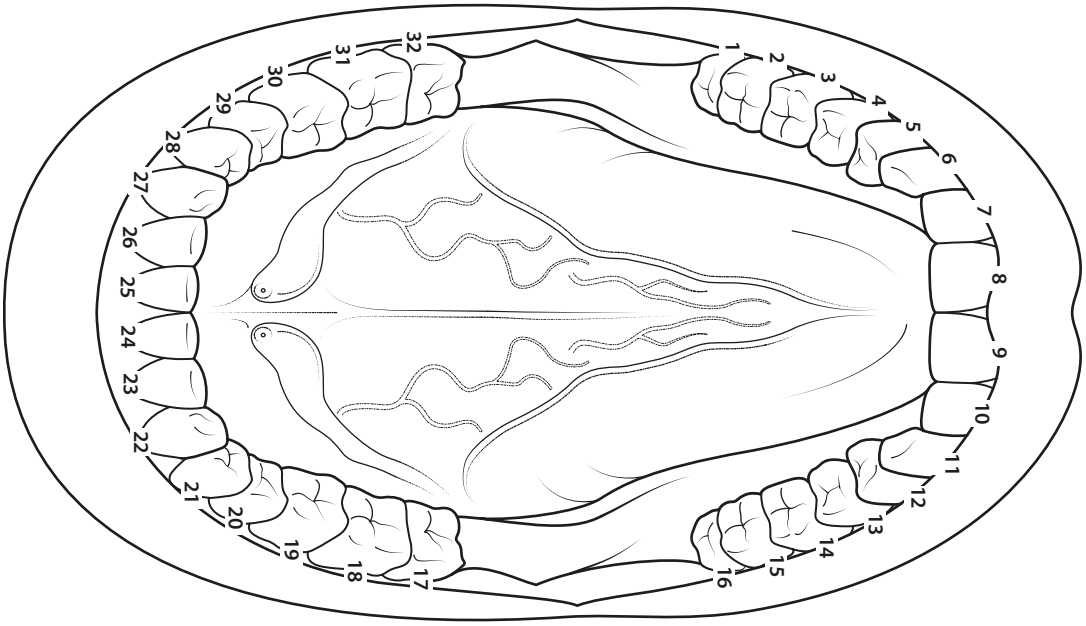
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....





Subject Name .....

Examiner Name .....

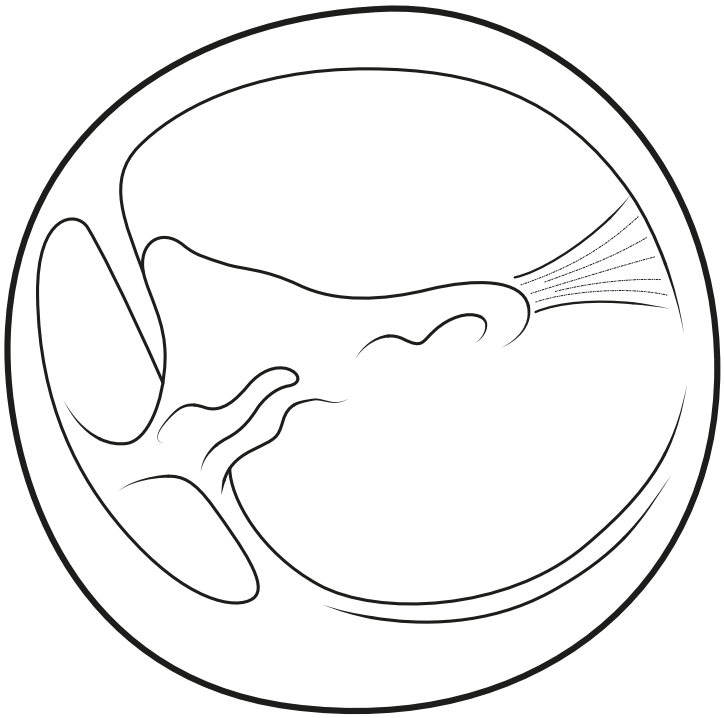
Date of Examination .....

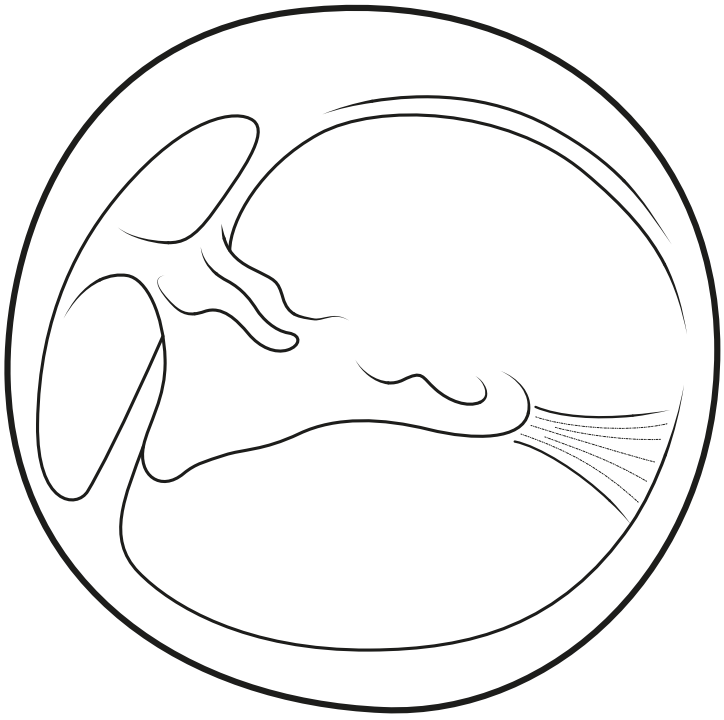
Time of Examination .....

Reference Number.....

Tympanic Membrane – Left and Right Views

R





L

Subject Name .....

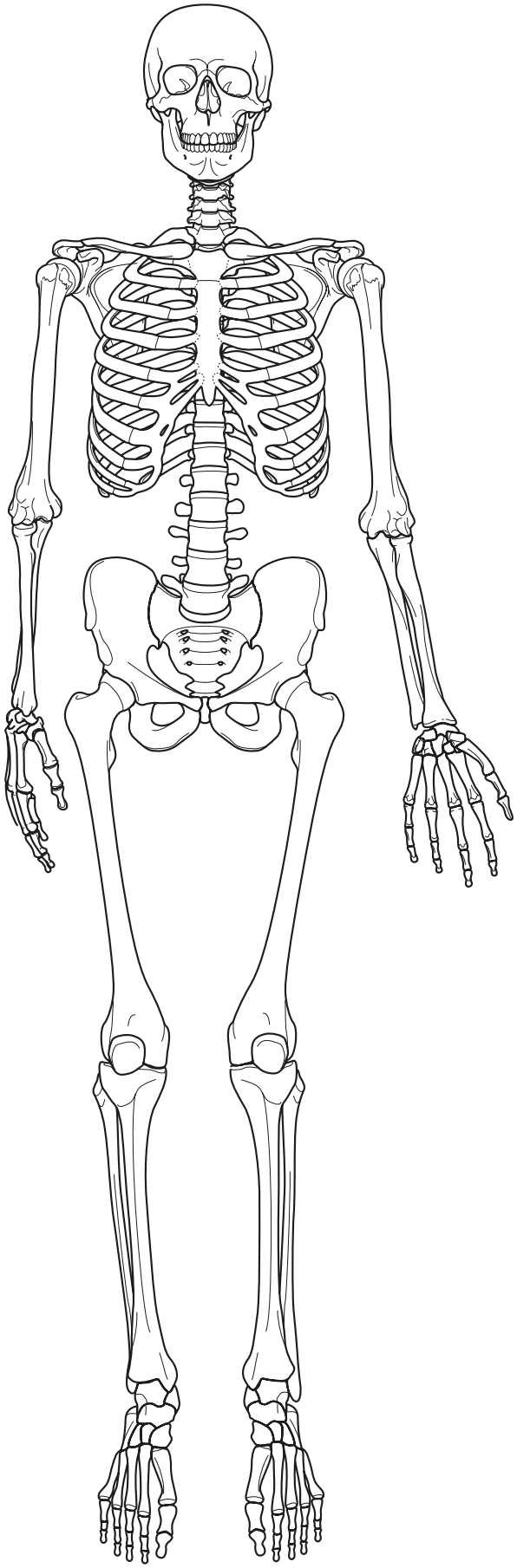
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Skeleton – Anterior View



Subject Name .....

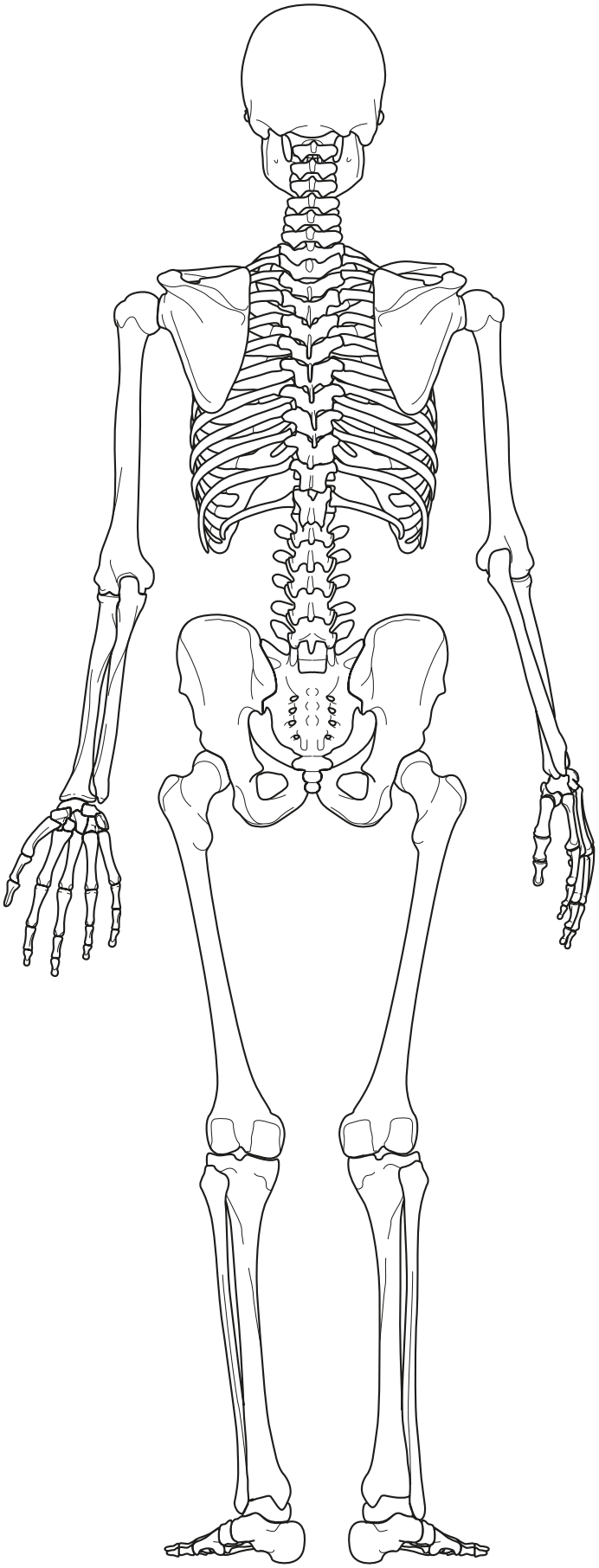
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Skeleton – Posterior View



Subject Name .....

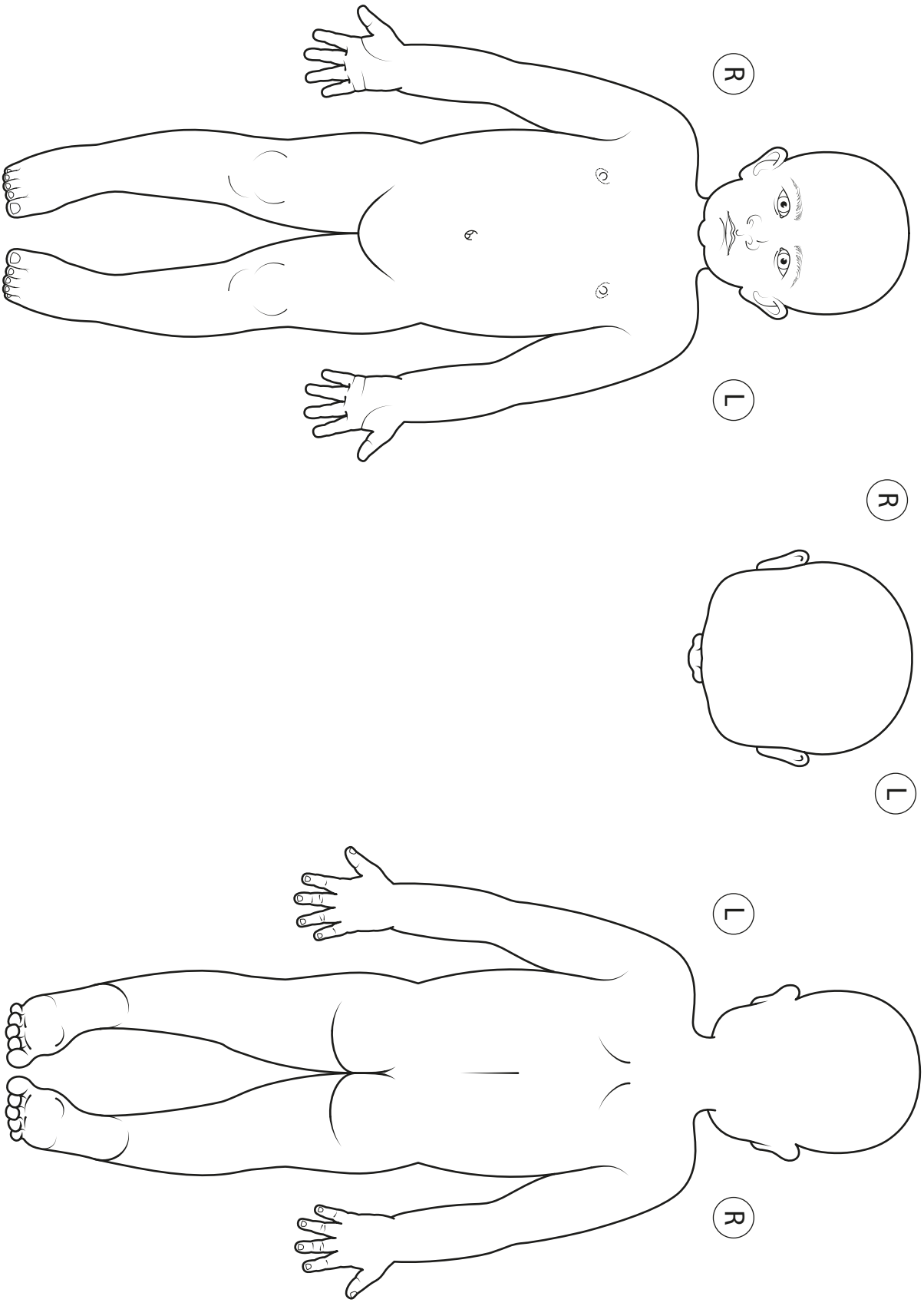
Examiner Name .....

Date of Examination .....

Time of Examination .....

Reference Number.....

Toddler – Posterior and Anteriorr Views



Subject Name .....

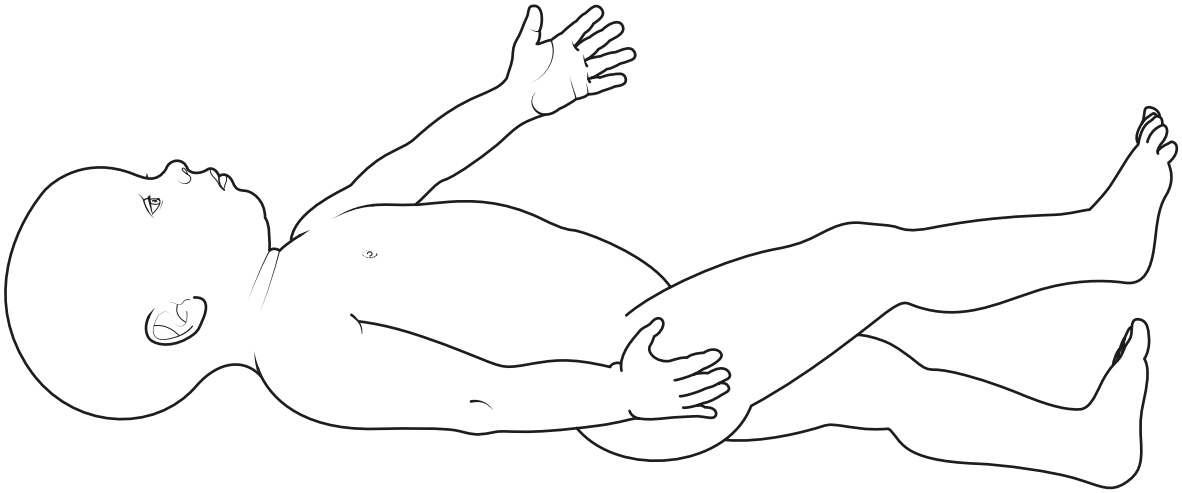
Examiner Name .....

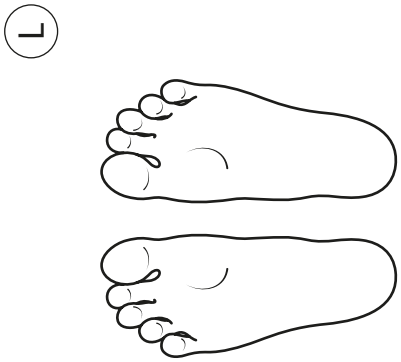
Date of Examination .....

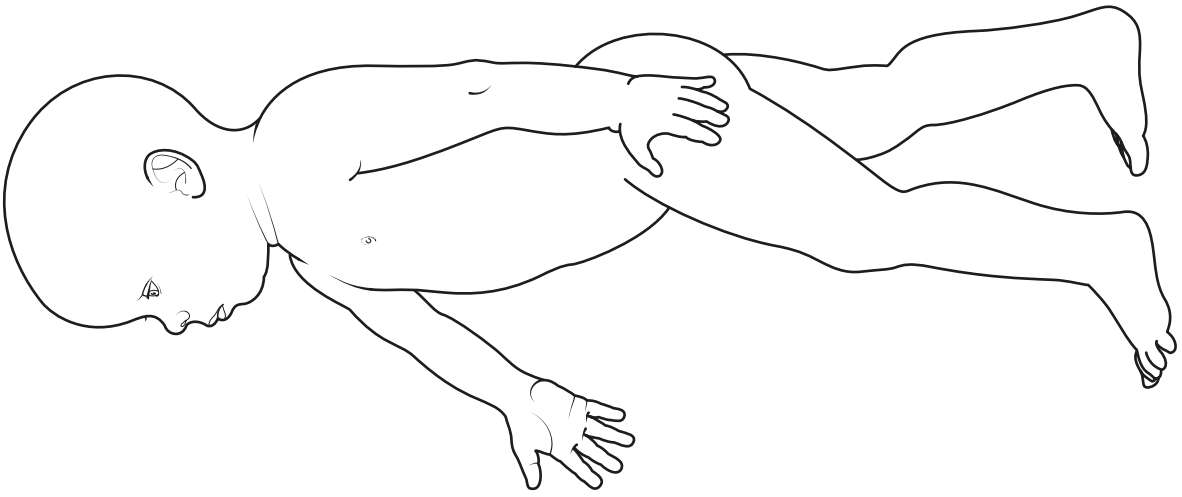
Time of Examination .....

Reference Number.....

Toddler – Right and Left Lateral Views







ANNEXES

Guidelines for the clinical evaluation of torture and ill-treatment

I. Case information

The following guidelines are based on the Istanbul Protocol. They are not intended to be a fixed prescription, but should be applied taking into account the purpose of the evaluation and after an assessment of available resources. Evaluation of physical and psychological evidence of torture and ill-treatment may be conducted by one or more clinicians, depending on their qualifications.

Date of exam: ..... Case or report No.: .....

Exam requested by (name/position): .....

Subject's ID No: .....

Duration of evaluation (hours/minutes): .....

Subject's given name: .....

Subject's family name: .....

Birth date: ..... Birth place: .....

Gender: ☐ male ☐ female ☐ other

Reason for exam: .....

Clinician's name: .....

Interpreter: ☐ yes ☐ no name .....

Informed consent: ☐ yes ☐ no If no informed consent, why?: .....

Subject accompanied by (name/position):.....

Persons present during exam (name/position):.....

Subject restrained during exam: ☐ yes ☐ no If "yes", how/why?.....

Clinical report transferred to (name/position/ID No.): .....

Transfer date:..... Transfer time: .....

Clinical evaluation/investigation conducted without restriction (for subjects in custody) ☐ yes ☐ no

Provide details of any restrictions: .....

II. Clinician's qualifications (for judicial testimony)

Clinical education and clinical training
Psychological/psychiatric training
Experience in documenting evidence of torture and ill-treatment
Regional human rights expertise relevant to the investigation
Relevant publications, presentations and training courses
Curriculum vitae.

III. Statement regarding veracity of testimony (for judicial testimony)

For example: "I personally know the facts stated below, except those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background information

General information (age, occupation, education, family composition etc.)
Past medical history
Review of prior clinical evaluations of torture or ill-treatment
Psychosocial history pre-arrest.

V. Allegations of torture or ill-treatment

1. Summary of detention and abuse
2. Circumstances of arrest and detention
3. Initial and subsequent places of detention (chronology, transportation and detention conditions)
4. Narrative account of ill-treatment or torture (in each place of detention)
5. Review of torture methods.

VI. Physical symptoms and disabilities

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute symptoms and disabilities
2. Chronic symptoms and disabilities

VII. Physical examination

1. General appearance
2. Skin
3. Face and head
4. Eyes, ears, nose and throat
5. Oral cavity and teeth
6. Chest and abdomen (including vital signs)
7. Genito-urinary system
8. Musculoskeletal system
9. Central and peripheral nervous system.

VIII. Psychosocial history/examination

1. Methods of assessment
2. Current psychological complaints
3. Post-torture history
4. Pre-torture history
5. Past psychological/psychiatric history
6. Substance use and abuse history
7. Mental status examination
8. Assessment of social functioning
9. Psychological testing (see para. 539 above for indications and limitations)
10. Neuropsychological testing (see paras. 549–565 above for indications and limitations)

IX. Photographs and body diagrams

X. Diagnostic test results (see paras. 480–484 above for indications and limitations)

XI. Consultations

XII. Interpretation of findings

1. Physical evidence

   A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
   B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: the absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)
   C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.

2. Psychological evidence

   A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.
   B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.

C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, that is what is the time frame in relation to the torture events and where in the course of recovery is the individual?
D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, and loss of family or social role) and the impact that these may have on the individual.
E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

XIII. Conclusions and recommendations

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc.) and allegations of torture or ill-treatment.
2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and care for the individual.

XIV. Statement of truthfulness (for judicial testimony)

For example: "I declare under penalty of perjury, pursuant to the laws of [country], that the foregoing is true and correct and that this affidavit was executed on [date] at [city], [state or province]."

XV. Statement of restrictions on the clinical evaluation/investigation (for subjects in custody)

For example: "The undersigned clinicians personally certify that they were allowed to work freely and independently and permitted to speak with and examine [the subject] in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities"; or "The undersigned clinician(s) had to carry out his/her/their evaluation with the following restrictions: ....."

XVI. Clinician's signature, date and place

XVII. Relevant annexes

A copy of the clinician's curriculum vitae, anatomical drawings for identification of torture and/or ill-treatment, photographs, consultations and diagnostic test results, among others.

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HUMAN RIGHTS
OFFICE OF THE HIGH COMMISSIONER

Office of the United Nations
High Commissioner for Human Rights

Palais des Nations
CH 1211 Geneva 10, Switzerland

Telephone: +41 (0) 22 917 92 20
Email: ohchr-infodesk@un.org
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