

ISTANBUL PROTOCOL HANDBOOK

FOR
MEDICAL PROFESSIONALS
LEGAL PROFESSIONALS
INVESTIGATORS
STATE OFFICIALS
CIVIL SOCIETY

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In addition, the handbook draws on and refers to materials developed as a 'Model Medical Curriculum' on the Istanbul Protocol by a number of organizations, including REDRESS, Physicians for Human Rights, the International Council for the Rehabilitation of Torture Victims and the Turkish Foundation for Human Rights (see further <http://www.phrtoolkits.org/toolkits/istanbul-protocol-model-medical-curriculum/>). This and other helpful materials produced by these organizations and others are referenced throughout.

The training, and the writing and publication of this manual, have been generously funded by the UN OPCAT Special Fund.

PART A: INTRODUCTION

INTRODUCTION TO THIS MANUAL

This manual is intended as a reference on Istanbul Protocol standards for documenting torture and ill-treatment for a variety of professionals in the Maldives. It is aimed at:

- medical professionals, including emergency doctors, those working in private clinics, prison doctors and mental health professionals
- members of the legal profession, including lawyers, judges and prosecutors
- state officials responsible for those in detention, including police officers, correctional services officials and officials from drug rehabilitation and mental health institutions
- staff of the Attorney-General's Office and relevant government ministries, including the Ministry of Home Affairs, Ministry of Law and Gender and Ministry of Health
- members of civil society, in particular those working for non-government organizations (NGOs) who come into contact with victims of torture or other ill-treatment.

The manual is divided into four sections:

- **Part A** provides important background for those using this manual: introductory information on the Istanbul Protocol, the reasons it is important to document allegations of torture and other ill-treatment, international and domestic law related to torture and other ill-treatment and their definitions, and experiences of torture and ill-treatment in the Maldives
- **Part B** provides information on standards and guidelines from the Istanbul Protocol of general relevance to all of those either documenting or investigating torture or other ill-treatment – including standards on investigation, professional ethics considerations, considerations for interviews and collecting evidence, and the potential medical and psychological effects of forms of torture and other ill-treatment
- **Part C** provides practical guidance for different professions in their role documenting torture and other ill-treatment, with reference back to the relevant sections of Parts A and B as necessary
- **Part D** provides a number of recommendations for reform and development in the Maldives to enable effective medico-legal documentation of torture and other ill-treatment in the Maldives, meeting Istanbul Protocol standards.
- **Annexes** providing further reference and resources for medico-legal documentation.

Coloured bars are used throughout the manual to indicate which sections are of relevance to the different professions as follows:

| | |
|---|-----------------------|
|  | MEDICAL PROFESSIONALS |
|  | LEGAL PROFESSIONALS |
|  | INVESTIGATORS |
|  | STATE OFFICIALS |
|  | CIVIL SOCIETY |

This is a detailed manual, meant as a reference, and is complemented by the following shorter publications for practical use:

- **Medical Documentation of Torture and Other Ill-Treatment: Basic guide for medical professionals in the Maldives**
- **Medical Documentation of Torture and Other Ill-treatment – Quick guide for lawyers**
- **Medical Documentation of Torture and Other Ill-treatment – Fact sheet for judges and prosecutors**



1. INTRODUCTION TO THE ISTANBUL PROTOCOL

Torture and other forms of prohibited ill-treatment are recognised in international law as both crimes which the state must prosecute and serious human rights violations.

Torture, by its very nature, is committed by those with power, often behind closed doors. Those responsible – whether state officials or others who the state protects – are shielded from accountability, resulting in denial and impunity. Victims face significant legal and practical barriers to achieve any form of redress, including the difficulty of proving what has happened to them when much of the information required is often in the hands of state authorities.

Those responsible for drafting the **Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**, known as the “**Istanbul Protocol**” recognised the important role that sound documentation of evidence showing torture and other ill-treatment plays in addressing impunity. In particular, they recognised the crucial role that those given early access to potential victims of torture and other ill-treatment, especially independent doctors, lawyers and human rights investigators could play in documenting such treatment.

Although standards existed on the prohibition of torture, particularly under the 1984 United Nations (“UN”) Convention on Torture and Other Cruel, Degrading or Inhuman Treatment or Punishment (“UNCAT”), before the Istanbul Protocol there was no single document setting out how to document and investigate allegations of torture and its consequences. There was also no document comprehensively setting out medical professionals’ obligations in situations where they were coerced to neglect, misrepresent, or falsify evidence of torture. The Istanbul Protocol was designed to fill that gap.

The Protocol was the outcome of a long process of sharing of expertise and experience among more than 75 forensic scientists, physicians, psychologists, human-rights monitors and lawyers, spearheaded by professionals at the Turkish Human Rights Foundation, and Physicians for Human Rights. The experts involved in the drafting were working in a wide range of countries, including Chile, Costa Rica, Denmark, France, Germany, India, Israel, the Netherlands, the occupied Palestinian territories, South Africa, Sri Lanka, Switzerland, Turkey, the United Kingdom, and the United States of America.

The Protocol was submitted to the UN High Commissioner for Human Rights on 9 August 1999, and the principles it contained were endorsed by the UN General Assembly and the UN Commission on Human Rights in 2000.¹ The Protocol as a whole has since been endorsed in a number of resolutions by the UN General Assembly and UN Human Rights Council, which replaced the UN Commission on Human Rights in 2006, as well as by the Committee Against Torture, regional human

¹ General Assembly resolution 55/89 of 4 December 2000 and to Commission on Human Rights resolution 2000/43 of 20 April 2000, both adopted without a vote.

rights courts and the UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.²

The Istanbul Protocol

- Is “a set of **international guidelines** for the **assessment of persons who allege torture and ill treatment**, for **investigating cases of alleged torture**, and for **reporting such findings to the judiciary and any other investigative body**”³

Guidance for Medical Professionals and Lawyers

- provides guidance as to **international professional ethics obligations for medical professionals and lawyers** in relation to documenting torture and other ill-treatment
- provides information on the **medical and psychological effects** of torture and other ill-treatment and how to assess them
- outlines **specific considerations for interviewing** alleged victims of torture and other ill-treatment

Standards for medico-legal reports

- contains internationally recognised standards and procedures on how to identify and document symptoms of torture **so the documentation may serve as valid and useful evidence in court**
- provides standards for producing, and critically evaluating, **medico-legal reports** for use as evidence

Standards on investigations

- outlines **procedures and minimum standards for investigations** into torture and other ill-treatment

Guidance for States

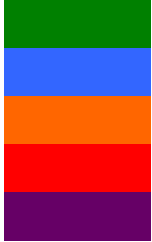
- provides **States with guidance as to procedures that need to be established in places of detention** and elsewhere to allow effective medical documentation of allegations of torture and other ill-treatment in line with obligations under international human rights law

Relevance & Status

- can be used for **criminal investigations, human rights investigations and monitoring, refugee application evaluations, the defence of individuals who “confess” to crimes during torture and needs assessments for the care of torture victims**, as well as gathering evidence for advocacy

² See eg. Committee Against Torture, General Comment No. 3: Implementation of Article 14 by States Parties (2012), CAT/C/GC/3, paras. 18 and 25; Human Rights Council, Resolution 22/21: ‘Torture and other cruel, inhuman or degrading treatment or punishment: rehabilitation of torture victims’, A/HRC/22/L.11/Rev.1, 22 March 2013; General Assembly, ‘Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment’, A/69/387, 23 September 2014.

³ UN Office of the High Commissioner for Human Rights (OHCHR), Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“**Istanbul Protocol**”), 2004, HR/P/PT/8/Rev.1, p. 1.

- 
- is a **recognized United Nations document** and an “**international point of reference**” for health professionals, judges, lawyers, state officials, human rights monitoring bodies and non-government organizations

The Istanbul Protocol has two key parts: **guidelines for the medical assessment and documentation of torture and other ill-treatment**, and **guidelines for commissions of inquiry into allegations of torture and other ill-treatment**. This manual focuses on the first of these aspects, with reference to the second as necessary.

2. BASICS OF DOCUMENTATION

When an allegation of torture is made it is necessary to assemble evidence of the facts surrounding the allegation so that further action can be taken – whether through the criminal justice process, civil courts, national human rights commission, or at the international level. This collection of evidence, or parts of it, may be done by the individual, the police, the individual’s lawyer, a prosecutor or judge, prison authorities, medical professionals, a non-government organisation, or a national investigatory body, such as a national human rights commission.


Documentation of a case involves recording the individual’s version of events and collating other forms of evidence which may support it. In reality, documentation of a case is often done by a number of individuals, though it may be directed or collected by one – such as the individual’s lawyer, the police or an investigative body. Medical professionals may provide documentation either through the medical records they produce for a patient they are treating, or through more formal medico-legal examination and documentation (such as through the use of a Medico-Legal form, or the production of an expert report). This documentation should then be taken into account in an investigation into the allegation and may be used in subsequent legal proceedings.

2.1 HOW CAN TORTURE AND OTHER ILL-TREATMENT BE DOCUMENTED?

Evidence to support a case relating to an allegation of torture or other ill-treatment may take a number of forms. These can include:⁴

- witness statements from the complainant and other witnesses
- medical and psychological expert reports
- medical records
- physical evidence (soiled clothes, weapon, etc)
- photographs/videos
- diagrams, maps, drawings of the scene of the alleged torture
- official records, such as custody records or personnel records
- statistical evidence, for example to demonstrate discriminatory practices
- reports of trends and systematic practices
- other expert evidence, such as evidence as to calculation of loss.

⁴ See further Istanbul Protocol, paras. 88-102, 106.



The **Istanbul Protocol** provides particular guidance on taking **witness statements**, collecting and presenting **medical and psychological evidence**, and the **collection of physical evidence**. Other protocols have also been developed which provide further helpful guidance in certain circumstances, including the **International Protocol on Documentation and Investigation of Sexual Violence in Conflict**, which provides detailed guidance on photographs and video, maps, diagrams, witness statements, reports and physical evidence, in the context of international crimes in a conflict setting.

2.2 WHAT IS THE AIM OF DOCUMENTATION?

The aim of documentation will vary depending on what it is intended to be used for (criminal prosecution, advocacy, civil claims, etc). Generally, however, good documentation will help an investigation into torture to:⁵

- clarify the **facts**, including whether torture or other ill-treatment took place
- establish **responsibility** of individuals and states
- establish **patterns** of violations
- identify measures needed to **prevent recurrence**
- facilitate **prosecution** and provision of **reparation** to victims.

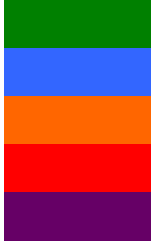
2.3 HOW CAN DOCUMENTATION BE USED?

International human rights law makes it clear that where there is any reasonable suspicion that torture has been carried out, an investigation must be undertaken by State authorities and those identified as being responsible must be prosecuted and punished. Effective documentation is vital to such an investigation and any subsequent prosecution. However, documentation may be useful in other contexts and for other purposes including:⁶

- to bring the authorities to open an official investigation
- judicial and quasi judicial proceedings for redress, including compensation and rehabilitation, for the individual victim, at both the domestic (civil proceedings) and international level (such as through international or regional human rights courts or bodies – in the Maldives this could be the UN Human Rights Committee)
- to prevent further violations for individual victim (eg. to have a confession excluded from trial, to have the individual moved from the place where torture or other ill-treatment is being carried out)
- to assist victims to access services
- in asylum applications

⁵ See Istanbul Protocol, para. 78.

⁶ See further Istanbul Protocol, para. 121.

- 
- to use in evidence-based advocacy for law reform and reform of polices and institutions at the domestic level
 - to use in evidence-based advocacy at international level, such as reporting to UN bodies such as treaty bodies or special procedures
 - for the media, to increase public awareness of the issue.

2.4 WHAT IS GOOD DOCUMENTATION FOR LEGAL PURPOSES?

A number of factors will affect the strength of documentation, and its ability to be used in legal proceedings. Documentation will be strongest if it is:

- **from a reliable and identifiable source:** if the source and circumstances of collection cannot be identified and proved evidence is likely to be of no use in court
- **detailed:** generally, the more detailed the documentation is, the better. In legal proceedings it is necessary to prove a number of elements to show that torture or other ill-treatment have been carried out, including the act that was carried out, the intention of the perpetrator, the purpose of the act, the identity of the perpetrator, the identity of the victim, and the loss associated with it. This may mean that the words used by the perpetrator, the specifics of the location, or the exact nature of the injuries may be of crucial importance.
- **internally consistent:** human memories are not foolproof – particularly after a traumatic event (see further Chapter 7), and so it is almost inevitable that there will be inconsistencies in an individual’s account. However, the extent to which other evidence corroborates or contradicts the account in general will impact on the chances of success in any legal proceedings.
- **collected as soon as possible:** the earlier information is collected, the stronger it is likely to be – for example it is more likely that any physical injuries will still be identifiable. However, this should not dissuade collection of evidence much later if necessary – in such cases medical and psychological evidence can be particularly useful.



3. INTERNATIONAL LAWS ON TORTURE AND OTHER ILL-TREATMENT

Torture and cruel, inhuman and degrading treatment (other ill-treatment) are absolutely prohibited, as a matter of both treaty and customary international law. The prohibition of torture has attained the status of *jus cogens*, that is, a norm that cannot be derogated from under any circumstances. Torture is so serious that it is also recognised as an international crime – the violation of an international rule that leads to the personal criminal responsibility of the individual perpetrator under international law.

3.1 THE MEANING OF TORTURE AND OTHER ILL-TREATMENT

Torture and other ill-treatment are specifically prohibited under the UN Convention Against Torture, and the International Covenant on Civil and Political Rights (“ICCPR”), among many other treaties.

It is important to have a clear understanding of what torture is for documentation purposes, as information must be gathered that is relevant to the particular elements of the crime/violation. If documentation is incomplete, vital information on particular elements may be missing.


Under the UN Convention Against Torture, an act will amount to torture if it fulfils a number of key elements. Article 1 of the Convention defines it 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.**

Consent or acquiescence of the state – and therefore state responsibility – may be shown where an act was committed by a private person, and the state knew about it but did not act effectively to prevent it.⁷

Cruel, inhuman or degrading treatment is not specifically defined in the Convention, but significant jurisprudence exists under the Convention and other international treaties discussing what amounts to such treatment.

⁷ See, eg. Committee Against Torture, General Comment No. 2: Implementation of article 2 by States Parties, U.N. Doc. CAT/C/GC/2/CRP. 1/Rev.4 (2007), para. 18; Human Rights Committee, General Comment No. 20: Article 7 (Forty-fourth session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994), paras. 2 and 13.



It is generally accepted that there is a minimum threshold to be met for conduct to amount to one of the **forms of prohibited ill-treatment**. The European Court has held, for example, that for conduct to fall within Article 3 of the Convention, it must reach a “minimum level of severity”.⁸ The assessment of this minimum is relative, depending on “all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim”.⁹ It is therefore both an objective and subjective test – what effect the treatment was likely to have had on an individual *in the position of the victim*. A similar approach has been taken by the UN Human Rights Committee.¹⁰ The European Court’s approach has also been explicitly followed by the African Commission,¹¹ which has also stressed that the prohibition is to be interpreted as widely as possible to encompass the widest possible array of physical and mental abuses.¹²

Different approaches have been adopted to the requisite threshold for “**cruel**” or “**inhuman**” treatment. Some courts and tribunals have required demonstration of the infliction of “severe” pain or suffering, whether physical or psychological.¹³ Others have maintained the “severe pain and suffering” threshold for torture, and have adopted a lower threshold for cruel or inhuman treatment.¹⁴ The European Court has held treatment to be “inhuman” because, among other things, it was premeditated, was applied for hours at a stretch, and caused either actual bodily injury or intense physical and mental suffering.¹⁵ The International Criminal Tribunal for the Former Yugoslavia held that treatment is inhuman where it causes “serious mental or physical suffering or injury or constitutes a serious attack on human dignity”.¹⁶

For **degrading treatment**, a lower threshold of pain or suffering is required, if the act or combination of acts is carried out in a particularly degrading manner. For example, the European Court has held that treatment will be degrading if it “humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance”.¹⁷

⁸ ECtHR, *Ireland v United Kingdom* (1978) Judgment of 18 January 1978, Series A no. 25 at para. 162.

⁹ ECtHR [GC], *El Masri v Former Yugoslav Republic of Macedonia* (2012) App. No. 39630/09, Judgment of 13 December 2012, at para. 196.

¹⁰ See, eg. HRCtee, *Vuolanne v Finland* (1989) Comm. No. 265/1987, Views adopted 2 May 1989, U.N. Doc. Supp. No. 40 (A/44/40) at 311 at para. 9.2.

¹¹ AfrComHPR, *Huri-Laws v Nigeria* (2000) Comm. No. 225/98, at para. 41.

¹² *Ibid.*, at para. 40; AfrComHPR, *Curtis Francis Doebbler v Sudan* (2003) Comm. No. 236/2000, at para. 37.

¹³ Manfred Nowak, 'Torture and Enforced Disappearance', in Catarina Krause and Martin Scheinin (eds.), *International Protection of Human Rights: A Textbook* (Turku: Institute for Human Rights, Abu Akademi University, 2009) at p. 153. See also International Criminal Court, *Elements of Crimes*, U.N. Doc. PCNICC/2000/1/Add.2 (2000) (“ICC Elements of Crimes”), elements of the war crime of inhuman treatment (Art. 8(2)(a)(ii)-2): “The perpetrator inflicted severe physical or mental pain or suffering upon one or more persons...”. See Rodley’s discussion of the three different approaches taken to the severity requirement in Nigel S. Rodley and Matt Pollard, *The Treatment of Prisoners under International Law* (3rd edn.; Oxford: Oxford University Press, 2011) at pp. 98-99.

¹⁴ Rodley and Pollard, *The Treatment of Prisoners under International Law* at p. 99.

¹⁵ ECtHR, *P & S v Poland* (2012) App. No. 57375/08, Judgment of 30 October 2012 at para. 158.

¹⁶ ICTY, *Delalić case*, Judgment, § 1328; *Kordić and Čerkez case*, Judgment, § 1330.

¹⁷ ECtHR, *Pretty v UK* (2002) App. No. 2346/02, Judgment of 29 April 2012 at para. 52.



Cruel, inhuman or degrading treatment can be committed by state officials in institutions such as prisons, police stations, mental health facilities, drug rehabilitation centres, hospitals and schools. States also have the positive obligation to prevent and respond to such treatment by private individuals, wherever it occurs.¹⁸

3.2 USE OF FORCE BY STATE OFFICIALS IN PUBLIC ORDER SITUATIONS

Excessive use of force by police or other state officials in public order situations may amount to ill-treatment or torture. The general rule is that force may be used by such officials, but it must be:

- to achieve a legitimate aim (such as a lawful arrest, preventing escape of someone lawfully detained, defending someone from unlawful violence, self-defence, or an action lawfully taken to dissolve a demonstration or to quell a riot)
- necessary and
- proportionate.¹⁹

Where force is **not used with a legitimate aim**, or the force used is **unnecessary or disproportionate**, it will amount to prohibited ill-treatment, and could amount to torture.²⁰ State officials have therefore been found responsible for violations carried out in the context of **protests**, for example through **beatings, sexual assault**, or the unnecessary or disproportionate use of **tear gas** or **pepper spray**.²¹

3.3 STATE RESPONSIBILITIES IN RELATION TO TORTURE AND OTHER ILL-TREATMENT

The key responsibilities States have under international treaty law and customary international law to prevent torture from occurring in their jurisdiction, and to respond to it when it does occur.²²

Treaties and customary international law set out a series of specific obligations that states have in order to do this. These include:


¹⁸ For the Human Rights Committee see: General Comment No. 20, above, para. 8. For the European Court of Human Rights see ECtHR, *A v United Kingdom* (1998) App. No. 25599/94, Judgment of 23 September 1998, at para. 22.

¹⁹ UN General Assembly, Code of Conduct for Law Enforcement Officials, Res. 34/169, 17 December 1979, (“UN Code of Conduct for Law Enforcement Officials”), Art. 3. See also UN Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, UN Congress on the Prevention of Crime and the Treatment of Offenders, Havana, Cuba, 27 August to 7 September 1990 (“UN Basic Principles on the Use of Force”), Principle 9.

²⁰ See, eg. Manfred Nowak & Elizabeth McArthur, ‘The Distinction Between Torture and Cruel, Inhuman or Degrading Treatment’, 16 *Torture* (2006); REDRESS, ‘*Sirenko v Ukraine: Written Comments by REDRESS*’, ECHR App. No. 9078/14, 16 April 2014, paras. 12-16, <http://www.redress.org/case-docket/sirenko-v-ukraine>.

²¹ See eg. ECtHR, *Yaşa and Ors. v Turkey* (2013), App. No. 44827/08, 16 July 2013, §47; *Ribitsch v Austria* (1995), App. No. 18896/91, 4 December 1995, §38; *Ali Güneş v Turkey* (2012), App. No. 9829/07, 10 July 2012, §41 (in relation to the use of tear gas against a person under control).

²² UNCAT, Article 2.



Preventive measures:

- Implementing custodial safeguards, such as access to a lawyer, access to a doctor, and review of detention by the courts²³
- Preventive mechanisms, such as monitoring places of detention – including prisons and mental health facilities – through OPCAT mechanisms
- Ensuring that forced confessions are not admitted as evidence²⁴
- Ensure people are not extradited to a place where there is a real risk they may be tortured or subjected to other ill-treatment (*non-refoulement*)
- Ensure training of law enforcement personnel, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment²⁵

Accountability measures:

- Criminalise torture and participation in it
- Make torture subject to universal jurisdiction, so that it can be prosecuted wherever in the world it was committed
- Investigate allegations of torture promptly, impartially and effectively
- Where sufficient evidence is available, adequately punish perpetrators of torture

Reparation measures:

- Provide torture victims with effective access to justice
- Provide torture victims with adequate forms of reparation (compensation, rehabilitation, restitution, satisfaction, guarantees of non-repetition)

States' obligations are not limited to acts carried out by their own officials. They are also required to use due diligence to prevent and respond to any act of torture or other ill-treatment carried out by a private individual.²⁶

The **Istanbul Protocol** is very relevant to many of these obligations. Most centrally, it has specific guidance on ensuring that investigations are prompt, effective, independent and impartial. In addition, allowing access to an independent doctor to effectively document evidence of torture or other ill-treatment (allowing for medical documentation using the Istanbul Protocol) is a crucial custodial safeguard. Monitoring of places of detention may provide documentation of allegations, and Istanbul Protocol standards should be considered in such monitoring. Moreover, effective documentation of allegations, and appropriate understanding of such documentation by prosecutors and the Courts, is vital to ensure that forced confessions are not admitted as evidence, to prevent *refoulement* to torture, to ensure successful prosecutions of perpetrators, and to enable victims of torture and other ill-treatment to obtain redress.

²³ UNCAT, Article 11

²⁴ UNCAT, Article 15.

²⁵ UNCAT, Article 10.

²⁶ See above n.7.



3.4 SPECIFIC RULES ON ROLE OF MEDICAL PROFESSIONALS IN DETENTION SETTINGS

The Standard Minimum Rules for the Treatment of Prisoners, first adopted in 1955, provide important standards for the provision of healthcare to detainees.²⁷ These have been revised and expanded in the recently Revised Standard Minimum Rules for the Treatment of Prisoners (known as the “Mandela Rules”), adopted by the Commission on Crime Prevention and Criminal Justice at the Vienna Crime Commission in May 2015.²⁸ The rules “set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management”.²⁹


An extract of the rules is reproduced at [Annex One](#) – some important standards relevant for medical documentation of torture and other ill-treatment include:

- Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status (Rule 24)
- The health-care service of a prison must consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in **psychology and psychiatry** (Rule 25)
- Accurate and up to date **medical records** of prisoners should be maintained by the prison’s health care service, and must be kept confidential (Rule 26)
- All prisoners should be granted **access to their medical files** upon request, and a prisoner may appoint a third party to access his or her medical file. (Rule 26)
- Where a prisoner is moved to another health care institution, medical files must be transferred and must be subject to **medical confidentiality** (Rule 26)
- Clinical decisions may only be taken by the responsible health-care professionals and **may not be overruled or ignored by non-medical prison staff** (Rule 27)
- Prisoners must be examined by a physician or other qualified health care professional as soon as possible following their admission into custody, and particular attention should be given to “[i]dentifying any ill-treatment that arriving prisoners may have been subjected to prior to admission” (Rule 30)
- 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, including:

²⁷ United Nations, *Standard Minimum Rules for the Treatment of Prisoners*, Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977, Rules 22-26.

²⁸ Revised United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), adopted by the Commission on Crime Prevention and Criminal Justice on 21 May 2015, E/CN.15/2015/L.6/Rev.1.

²⁹ *Ibid.*, Preliminary Observation 1.

- 
- The duty of protecting prisoners' physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only
 - Adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship
 - The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others
 - An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation that may be detrimental to a prisoner's health, such as the removal of a prisoner's cells, body tissues or organs. (Rule 32)
 - If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, **they shall document and report such cases to the competent medical, administrative or judicial authority.** Proper procedural safeguards shall be followed in order **not to expose the prisoner or associated persons to foreseeable risk of harm.** (Rule 34)



4. RESPONDING TO TORTURE AND OTHER ILL-TREATMENT IN THE MALDIVES

Torture has been outlawed under successive Maldivian Constitutions. Article 8 of the 1968 Constitution provided that “no act that constitutes torture and harm should be conducted under any circumstances”. Similarly, although the 1998 Constitution did not specifically refer to the prohibition of torture and other ill-treatment, it provided that “No act detrimental to the life, liberty, body, name, reputation or property of a person shall be committed except as provided by law” (Article 15(c)). The Constitution further stipulated that: “Any Maldivian citizen subjected to oppressive treatment shall have the right to appeal against such treatment to the concerned authorities and to the President of the Republic” (Article 15(d)).


4.1 THE USE OF TORTURE AND OTHER ILL-TREATMENT PRIOR TO THE DEMOCRATIC TRANSITION

There is evidence that torture and other forms of ill-treatment were used regularly in the past with impunity in the Maldives. Prior to 2008, the Maldives was ruled under a dictatorship characterized by absolute executive power, a powerful national security service, and significant restrictions on personal liberty, including widespread use of arbitrary detention. Non-governmental organizations including Amnesty International and the Asian Human Rights Commission published a number of reports during this period referring to widespread torture and other ill-treatment in places of detention.³⁰

More recently, testimonies of a number of survivors of torture and other ill-treatment from this period were published in a report presented to the UN Human Rights Committee in July 2012 by the Torture Victim’s Association of the Maldives and REDRESS.³¹ These testimonies detailed severe and repeated violence against, and abuse of, those in state custody. Forms of torture and other ill-treatment reported included the use of suspension, lengthy use of stocks, being beaten with fists and bars, kicked, blindfolded, handcuffed, the dislocation of joints and breaking of bones, being forced to roll and squat on sharp coral, being drowned or forced into the sea, being put in a water tank, being burned, having bright lights shone in eyes, being left outside for days while tied or handcuffed to a tree, and being covered in sugar water or leaves to attract ants and goats, and in one case being tied to a crocodile’s cage. Sexual assault and humiliation were also reported to have been routinely used.

³⁰ See, eg. Amnesty International, Republic of Maldives: Prisoners of conscience and unfair trial concerns 1990 – 1993, May 1993; Amnesty International, The Maldives: Prisoners of conscience / fear of torture or ill-treatment, July 1998; Amnesty International, Republic of Maldives: Repression of Peaceful Opposition, July 2003, pp. 6-7; Asian Human Rights Commission, Maldives: Government of Maldives must end intolerable rights abuses, July 2004; Asian Human Rights Commission, Maldives/India: Torture, harassment, humiliation and inhuman treatment of Tamil prisoners in Maldives jail, September 2005.

³¹ TVA and REDRESS (2012), ‘This is what I wanted to tell you: Addressing the legacy of torture and ill-treatment in the Maldives’, June 2012, http://www.redress.org/downloads/country-reports/1206_maldivesreport.pdf.



The effects of this torture on survivors was often devastating, leading to significant social, educational medical and psychological problems. A number of those interviewed had complained to state authorities about the treatment they had been subjected to, but none had received any form of redress.

The issue of torture in detention was a catalyst for dramatic changes in the Maldives in the mid-2000s. On 19 September 2003, a young man, Evan Naseem, was taken outside his prison block in Maafushi prison, cuffed to an iron rail with his hands above his head, and beaten to death by jail security personnel using batons, wooden boards, chairs and iron pipes. Civil unrest followed, and the next day guards opened fire at unarmed prisoners, wounding 21 and killing three. According to an International Commission of Jurists mission to the Maldives, Evan Naseem's death and the civil unrest that followed continue to be seen as "an historic turning point after which a series of significant reforms were possible".³²

4.2 TORTURE AND OTHER ILL-TREATMENT AFTER THE DEMOCRATIC TRANSITION

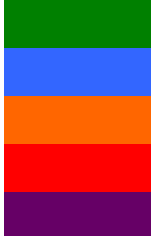
Although the Maldives has not addressed the legacy of torture and other ill-treatment in the country, steps have been taken since 2004 and the democratic transition in 2008 to address the factors which allowed torture and other ill-treatment to occur. This began with the acceptance of international obligations under the UNCAT and ICCPR in 2004 and 2006 respectively, and the creation of the Human Rights Commission of the Maldives ("HRCM") by an Act of Parliament in 2006. Prison reform began in September 2004, when the police and correction services were separated from the armed forces and placed under civilian control. Monitoring of places of detention by the ICRC began in October 2004, and in 2006, the Maldives acceded to the Optional Protocol to the Convention against Torture ("OPCAT"). From 2007 the HRCM was appointed as the National Preventive Mechanism ("NPM").

The Maldives also brought in outside expertise in relation to reform of the prison services, inviting the Subcommittee on the Prevention of Torture to visit in December 2007. Following this, steps were undertaken to reform the police and prisons, including by adopting legislation. A number of new bodies, including the Maldives Police Service Ethical Standards Command, the independent Police Integrity Commission, and the Home Ministry's Inspector-General, were also tasked with visiting places of detention, and responding to complaints of torture and other ill-treatment. A new constitution was finalised in June 2008, guaranteeing personal liberties and prohibiting torture (see next section). Further important legislation – including an Anti-Torture Act – has been adopted since that time, as discussed in the next section.

These changes have led some improvements in responding to complaints of torture and other ill-treatment in the period since the reforms were implemented.³³ There

³² International Commission of Jurists (2011), 'Maldives: Securing an Independent Judiciary in a Time of Transition', para. 7, <http://www.icj.org/dwn/database/Maldives%20ICJ%20Mission%20Report%2021-02-11.pdf>.

³³ For example, in January 2008, two policemen were investigated, found guilty and sentenced to one year's imprisonment for torturing a man in custody in 2006. Between the establishment of the Anti-Torture Section of the HRCM in March 2014 (see further next section) and January 2015, 19 allegations had been investigated, with



also appears to have been a significant reduction in the use of torture and other ill-treatment in detention, although reports of excessive use of force by police in arrest and protest situations continue.³⁴

The experience of individuals working in the field was that the forms of torture and other ill-treatment have decreased, but have changed, and allegations are now more likely to include excessive force at the time of arrest, disproportionate and unnecessary use of force during protests (including use of pepper spray and tear gas, batons and riot equipment, and sexual assault), beating and kicking, handcuffing for indefinite periods and deliberate tightening of handcuffs leading to injury, ‘joy-riding’ with arrested persons in police vans in a way that causes injury, verbal abuse and psychological pressure of detainees brought in for questioning, and denial of medical treatment. Further concerns have been raised about inhumane conditions of detention, including overcrowded cells, denial of access to clean water, infestation including mosquitoes, cockroaches and rats, and the use of solitary confinement as a form of punishment. These forms of ill-treatment can be documented just as other forms of torture and ill-treatment in detention can be.

4.3 NATIONAL LEGAL STANDARDS ON THE PROHIBITION OF TORTURE AND OTHER ILL-TREATMENT

The 2008 Maldives Constitution enshrines the right to life, liberty and security of the person, the right to be free from cruel, inhumane or degrading treatment or punishment, or to torture, the right not to be arbitrarily detained, arrested or imprisoned and the right of arrested and detained persons and persons under state care to be treated with humanity and with respect for the inherent dignity of the human person.³⁵ In particular, Article 54 provides that “No person shall be subjected to cruel, inhumane or degrading treatment or punishment, or to torture”.³⁶

4.3.1 The Anti-Torture Act 2013

The Anti-Torture Act 2013³⁷ defines and criminalises torture and other ill-treatment and makes them punishable by up to 20 years imprisonment.


one case sent to the prosecutor general’s office for prosecution, and 18 cases closed for lack of sufficient evidence.

³⁴ See eg. Amnesty International (2015), ‘Amnesty International Report 2014/15: The state of the world’s human rights’, p. 242; Amnesty International, ‘Maldives: Former president Mohamed Nasheed ill-treated after arrest, denied medical treatment and legal representation’, 3 March 2015, ASA 29/1114/2015, <https://www.amnesty.org/en/documents/asa29/1114/2015/en/>; Amnesty International (2012), The Other Side of Paradise: a Human Rights Crisis in the Maldives, September 2012, ASA 29/005/2012, <https://www.amnesty.org/en/documents/asa29/005/2012/en/>; US Bureau of Democracy, Human Rights and Labour, ‘Country Reports on Human Rights Practices for 2013: Maldives’, pp. 2-3, <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm?year=2013&dld=220399>.

³⁵ See in particular Articles 45-49, 51, 54 and 57.

³⁶ Translation of the Constitution of the Republic of Maldives by Dheena Hussain for Ministry of Legal Reform Information and Arts (2008), www.majlis.gov.mv/en/wp-content/uploads/Constitution-english.pdf.

³⁷ Law Number 13/2013.



Article 9 of the Anti-Torture Act defines **torture** as:

an act by a government official, or with orders from such an official or with the consent of such an official or upon notification from such an official, or with the knowledge of an official or a private person performed intentionally to cause physical or psychological pain or to experience pain in order to achieve the following objectives:

1. To obtain information or a confession from a primary source or third party, or;
2. To inflict a punishment not declared by law to a person who has performed an action or is accused of performing an action, or a third party that has performed an action or a third party that has been accused of performing an action, or;
3. To threaten or to humiliate a person who has committed an action or is accused of committing, or a third party that has performed an action or is accused of performing an action an action, or;
4. To threaten or humiliate a third party in relation to an action by a person or a person accused of performing an action, or;
5. To discriminate between two persons upon a basis not prescribed by law.

(b) Notwithstanding (a) of this article, having to endure the pain as intended due to punishment that has been prescribed by law, for the purposes of this Act, shall not be considered an act of torture.

Note that the Anti-Torture Act definition therefore includes actions by private officials as well as by state officials.

The Act goes on to list a number of forms of both physical and psychological torture in Articles 13 and 14. It stresses however that these are not closed lists and “other actions of a similar nature are also to be considered as ... torture”. These lists are reproduced in [Annex Two](#).

Article 11 of the Act defines “**cruel, inhumane or degrading treatment**” as:

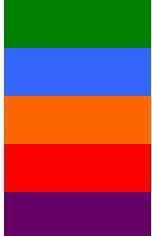
any action or incident that does not fall under the acts of torture stated in articles 13 and 14 of this Act, that inflict extreme pain or actions that may kill the person’s spirit of survival, or actions to convince a person that the person is below the limits of human dignity, inflicted upon a person under the care of a state official, or upon the orders of such an official, or with the consent of such an official, or upon the notification of such an official or with the knowledge of such an official.

Article 15 of the Act gives a separate definition of “cruel, inhumane or degrading treatment” as:

any action or incident that does not fall under the acts of torture stated in articles 13 and 14 of this Act, done with the explicit intention to cause agony, humiliation, or inflicting a sensation of degradation to a person who is under the care of a state official, or upon the orders of such an official, or with the consent of such a official, or with the knowledge of such an official.

(b) An action shall be considered as a cruel, inhumane degrading action only after giving careful consideration to all points and the nature of that action.

(c) In determining whether an action as a cruel, inhumane, degrading act as stated in (b) of this article, the sequence of events of the incident, the conditions




surrounding the incident, the period, time and duration of the incident, the physical and psychological conditions to which the person was subjected, the person's gender, age, health and wellbeing shall be given consideration.

Torture and cruel, inhuman and degrading treatment are **criminalised** by Article 21. Ordering, aiding and assisting or participating in torture are considered equally criminal (Arts. 24 and 25). The Act also criminalises military and police officers who fail to prevent torture when they know it is occurring or are negligent to stop it occurring (Art. 26). **Punishments** range from 15 to 20 years for aggravated cases of torture, and seven to ten years for other cases. Cruel, inhuman or degrading treatment or punishment is punishable by imprisonment of one to three years (Art. 23).

Among other things, the Anti Torture Act also:

- Requires that actions amounting to torture under the Act must be charged under the Act rather than the Penal Code (Art 3(a))
- Provides that **evidence obtained by torture** cannot be used against the accused (Art 5(a))
- Gives priority of the Act over inconsistent provisions in other Acts in relation to torture (Art 8)
- Provides that there is **no justification or excuse** for torture or the infliction of cruel, inhuman or degrading treatment, and that superior orders are no defence (Art 16)
- Requires **registration of places** established for: detention during investigation and pending trial; detention until the completion of the trial; detention of juveniles; detention of people serving their sentences; providing rehabilitation services; providing treatment for mental illness; people with special needs; detention of people for detoxification (Art. 17)
- Guarantees a person alleging torture the **right to lodge a complaint** with the HRCM and provides detailed provisions including timelines as to the procedures for investigating such a complaint (Art. 18)
- Criminalises detaining a person in a place not publicly announced as a detention centre under the Act, or incommunicado, or without informing them about the location or in an environment where it is possible easily carry out acts of torture is also made a criminal offence (Art. 22)
- Provides victims of torture and other ill-treatment with the right to **compensation** (Arts. 29-33) and **rehabilitation** (Art. 34). The Health Ministry, Attorney-General's Office and HRCM are to provide rehabilitation programmes, with NGOs to play a role (Art. 34)
- Designates the HRCM to monitor whether the Act is being implemented, and to submit an annual report on the implementation of the Act to the President and Peoples' Majlis (Art. 37)
- Provides for a form of universal jurisdiction over crimes of torture and cruel, inhuman or degrading treatment (Arts. 38-41)

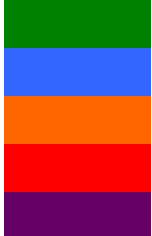
- 
- Requires that people are not deported to countries where there is a risk that they would be subjected to torture (Art. 42)

The Act also has specific provisions on the **right to consultation with a doctor**. It grants a person being detained for more than 24 hours, and a person released from detention, the right to request access to a doctor working in a location other than the place where the person is/was detained. Access to the doctor must be provided within 24 hours. Costs are to be borne by the person seeking access unless the HRCM finds that the person lacks the financial capacity to pay, in which case the State must pay within the 24 hour period (Art. 19).

The consulting doctor must produce a **medical report**, which is to be included in the person's detention file. Article 20 (c) requires this report to include specific information, set out further in Chapter 10.

The Act mandates the **HRCM to investigate allegations of torture** made under the Anti-Torture Act (Art. 18), and provides specific timelines under which this should be carried out. This establishes that:

- Persons must be provided with resources to lodge a complaint from his or her place of detention
- Each investigation is to be conducted with reasonable promptness and must be conducted and concluded within three months of submission
- The complainant must be informed of progress in the investigation within two months of submission
- The investigation report must be provided to the complainant within 14 days of conclusion of the investigation
- If the investigation finds that the complainant has been subjected to torture the HRCM must forward the case to the Prosecutor General's Office within 14 days of completion of the investigation
- The Prosecutor General shall decide whether or not to proceed with a prosecution within 60 days of receiving the case
- If the Prosecutor General proceeds, the case must be sent to court within 90 days
- If the Prosecutor General does not proceed, they must state the reason for the decision and submit it in writing to the HRCM within 90 days
- Court and state authorities must provide adequate protection to a person filing a complaint, their lawyers and their family
- The HRCM must monitor actions being taken by state authorities concerning the progress of the case and share this with the complainant
- Detaining authorities are not to check or read complaints submitted under the Act.



In March 2014, HRCM established an **Anti-Torture Section** to fulfil its obligations under this Act, and has formulated regulations required by the Act. In the period March 2014 to January 2015 19 cases were investigated by the Section, with one sent to the Prosecutor-General's office for prosecution.

The Act also designates the HRCM as the **National Preventive Mechanism (NPM)** in the Maldives, and mandates that it be provided with all the necessary resources to ensure that it can function as such (Art 44(c)). In its role as NPM, the HRCM makes preventive visits to places of detention and provides reports to the government with recommendations.

4.3.2 Other relevant legislation and monitoring bodies

Other relevant legislation includes:

- **Maldives Prisons and Parole Act 2013.**³⁸ This enshrines as a core principle of detention that the conditions of detention should not amount to additional punishment and not to deprive prisoners of any basic right apart from being imprisoned, and grants comprehensive access to independent institutions, international organizations and **Parliamentary Committees.**³⁹ It provides the **Inspector of Correctional Services** with the responsibility to receive complaints of torture in prisons and report to the Minister, and to investigate if a person is grievously harmed or dies in prison. It also establishes a **disciplinary board** to consider allegations of torture or other ill-treatment, however this is not yet fully functional.
- **Police Act 2008.**⁴⁰ The Police Act requires police to respect and protect the fundamental rights of the citizens while performing their role, prohibits them from acting cruelly, in a degrading manner, inhumanely or mercilessly towards another person, and requires them to abstain from the exercise of disproportionate force while performing police duties.⁴¹ The Act establishes a **professional standards unit** to consider allegations made against Maldives Police Service ("MPS") personnel, and to conduct visits to places of custodial detention to monitor the services given and the conditions of custody facilities. It also establishes the **Police Integrity Commission** to investigate allegations made against MPS personnel, which reports to the Home Minister. The Police Integrity Commission is also empowered to conduct visits to places of detention.
- **Human Rights Commission of the Maldives Act 2006.**⁴² This establishes the HRCM as an independent institution. Aside from its specific powers under the Anti-Torture Act, the Act gives the HRCM the power to visit and make recommendations in relation to places of detention and to investigate

³⁸ Law No. 14/2013.

³⁹ Art. 15. The powers include to enter and inspect all areas of the jail, meet prisoners separately or otherwise and obtain information from them, obtain samples of food and water provided to prisoners, for testing, look at prison records and make copies, obtain other relevant information, obtain recordings of security cameras and audio recordings installed within the prison.

⁴⁰ Law No. 5/2008.

⁴¹ Art. 7.

⁴² Law No. 6/2006.



allegations of human rights violations brought to its attention. Article 33 restricts the HRCM's jurisdiction over cases that occurred before 1 January 2000 and limits the HRCM from investigating cases after that date until the coming into force of the Act in 2006, to those filed within one year of the alleged violation. However, at the same time, Article 33(c) provides the HRCM with powers to investigate any complaints "where the Commission deems such a complaint is necessary to be investigated based on its nature and severity".

- **Protection of the Rights of the Child Act 1991.** This provides certain additional protections to children, including a preference for rehabilitation over punishment and that punishment should not be physically or psychologically harmful.

PART B: GENERAL INFORMATION

5. MINIMUM STANDARDS FOR INVESTIGATION & DOCUMENTATION

The Istanbul Protocol includes a set of **Principles for the effective investigation and documentation of torture, and other cruel, inhuman or degrading treatment or punishment**.⁴³ These reflect the requirements of international human rights law and “outline **minimum standards for States** in order to ensure the effective documentation of torture”.⁴⁴ The Principles were endorsed by both the UN General Assembly and the UN Commission on Human Rights in 2000.⁴⁵

It is useful for those involved in documenting torture and other ill-treatment to be aware of these minimum standards, so that they can ensure or insist that those relevant to their work are upheld in individual cases, and push for more general reform where they are not routinely followed. **Principle 6 is particularly relevant to medical professionals involved in investigations.**

The Principles include the following minimum standards:

Investigations

- The **purposes of effective investigation and documentation** of torture and other ill-treatment include:
 - Clarifying the facts and establishing and acknowledging individual and State responsibility for victims and their families;
 - Identifying measures needed to prevent recurrence;
 - Facilitating prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible;
 - Demonstrating 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. (Principle 1)
- States **must ensure that complaints and reports of torture or other ill-treatment are promptly and effectively investigated**, even in the absence of an express complaint. (Principle 2)
- Investigators must be **independent of the suspected perpetrators** and the agency they serve, and must be **competent and impartial**. (Principle 2)
- Investigators **must have access to, or be able to commission investigations by, impartial medical or other experts**. The methods used to carry out such investigations must meet the highest professional standards and the findings must be made public. (Principle 2)
- The investigative authority **must have the power and obligation to obtain all the information necessary to the inquiry**, including the authority to oblige state officials allegedly involved and any witness to appear and testify and to demand the production of evidence (Principle 3)

⁴³ See Istanbul Protocol, Annex I (p. 59).

⁴⁴ Istanbul Protocol, p. 2.

⁴⁵ The Principles are annexed to General Assembly resolution 55/89 of 4 December 2000 and to Commission on Human Rights resolution 2000/43 of 20 April 2000, both adopted without a vote.

- Alleged victims of torture or other ill-treatment, witnesses, those conducting the investigation and their families **must be protected from violence**, threats of violence or any other form of intimidation. (Principle 3)
- Those potentially implicated in torture or other ill-treatment **must 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. (Principle 3)
- Alleged victims of torture or other 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 shall be **entitled to present other evidence**. (Principle 4)

Independent Commissions of Inquiry

- Where established investigative procedures are inadequate,⁴⁶ States must ensure investigations are carried out through an **independent commission of inquiry** or similar procedure. Members of such a commission must be recognised as **impartial, competent and independent**. (Principle 5)
- Any such Commission must provide a **written report outlining its procedures and methods, conclusions and recommendations** based on findings of fact and applicable law, and the report must be made public. (Principle 5)

Examination and report by medical experts

- Medical experts involved in the investigation of torture or other ill-treatment must behave at all times in conformity with **the highest ethical standards** and, in particular, **shall obtain informed consent before any examination** is undertaken. (Principle 6)
- The **examination must conform to established standards of medical practice**. In particular, **examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents** and other government officials. (Principle 6)
- The medical expert must promptly prepare an **accurate written report**, which must include certain minimum information. (Principle 6)
- The medical expert's **report must 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 must be solicited and recorded in the report. (Principle 6)
- The **report must also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or other ill-treatment**. The State must ensure that it is delivered securely, and the report must 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. (Principle 6)

⁴⁶ For example because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse or for other substantial reasons.

6. KEY PRINCIPLES OF PROFESSIONAL ETHICS

Both legal and medical professionals are governed by codes of ethics that give rise to a responsibility to play a role in combating torture and other ill-treatment, and provide crucial guidance in difficult situations. The Istanbul Protocol sets out important ethical principles which professionals should have firmly in mind when coming into contact with suspected torture or other ill-treatment. Although these ethical principles are specifically relevant to the two professions, they should also be borne in mind by others coming into contact with victims of torture and other ill-treatment, including members of civil society.

6.1 ETHICS COMMON TO MEDICAL AND LEGAL PROFESSIONS

Unsurprisingly, a number of ethical principles are closely matched across both professions. These include:

- **The duty to act in the best interests of the patient / client**

The fundamental ethical duty of **medical professionals** is to “always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations”.⁴⁷ This guides all other considerations. Similarly, across legal professions, **lawyers** generally hold ethical principles to act in the best interests of their client, while upholding the rule of law and the proper administration of justice.⁴⁸

- **The duty to promote and protect human rights**

The general duty to promote human rights applies to both legal and medical professionals.⁴⁹ **Judges** in particular have the ethical duty to “ensure that judicial proceedings are conducted fairly and that the rights of the parties are respected”,⁵⁰ while **prosecutors** have “ethical duties to investigate and prosecute a crime of torture committed by public officials”.⁵¹

United Nations Principles also make it clear that “**health professionals** have a moral duty to protect the physical and mental health of detainees”.⁵² For medical professionals, in particular it is “a gross contravention of health-care ethics to participate, actively or passively, in torture or condone it in any way”.⁵³ The Istanbul Protocol also stresses that “[h]ealth professionals also have a duty to support colleagues who speak out against human rights violations”,⁵⁴ and that

⁴⁷ See Istanbul Protocol, para. 51.

⁴⁸ See, eg. UN Basic Principles on the Role of Lawyers, Principles 12-15; England and Wales: Solicitors Regulation Authority Code of Conduct, Principles 1 and 5.

⁴⁹ Istanbul Protocol paras. 49-50 (legal profession); paras. 51-55.


⁵⁰ Istanbul Protocol, para. 49, citing Principle 6 of the United Nations Basic Principles on the Independence of the Judiciary.

⁵¹ Article 15 of the United Nations Guidelines on the Role of Prosecutors, cited in the Istanbul Protocol, para. 49.

⁵² Istanbul Protocol, para. 52, referring to the UN 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 (1982).

⁵³ Istanbul Protocol, para. 52. See also paras. 53-54.

⁵⁴ Istanbul Protocol, para. 55.



the World Medical Association has “called upon individual doctors to speak out against maltreatment”.⁵⁵

- **The duty of confidentiality**

Both medical and legal professionals owe duties of confidentiality to their patients/client. For both **lawyers** and **medical professionals** the duty of confidentiality “is not absolute and may be ethically breached in exceptional circumstances where failure to do so will foreseeably give rise to serious harm to people or a serious perversion of justice”.⁵⁶ Generally however, the confidentiality of identifiable information about individuals can only be overridden with the informed permission of the individual.⁵⁷

- **Informed consent**

Medical ethics recognise that a patient is the best judge of his or her own interests, and so requires doctors “to obtain voluntary and informed consent from mentally competent patients to any examination or procedure”.⁵⁸ This means that “[b]efore examining patients, health professionals must ... explain frankly the purpose of the examination and treatment”.⁵⁹ Similarly, **lawyers** have ethical duties to provide a proper service to their client and to respect their client’s confidentiality. This requires ensuring that their client understands the action that a lawyer proposes to take on their behalf, and gives appropriate, informed consent for such action and disclosure of information. This consent to act should normally be obtained in writing.

- **Non-discrimination**

Medical and legal professionals also have ethical duties to ensure that in their practice they do not discriminate between patients (on any basis other than the urgency of their medical needs) or clients.⁶⁰

6.2 SPECIFIC ETHICAL DUTIES OF THE MEDICAL PROFESSION, AND WIDER RELEVANCE

- **The principle of ‘do no harm’**

The duty to ‘do no harm’ is central to medical ethical principles, requiring **medical professionals** to consider the possible harm that intervention might cause before carrying it out.⁶¹ This is one reason why participation in torture is such a gross violation of those ethics. The principle, although not generally

⁵⁵ *Ibid.* See eg. World Medical Association’s Declaration of Tokyo (1975); World Psychiatric Association’s Declaration of Hawaii (1977); World Medical Association’s resolution on human rights (1990); World Medical Association’s Declaration of Hamburg (1997).

⁵⁶ Istanbul Protocol, para. 65.

⁵⁷ *Ibid.*

⁵⁸ Istanbul Protocol, para. 64.

⁵⁹ *Ibid.* Although note that in an emergency situation where a patient is unconscious and treatment required immediately, the consent may be implied.

⁶⁰ Istanbul Protocol, paras. 56 and 62 (medical professionals); UN Basic Principles on the Role of Lawyers, Principle 2 (legal professionals).

⁶¹ The principle is referred to in the Istanbul Protocol, para. 56.



found in legal ethics codes,⁶² is closely connected to **lawyers'** duties to uphold the rule of law and to act in the best interests of the client. It has also been adopted by **humanitarian and civil society organisations** as an important guiding principle in their work.⁶³

- **The duty to provide compassionate care**

Medical professionals have the ethical duty to “respond to those in medical need”.⁶⁴ This requires doctors to be independent and “to adhere to best medical practices despite any pressure that might be applied”.⁶⁵

- **Guidance for health professionals with dual obligations**

The Istanbul Protocol also provides guidance for **medical professionals** with dual obligations, such as prison doctors who owe duties to their patients and their employer and non-medical colleagues. In particular, it stresses that “[i]n all cases where doctors are acting for another party, they have an obligation to ensure that this is understood by the patient”.⁶⁶ Duties to act in the best interest of the client, to act with independence and to maintain patient confidentiality remain. The Protocol provides specific guidance for **doctors in a therapeutic situation** (para. 70), **forensic doctors** (para. 71) and **prison doctors** (para. 72) in this regard.

Summary of relevant ethical principles

Medical and legal professionals have ethical duties to:

- Act in the best interests of the patient / client
- Promote and protect human rights
- Protect patient/client confidentiality
- Obtain informed consent
- Ensure non-discrimination

Medical professionals also have the following ethical duties, which are also relevant to other actors:

- Above all, to ‘do no harm’
- To provide compassionate care


⁶² Although some have argued that it should be, see, eg. ABA Journal (2014), ‘Should ‘do no harm’ be added to lawyer ethics rules? Torture memo shows need for change, op-ed says’, 16 December 2014, http://www.abajournal.com/news/article/should_do_no_harm_be_added_to_lawyer_ethics_rules_torture_memo_shows_need_f.

⁶³ See eg. Oxfam, ‘Oxfam’s Role in Humanitarian Action’, Oxfam Policy Compendium Note, June 2013, <https://www.oxfam.org/sites/www.oxfam.org/files/hpn-role-humanitarian-action-010613-en.pdf>; UNICEF, ‘UNICEF’s Humanitarian Principles’ (2003), <http://www.unicef.org/nutrition/training/1.4/10.html>; UK Foreign Office, ‘International Protocol on the Documentation and Investigation of Sexual Violence in Conflict: Basic Standards of Best Practice on the Documentation of Sexual Violence as a Crime under International Law’ (“PSVI Protocol”), June 2014, Section 2.3, <https://www.gov.uk/government/publications/international-protocol-on-the-documentation-and-investigation-of-sexual-violence-in-conflict>.

⁶⁴ Istanbul Protocol, para. 58.

⁶⁵ Istanbul Protocol, para. 61.

⁶⁶ Istanbul Protocol, para. 67.

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- For medical professionals with dual obligations the overriding principles are to do no harm and to maintain professional independence to provide compassionate care

7. TORTURE AND OTHER ILL-TREATMENT AND THEIR MEDICAL AND PSYCHOLOGICAL EFFECTS

When investigating an allegation of torture or other ill-treatment or examining an individual who alleges torture or other ill-treatment it is important to be aware of methods of torture commonly used in a particular location, and the physical and psychological effects that they may have on an individual.

As the Istanbul Protocol notes, “[t]he distinction between physical and psychological methods is artificial. For example, sexual torture generally causes both physical and psychological symptoms, even when there has been no physical assault”.⁶⁷ Different forms of other ill-treatment may result in both physical and psychological symptoms, or none at all.

The Istanbul Protocol recognises that “[t]o the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person has been tortured. However, **the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars**”.⁶⁸

7.1 FORMS OF TORTURE AND OTHER ILL-TREATMENT THAT MAY LEAD TO PHYSICAL & PSYCHOLOGICAL EVIDENCE

As in the Istanbul Protocol itself, the following list of torture methods and possible consequences “is given to show some of the categories of possible abuse” and their possible effects, but **is not meant to be used as a checklist or as a model for listing torture methods in a report as further forms of torture and ill-treatment may be developed and used**.

Note that further information concerning this section is available in training materials in Module 4 of the Model Medical Curriculum for the Istanbul Protocol, created as part of the Prevention through Documentation Project carried out by IRCT, Physicians for Human Rights, Human Rights Foundation Turkey and REDRESS – the full version is available at: <http://phrtoolkits.org/downloads/?did=33>.

- (i) **Blunt trauma** (see further IP, paras. 189-193, 197, 198-199, 201-202, 203-205)

May include slapping, kicking, punching & hammering by blunt objects, beating with heavy whip, baton, stick etc, application of repeated blows to the head after fitting the victim with a helmet, blunt force trauma to sexual organs, *Falanga* (repeated beating to soles), *Telefono* (simultaneous beating of both ears with palms of both hands).

⁶⁷ Istanbul Protocol, para. 145.

⁶⁸ Istanbul Protocol, para. 161 (emphasis added).

⇒ *For possible physical evidence and further investigations see flowcharts – Beating to Head, Beating to Chest and Back, Beating to Internal Areas and Back – in **Annex Four**.*

(ii) Positional torture (see further IP, paras. 206-211)

May include suspension and other positional torture where the victim is tied or restrained in a contorted, hyperextended or other unnatural position.

⇒ *For possible physical evidence and further investigations see flowchart – Suspension – Positional Torture – in **Annex Four**.*

(iii) Heat torture (see further IP, para. 194-195)

May include burning of the skin with heated instruments, cigarettes, scalding liquid or a caustic substance.

⇒ *For possible physical evidence and further investigations see flowchart – Electric – Heat Appliance – in **Annex Four**.*

(iv) Electric shock torture (see further IP, para 212)

⇒ *For possible physical evidence and further investigations see flowchart – Electric – Heat Appliance – in **Annex Four**.*

(v) Dental torture (see further IP, para. 213)

In the form of breaking or extracting teeth or through application of electrical current to the teeth.

(vi) Asphyxiation (see further IP, para. 214)

Near asphyxiation by suffocation through eg. covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or waterboarding.

⇒ *For possible physical evidence and further investigations see flowchart – Asphyxiation – in **Annex Four**.*

(vii) Violent shaking (see further IP, para. 200)

(viii) Irritant torture and other ill-treatment

Exposure to irritants such as salt, chillis to body or eyes, or irritants to eyes and respiratory system such as tear gas or pepper spray.

(ix) Cutting & stabbing (see further IP, para. 196)

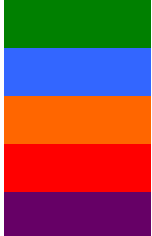
Cutting of the skin with a sharp object, such as a knife, bayonet or broken glass.

(x) Crush injuries

(xi) Pressure/twist/squeeze to eyes, breasts, genitals

(xii) Sexual torture (see further IP, paras. 215-232)

May include forced nudity, verbal sexual threats, sexual humiliation and mocking, groping and rape.



⇒ *For possible physical evidence and further investigations see flowcharts – Sexual Torture – Women and Sexual Torture - Men – in Annex Four.*

(xiii) Prolonged isolation and sensory deprivation

(xiv) Sleep deprivation

(xv) Pharmacological torture

Using toxic doses of sedatives, neuroleptics, paralytics, etc.

(xvi) Denial of medical treatment

(xvii) Detention in inhumane conditions

7.2 FORMS OF TORTURE AND OTHER ILL-TREATMENT THAT MAY NOT LEAVE PHYSICAL EVIDENCE

Other forms of torture or other ill-treatment that may not lead to direct physical evidence, but may (or may not) lead to psychological evidence include:

(i) Humiliation, such as verbal abuse, performance of humiliating acts

(ii) Threats of death, harm to family, further torture, imprisonment, mock executions

(iii) Threats of attack by animals

(iv) Psychological techniques to break down the individual, including forced betrayals, accentuating feelings of helplessness, exposure to ambiguous situations or contradictory messages

(v) Violation of taboos

(vi) 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, forced betrayal of someone placing them at risk of harm


(vii) Forcing the victim to witness torture or atrocities being inflicted on others.⁶⁹

7.3 PSYCHOLOGICAL EVIDENCE OF TORTURE AND OTHER ILL-TREATMENT

The Istanbul Protocol is important in recognizing the central place of psychological evidence in investigating allegations of torture and other ill-treatment, and specifies that **any evaluation of torture should include a psychological assessment.**⁷⁰ All kinds of torture inevitably comprise psychological processes, and contrary to the physical effects of torture, psychological effects may be more persistent and troublesome.

⁶⁹ See Istanbul Protocol, para. 145.

⁷⁰ Istanbul Protocol, para. 104.



The Istanbul Protocol recognises that “torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering”, and 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”.⁷¹ The sense of powerlessness, terror, dehumanisation and loss of will involved in torture and other ill-treatment can lead to the impairment or destruction of the psychological and social integrity of the victim.⁷² In addition, “torture can profoundly damage intimate relationships between spouses, parents, children, other family members and relationships between the victims and their communities”.⁷³

Not every person who has been tortured or ill-treated develops a diagnosable mental illness, however, many victims of torture and other ill-treatment experience profound emotional reactions and psychological symptoms.⁷⁴

Similarly, all forms of torture will not have the same outcome, and the effect of a particular form of torture may be different on different people. “Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity”.⁷⁵

7.3.1 Factors that may affect psychological manifestations

A number of factors can affect psychological manifestations of torture and other ill-treatment in a particular individual. These include:

- The social context before, during and after the event
- The individual’s belief system and preparedness for the events
- Previous history of psychological problems
- Previous traumas
- The individual’s coping strategies and support system
- The individual’s age and physical health
- The conditions of torture and additional losses caused by it.⁷⁶

7.3.2 Common psychological responses to torture and other ill-treatment

The Istanbul Protocol outlines (at para. 241) a number of commonly experienced psychological responses, including:

⁷¹ Istanbul Protocol, para. 234.

⁷² On this, see the definition of torture in the Inter-American Convention to Prevent and Punish Torture, Art. 2 (“torture shall be understood to be 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”).

⁷³ Istanbul Protocol, para. 235.

⁷⁴ Istanbul Protocol, para. 236.

⁷⁵ Istanbul Protocol, para. 234.

⁷⁶ Dr Yvonne Eligado Entico, ‘Psychological Sequelae of Torture’, slides presented at training in Malé January 2015.



- Re-experiencing the trauma – involving flashbacks or intrusive memories, recurrent nightmares and lack of trust in and fear of authority figures
- Avoidance and emotional numbing – involving avoidance of any thought, conversation, activity, place or person that arouses a recollection of the trauma
- Hyperarousal – including difficulty falling or staying asleep, irritability or anger, difficulty concentrating, hypervigilance, generalized anxiety and shortness of breath, sweating, dry mouth or dizziness and gastrointestinal distress
- Symptoms of depression including 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
- Damaged self-concept and a sense of foreshortened future
- Dissociation, depersonalization and atypical behaviour
- Somatic complaints such as pain, headache or other physical complaints
- Sexual dysfunction
- Psychosis
- Substance abuse, including of alcohol and drugs
- Neuropsychological impairment – eg. from blows to the head, suffocation and prolonged malnutrition

7.3.3 Commonly diagnosed disorders among trauma and torture survivors

Findings among torture survivors are widely diverse and will “relate to the individual’s unique life experiences and his or her cultural, social and political context”.⁷⁷ However, there are a number of commonly diagnosed disorders among trauma and torture survivors which it is useful for practitioners and others working with torture survivors to be aware of. These include (IP, paras. 250-259):

- Acute stress reaction
- Depressive disorders
- Post-traumatic stress disorder
- Enduring personality change
- Substance abuse

Other diagnoses which may also be considered include, but are not limited to (IP, para. 259):

- Generalized anxiety disorder features excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity

⁷⁷ Istanbul Protocol, para. 250.

- 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
- Acute stress disorder has essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event
- Somatoform disorders featuring physical symptoms that cannot be accounted for by a medical condition
- 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 may be triggered or exacerbated by torture or other ill-treatment
- Phobias such as social phobia and agoraphobia

Some issues which are frequently overlooked include:

- Symptoms of complex PTSD
- Co-morbidity of disorders
- Behavioural consequences
- Functional sexual disorders
- Cultural specific reactions
- Mild traumatic brain injury

The process of carrying out a psychological/psychiatric evaluation is covered in Chapter 10 of this Manual, and in detail in Chapter VI (c) of the Istanbul Protocol.

It is very important to note that “even though a diagnosis of a trauma-related mental disorder may support a claim of torture, not meeting the criteria for a psychiatric diagnosis does not mean that the person was not tortured”.⁷⁸

⁷⁸ Turkcan Baycal et al., ‘Psychological Evidence of Torture and Ill-Treatment’, Module 6 of Model Medical Curriculum, Prevention Through Documentation Project (IRCT, HRFT, REDRESS, PHR), Slide 7, <http://phrtoolkits.org/downloads/?did=29>.

8. GENERAL INTERVIEW CONSIDERATIONS

This chapter is primarily aimed at those in a formal interview situation (eg. lawyers investigators, medical professionals instructed to carry out a formal medical evaluation and civil society activists).

The same ideal standards may not be able to be reached by, eg. treating emergency physicians and lawyers interviewing detainees, however the standards should be borne in mind and adapted as possible and appropriate in all settings.

Documentation by lawyers, medical professionals, investigators and civil society will almost certainly involve interviewing the alleged victim of torture or other ill-treatment.

The interview with an alleged victim is often the most important part of any documentation process, providing crucial evidence in itself and allowing for the identification of other evidence to be collected or documented.

It is important to bear in mind that retelling the facts of torture or other ill-treatment may be difficult, and could cause the person to “relive the experience or suffer other trauma-related symptoms”.⁷⁹ It is therefore necessary to ensure that alleged victims are not made to go through this process more than is absolutely necessary, that interviewers deal with interviewees sensitively and that the process itself is made as easy as possible for them. In carrying out an interview, “two important requirements should be balanced:

- the need to obtain a useful detail account, and
- the importance of respecting the needs of the person being interviewed”.⁸⁰

8.1 AVOIDING DUPLICATION

At the outset, it is important to consider whether the individual has already been interviewed, and if a further detailed interview is necessary.

For the purposes of compiling an expert medico-legal report, or an official investigation, re-interviewing will almost certainly be necessary. In such circumstances it is important to ensure sufficient preparation to enable the right questions to be asked, avoiding the need for unnecessary follow-up interviews.

Lawyers and NGOs may however find that interviews have already been carried out, or witness statements compiled, and may seek to obtain these before doing further detailed interviews.

⁷⁹ Istanbul Protocol, para. 49; see also Istanbul Protocol, Chapter IV, Section H.

⁸⁰ IRCT, ‘Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment’, Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007), p. 4, <http://www.irct.org/Admin/Public/Download.aspx?file=Files%2Ffiler%2FIPIP%2Ftraining2009%2Fmedical+materials+for+practitioners%2FFinal+Medical+Checklist.pdf>.



8.2 THE SETTING

The interview should be conducted in an appropriate **location**:

- in a room of appropriate size, with sufficient ventilation and light
- allowing for privacy and confidentiality
- allowing for the safety and security of interviewee and interviewer
- security forces / law enforcement personnel should not be present
- there should be adequate facilities for the interviewee, such as refreshments, access to a toilet, etc.⁸¹

8.3 THE INTERVIEWER

Ideally, the person being interviewed should be able to choose the gender of the person interviewing them (and where necessary the interpreter).⁸² The Istanbul Protocol notes that this may be particularly important in cases involving sexual violence, as “the retraumatisation can often be worse if [the interviewee] ... has to described what happened to a person who is physically similar to [the] torturers”.⁸³

8.4 THE INTERVIEW

The interviewer should allow **sufficient time** for the interview. A detailed medico-legal interview, for example, may take at least four hours. Often, information may not be fully forthcoming in the first interview, and the interviewer should be prepared to conduct further interviews with the individual if required.

Interviewers – whether doctors, lawyers or investigators – should “use great care” in their contact with the alleged victim, as their “choice of language and attitude will greatly affect the alleged victim’s ability and willingness to be interviewed”.⁸⁴ The interviewer should:

- Explain the purpose of the interview, the use/s to which it may be put, which parts (if any) will be made public, and obtain the victim’s informed consent to proceed
- Explain that the interviewee can stop the questioning at any time, to take a break if needed, or to choose not to respond to any question⁸⁵
- Be “sensitive in tone, phrasing and sequencing of questions, given the traumatic nature of the alleged victim’s testimony”⁸⁶
- Use non-leading questions (eg. “What happened to you and where?” rather than “Were you tortured in prison?”)

⁸¹ *Ibid.*, p. 3. Istanbul Protocol, paras. 93 and 164.

⁸² Istanbul Protocol, para. 154.

⁸³ Istanbul Protocol, para. 154.

⁸⁴ Istanbul Protocol, para. 93.

⁸⁵ Istanbul Protocol, para. 93 (in relation to investigators). This is equally applicable to interviews carried out by others.

⁸⁶ Istanbul Protocol, para. 93.

- “Allow the person to tell his or her own story, but assist by asking questions that increase in specificity”⁸⁷
- Encourage the interviewee to use all their senses to describe what happened – “what he or she saw, smelled, heard and felt”⁸⁸ – particularly important where blindfolded or where it was dark

From: IRCT, ‘Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment’, Prepared by Society of Forensic Medicine Specialists, and revised through Prevention Through Documentation Project: IRCT (2007)

- Be attentive to tone, phrasing and sequencing of questions
- Design the interview, if possible, according to the needs of the interviewee:
 - Short episodes with breaks,
 - Begin with less sensitive issues, general questions,
 - Continue with more sensitive and deeper issues afterwards, seek for more specific details
- Before closing the interview, ensure that the emotional arousal has subsided.
- Avoid any manner, approach, style which may remind of the torture situation.
- Inform the interviewee that s/he can request breaks and interrupt the interview at any time s/he wishes.
- Provide adequate time and comfortable settings.
- Give time, space to his/her own needs, questions.
- Be open to learn and apprehend the patient’s situation.
- Use active listening.
- Create a climate of trust, courtesy, honesty, empathy.

Be aware of the:

- Potential risk of retraumatization.
- Potential emotional reactions that evaluations of severe trauma may elicit in the interviewee.
- The clinician’s own potential personal reactions, feelings that might influence the clinician’s perceptions and judgements.


8.5 USE OF INTERPRETERS

Ideally the interpreter used should be a **professional interpreter**, who is knowledgeable about torture issues.

Although it may sometimes be unavoidable, it is not advisable to use an interpreter from the interviewee’s own family or social group, as they may not feel comfortable

⁸⁷ Istanbul Protocol, para. 93.

⁸⁸ Istanbul Protocol, para. 93.



talking about their experience through people they know.⁸⁹ There may also be more scope for the interviewee to be intimidated by the process, or for the information to be misused.

Interpreters must be advised that “what they hear and interpret in interviews is strictly confidential”.⁹⁰ An interpreter should also identify themselves and their role at the start of an interview, and the individual should be assured that neither the interviewer nor the interpreter will misuse information.

When using an interpreter, the interviewer should remember to “talk to the person and to maintain eye contact, even if he or she has a natural tendency to speak to the interpreter”. To ensure this, using a triangular set-up of chairs is helpful, with the interviewer directly facing the interviewee. An interviewer should not use the time when the interpreter is translating the question or the interviewee answering it to take notes, as this may appear as if the interviewer is not listening.⁹¹

8.6 SUPPORT AND REFERRAL

Those interviewing individuals in relation to torture and other ill-treatment for the purpose of collecting evidence have the responsibility to ensure that interviewees can access psychological counseling and to refer them to further support.⁹²

“Before initiating any documentation process, practitioners should endeavour to identify options for referring survivors/witnesses for assistance and support, and should put in place procedures for the referral process itself. All survivors and witnesses have a right to know prior to interview what health, psychological, legal and social services are available to them”.

PSVI Protocol, Annex 5

For medical professionals, “examinations to document torture for medical-legal reasons should be combined with an assessment for other needs, whether referral to specialist physicians, psychologists, physiotherapists or those who can offer social advice and support”.⁹³ Medical professionals should “not hesitate to insist on any consultation or examination” that they consider necessary, and should refer those who appear to be in need of further medical or psychological care to the appropriate services.⁹⁴ Relevant protocols should be put in place in hospitals to allow medical professionals to do this.

8.7 SPECIFIC CONSIDERATIONS FOR INTERVIEWING THOSE IN DETENTION

Specific standards apply for the conducting of medico-legal examinations of individuals in detention – these are set out in Section 10.5.2.

⁸⁹ Istanbul Protocol, para. 98.

⁹⁰ Istanbul Protocol, para. 150.

⁹¹ Istanbul Protocol, para. 152.

⁹² Istanbul Protocol, para. 94.

⁹³ Istanbul Protocol, para. 156.

⁹⁴ Istanbul Protocol, para. 156.



Other more general considerations include the following:

- **Be careful of one-off visits** – those raising allegations of torture and other ill-treatment may be the subject of reprisals from those responsible, so any such visit without follow-up to ensure the safety of interviewees may be dangerous, and in some cases may be worse than no visit at all. Such visits can also give an incomplete picture.⁹⁵
- Visits “are best left to investigators who can carry them out and follow them up in a professional way and who have certain weathered **procedural safeguards** for their work”.⁹⁶
- “All precautions should be taken to **ensure that detainees do not place themselves in danger**. Detainees who have been tortured should be asked whether the information can be used and in what way. They may be too afraid to allow use of their names, fearing reprisals for example. Investigators, clinicians and interpreters are bound to respect that which has been promised to the detainee”.⁹⁷ They should also ensure that prisoners do not place themselves at risk of reprisals unnecessarily, especially if a follow-up visit is not guaranteed.⁹⁸
- Sometimes it may be clear from visible injuries that a large number of prisoners have been tortured but they refuse to allow investigators to use their stories for fear of reprisals. A useful way around this may be to organise a “**health inspection**” of all detainees together in a public area of the detention centre, directly observing visible signs of torture, and ensuring that no individual detainee is singled out as having made allegations.⁹⁹
- Ideally interpreters should be independent and clearly seen as coming from “outside”¹⁰⁰ – although in the Maldives there will of course be limits to this.
- Each prisoner deserves as much attention as the other; **time should be allocated** and managed accordingly.¹⁰¹

⁹⁵ Istanbul Protocol, para. 127.

⁹⁶ Istanbul Protocol, para. 128.

⁹⁷ Istanbul Protocol, para. 129.

⁹⁸ Istanbul Protocol, para. 132.

⁹⁹ Istanbul Protocol, para. 130.

¹⁰⁰ Istanbul Protocol, para. 133.

¹⁰¹ Istanbul Protocol, para. 134.

9. GENERAL CONSIDERATIONS FOR OTHER TYPES OF EVIDENCE

9.1 PHOTOGRAPHS

Photography should be a routine part of medical examination and a formal investigation. Others in contact with individuals who allege they have been tortured or ill-treated may also have the opportunity to photograph injuries or evidence before they fade or are destroyed, if a trained medical professional is not available.

For **medical examinations**

- Colour photographs of any physical injuries should be taken as a matter of routine

Investigators should take colour photographs of:

- injuries
- the premises where torture is alleged to have occurred (internal and exterior)
- any other physical evidence found

Photographs should:¹⁰²

- Be taken with informed consent only
- Be taken as soon as possible, even with a basic camera – professional photographs should then be obtained if possible
- Be taken from a number of angles
- Show a measuring tape or other readily identifiable means of showing scale
- Include a colour bar where possible to show accuracy of colours
- Be taken in daylight or with background lighting, with a neutral background
- Be correctly electronically dated, or have something to date them, such as the day's newspaper
- Where they are showing injuries, be able to be identified as belonging to a particular person, eg. by including a medium range and full body shot showing the person's face
- Be recorded in a log with an explanation of who took them, in what context, when, and chain of custody of the data, film, and any prints should be fully documented – without authenticating evidence photographs may be only weak evidence

Other means of recording the evidence, such as video may also be used. Where photographs and/or video are not possible a sketch may be an alternative. For further detailed guidance on taking photographs, using video and sketching see the **'International Protocol on the Documentation and Investigation of Sexual Violence**

¹⁰² Istanbul Protocol, para. 106; PSVI Protocol, above, Annex 8.

in Conflict: Basic Standards of Best Practice on the Documentation of Sexual Violence as a Crime under International Law' ("PSVI Protocol"), Annex 8.



Figure 1: Taken from PSVI Protocol, Annex 8

9.2 REAL EVIDENCE

As a general rule, **police and trained investigators and medical practitioners are the only actors who should collect real evidence/physical evidence** (medical practitioners may collect forensic evidence relevant to their examination, and may collect eg. clothes to be passed on to investigators as long as they are trained to properly handle such evidence).

As a general rule other practitioners, including lawyers and members of civil society, should **not** collect any item of physical evidence, as this may undermine its admissibility in judicial proceedings. In some limited circumstances it may be appropriate for others to collect real evidence – such as where there is no other possibility that it will otherwise be collected.

Real evidence must be carefully **collected, handled, packed, labelled, and stored**, and a **chain of custody** (see below) must be established. For further detailed guidance see the Istanbul Protocol paras. 102-103 and the PSVI protocol, pp. 61-62 and Annex 6.

In relation to **collection of real evidence by investigators**, the Istanbul Protocol provides (at paras. 102-103) that:

- “[t]he investigator should gather as much physical evidence as possible to document an incident or pattern of torture”
- “[i]nvestigators must be given authority to obtain unrestricted access to any place or premises and be able to secure the setting where torture allegedly took



place”

- “[a]ny building or area under investigation must be closed off so as not to lose any possible evidence. Only investigators and their staff should be allowed entry into the area once it has been designated as under investigation”
- “[i]f the torture 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 they be destined for that purpose or used circumstantially, should be taken and preserved”
- “[i]f recent enough to be relevant, any **fingerprints** located must be lifted and preserved”
- “A labelled **sketch of the premises** or place where torture has allegedly taken 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** must also be taken to record the same”
- “A record of the identity of all persons 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 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 were witness to the incidents of alleged torture”
- “Any relevant papers, records or documents should be saved for evidential use and handwriting analysis”

9.3 CHAIN OF CUSTODY

For evidence to be usable (especially in a criminal prosecution) it is important to be able to show that it is authentic and has not been ‘contaminated’ by events after the crime. To do this, it must be possible to show who collected the evidence, how it was collected, how it was stored, and who has had access to it. This is known as the “chain of custody”, and police, investigators and trained forensic doctors who collect physical evidence must have established procedures on collection, handling, packaging, labelling and storage in place to maintain and document this.¹⁰³

Establishing a “chain of custody” is particularly relevant to physical evidence but also applicable to original documents, to be able to prove their origin and authenticity.

For further detailed guidance on chain of custody, see the **PSVI Protocol, Annexes 6 and 7**.

¹⁰³ See Istanbul Protocol, paras. 102 and 222.

PART C: BY PROFESSION

10. DOCUMENTATION OF TORTURE AND OTHER ILL-TREATMENT BY MEDICAL PROFESSIONALS

10.1 WHY SHOULD MEDICAL PROFESSIONALS PLAY A ROLE?

Medical professionals have both ethical and legal duties relating to documenting torture and other ill-treatment.

First, medical professionals are guided by **ethical principles** that require them to act in the best interests of their patient, to ‘do no harm’, and to provide compassionate care to their patients. Following on from these basic principles, the United Nations Principles make it clear that “health professionals have a moral duty to protect the physical and mental health of detainees”.¹⁰⁴ It is “a gross contravention of health-care ethics to participate, actively or passively, in torture or condone it in any way”¹⁰⁵ and the World Medical Association has “called upon individual doctors to speak out against maltreatment”.¹⁰⁶ Therefore, where medical professionals come into contact with individuals who have been tortured or otherwise ill-treated, they have an obligation to act, and to support other colleagues who speak out.

See further
Chapter 6

Second, the **Maldives Anti-Torture Act 2013** provides a particular role for medical professionals in the fight against torture and other ill-treatment. The Act gives detainees and those recently released from detention the right to request consultation with a doctor from outside the prison for a medical examination. The consulting doctor must produce a medical report setting out specific information which is to be included in the person’s detention file.¹⁰⁷ This report could be used later as evidence.

See further
Section 4.3.1

Note however that:

- “it is rare for medical evidence to be conclusive”¹⁰⁸
- “many forms of torture leave very few traces and even fewer leave long-term physical signs that they ever occurred”¹⁰⁹
- with more transparency, methods used by state officials may change to leave fewer physical traces (eg. use mock executions rather than beating)
- injuries or marks which are alleged to have resulted from torture cannot always be distinguished with a high degree of certainty from the effects of other causes¹¹⁰

¹⁰⁴ Istanbul Protocol, para. 52, referring to the UN 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 (1982).

¹⁰⁵ Istanbul Protocol, para. 52. See also paras. 53-54.

¹⁰⁶ Istanbul Protocol, para. 55, referring to the World Medical Association’s Declaration of Hamburg (1997).

¹⁰⁷ Maldives Anti-Torture Act 2013, Sections 19-20.

¹⁰⁸ Camille Giffard, ‘The Torture Reporting Handbook: How to document and respond to allegations of torture within the international system for the protection of human rights’, Human Rights Centre, University of Essex, Section 5.1.

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

- “[t]he absence of such physical evidence should not be construed to suggest that torture did not occur”¹¹¹

10.2 HOW DO MEDICAL PROFESSIONALS COME INTO CONTACT WITH TORTURE AND ILL-TREATMENT?

In the Maldivian context, the most common ways in which medical professionals may come into contact with survivors include:

- treating an individual who presents him- or herself to a hospital or a private clinic with allegations of torture or other ill-treatment, or with injuries that suggest torture or other ill-treatment
- treating an individual who is brought to a hospital or private clinic by police from a detention facility
- as a doctor working in a place of detention, or part of a team visiting a place of detention
- being requested to examine an individual and to prepare an expert medical or psychological report, either under the Anti-Torture Act 2013, or at the request of an individual or their lawyer.

10.3 RELEVANT ETHICAL PRINCIPLES

In carrying out documentation of torture and other ill-treatment, medical professionals must always consider their ethical duties, which include:

See further
Chapter 6

- ‘Do no harm’
- Act in the best interests of the patient
- Provide compassionate care
- Promote and protect human rights
- Protect patient confidentiality
- Obtain informed consent
- Ensure non-discrimination.¹¹²

The Revised Standard Minimum Rules for the Treatment of Prisoners (2015) provide 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, including:

See further
Chapter 3 &
Annex 1

- The **duty of protecting prisoners’ physical and mental health** and the **prevention and treatment of disease on the basis of clinical grounds only**
- Adherence to prisoners’ autonomy with regard to their own health and **informed consent** in the doctor-patient relationship

¹¹¹ Istanbul Protocol, para. 161. See further paras. 157-159, 172.

¹¹² See further Istanbul Protocol, paras. 51-73.

- The **confidentiality of medical information**, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others
- An **absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment**, including medical or scientific experimentation that may be detrimental to a prisoner’s health, such as the removal of a prisoner’s cells, body tissues or organs. (Rule 32)

10.4 WHAT SHOULD MEDICAL PROFESSIONALS DO?

The Revised Standard Minimum Rules for the Treatment of Prisoners (see further above Chapter 3) provide that:

“If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, **they shall document and report such cases to the competent medical, administrative or judicial authority**. Proper procedural safeguards shall be followed in order **not to expose the prisoner or associated persons to foreseeable risk of harm**”. (Rule 34)

Medical professionals coming into contact with survivors of torture and other ill-treatment in any of these circumstances should therefore document medical evidence in the most detailed way possible given the context.

In a private clinic, hospital or detention setting, this means that the doctor should:

- obtain informed consent to conduct a medical examination and prepare a Medico-Legal Report
- make a detailed and accurate medical record of the findings in the medical notes
- complete a Medico-Legal Report giving as much detail and drawing appropriate conclusions as their expertise allows and referring for further evaluation and treatment if necessary
- take photographs of any physical injuries

Where a medical professional is specifically instructed to examine an individual and prepare an expert report in relation to allegations of torture or other ill-treatment, they should:

- obtain informed consent to conduct a medical examination and prepare a report
- take a detailed statement and conduct a medical examination of the complainant in line with standards set out in the **Istanbul Protocol** (see below)
- promptly prepare a written report of their findings, including their opinion as to the consistency of the medical evidence with the history given
- provide the report to the individual and, where consent has been given, the investigating authority

Expert medico-legal documentation consists of physical and psychological evidence by one or more qualified medical and psychological/psychiatric experts, who

“[c]orrelate the degree of consistency between examination findings and specific allegations of abuse by the patient”.¹¹³ The professional/s should be able to come to an opinion and should be able to communicate their findings and interpretations to the judiciary or other appropriate authorities.¹¹⁴

In either case, medical professionals should be prepared to report allegations of torture or other ill-treatment to appropriate authorities, including in line with existing protocols developed by their clinic or hospital.

In this regard, policies need to be established to give doctors **“clear guidelines on how, when and to whom alleged and medically documented cases of ill-treatment should be reported. If the detainee does not want his/her name to be included in the report, the doctor should do it in a way that safeguards the anonymity of the detainee”**.¹¹⁵

Medical confidentiality of records must be maintained and **records of examination should not be given to police or prison officials.**

10.5 THE PROCESS OF MEDICO-LEGAL DOCUMENTATION

The following is a summary of minimum standards and procedures outlined in the Istanbul Protocol for forensic medico-legal documentation of torture and other ill-treatment. It is important to note that the Istanbul Protocol’s standards are particularly directed towards **formal expert medico-legal documentation of torture through an interview and medical/psychological examination, followed by the production of a written report for use in an investigation or other legal process.**

As discussed above, medical professionals may be involved in documenting torture in other contexts – as treating physicians, in emergency rooms, or through general visits to places of detention. The procedures and considerations set out in this section may be taken into account and adapted as appropriate for each particular context.

For example, in an emergency setting it may not be possible to take a detailed history, and it will not be appropriate to write an ‘expert report’ (at least without further instruction). However the doctor may be in the best position to do a thorough medical examination and note medical findings, or procedures could be put in place to require referral to another doctor who is well-placed to do so. In such cases it is important that the doctor is mindful of medical findings that may be relevant to torture or other ill-treatment and records them with sufficient detail.

¹¹³ Istanbul Protocol, para. 122.

¹¹⁴ Istanbul Protocol, para. 122.

¹¹⁵ Subcommittee on Prevention of Torture, ‘Report on the Visit of the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment to the Maldives’, CAT/OP/MDV/1, 26 February 2009, para. 158.

10.5.1 Requests for formal medico-legal evaluation

The Istanbul Protocol is clear that **detainees, their lawyers or relatives “have the right to request a medical evaluation** to seek evidence of torture and ill-treatment”.¹¹⁶ As set out above, under the Maldives’ Anti-Torture Act 2013, detainees have the right to request a medical examination by a doctor from outside the place of detention (i) after 24 hours of detention, and (ii) immediately upon release.

Where the request comes from the state, the Istanbul Protocol provides that “[f]orensic medical evaluation of detainees should be conducted in response to **official written requests** by public prosecutors or other appropriate officials”.¹¹⁷ Such requests could relate to individuals in detention, or outside of detention.

Similarly, individuals assaulted outside of detention, or who have been released from detention – or their lawyers – may directly approach a medical professional to conduct an expert medico-legal evaluation for legal purposes.

10.5.2 Standards on procedural safeguards for those in detention

The Istanbul Protocol provides certain safeguards that should always be followed where the person being examined is a detainee.

The Istanbul Protocol provides (at para. 123-124) that:

- the detainee should be taken to the forensic medical examination by officials other than soldiers and police
- the officials who supervise the transportation of the detainee should be responsible to the public prosecutors and 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 medical evaluation by a qualified physician during and after the period of detention
- medical evaluation of detainees should be conducted at a location that the physician deems most suitable, which could be, eg. official medical facilities rather than in a prison
- each detainee must be examined in private
- police or other law enforcement officials should never be present in the examination room except where “in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner’s request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient”.
- If police or prison officers or other law enforcement personnel are in the

¹¹⁶ Istanbul Protocol, para. 123.

¹¹⁷ Istanbul Protocol, para. 123.

examination room, this should be noted in the report. Such presence may be grounds for disregarding a negative medical report.

- If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but should be brought before the prosecutor or judge to determine the detainee's legal disposition.

In the Maldives context, a number of these standards are currently not met – for example, it has been reported that police officers will bring detainees to the hospital for the carrying out of a medical evaluation, and will usually insist on staying in the room while interview and examinations are carried out. These issues need to be addressed at the policy level, through development of protocols and regulations governing the carrying out of such examinations. As a matter of urgency, protocols must be developed to ensure that state officials are not present in the examination room while medico-legal examinations are being carried out, and to allow the detainee's lawyer to be present at the detainee's request.

10.5.3 Interview and evaluation

The medical documentation of torture and other ill-treatment involves:

- obtaining informed consent to conduct an examination and prepare a report
- taking a history from the patient
- conducting a detailed medical and psychological examination
- taking photographs of any physical injuries
- preparing a report of the findings, including an opinion as to the consistency of the medical and psychological findings with the history given.

Where the patient being examined is a minor, it must be conducted in the presence of parents or another guardian, “unless a minor clearly expresses the contrary”.¹¹⁸

In the Maldives, the results of such an examination by a medical professional in a hospital or private clinic setting will usually be recorded on a standard **Medico-Legal Form**. This form requires the brief recording of the patient's history, detailed recording of the results of the physical and psychological examination, taking of photographs and – to the extent possible – the medical professional's opinion as to the consistency of the medical findings with the patient's history.

The flowcharts below provide a summary of the process to be followed when interviewing and examining a patient about torture and other ill-treatment for the purpose of medico-legal evaluation.

Prior to carrying out any evaluation, the medical professional should also be familiar with the information in the following chapters:

¹¹⁸ Subcommittee on Prevention of Torture, 'Report on the Visit of the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment to the Maldives', CAT/OP/MDV/1, 26 February 2009, para. 139.

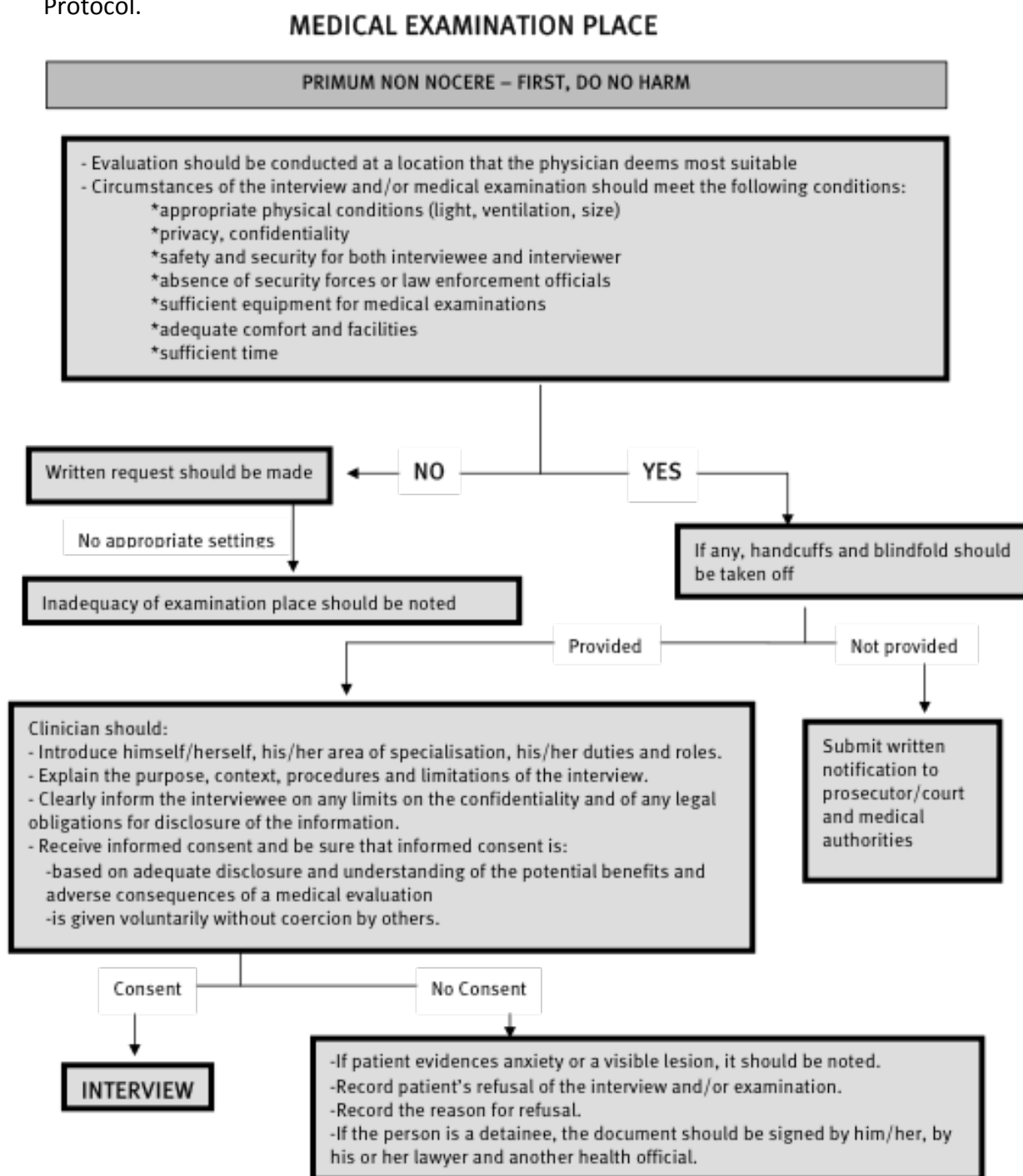
- Chapter 5 (Minimum standards for investigation and documentation)
- Chapter 6 (Key principles of professional ethics)
- Chapter 7 (Torture and ill-treatment and their medical and psychological effects)
- Chapter 8 (General interview considerations)
- Chapter 9 (General considerations for other types of evidence)

Ideally, where allegations of torture and other ill-treatment are made, **fuller medico-legal evaluations would also be carried out by forensic and psychological / psychiatric specialists leading to a more detailed report in line with the format set out in the Istanbul Protocol.**

10.5.4 Interview and examination: a flowchart

The following flow-charts for a medico-legal evaluation are reproduced from *IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)*. For the full description see Chapter IV (Medical Evidence) and Chapter VI (Psychological Evidence) of the Istanbul Protocol, along with Annexes II -III.

For a model standard form for a medico-legal interview, see Annex IV of the Protocol.



Source: *IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)*

INTERVIEW

REGISTER:

- *Name and identity of the interviewee.
- *Description of physical and visible characteristics (e.g. height, weight, eye colour, visible scars, age, hair colour).
- *Exact time and date of the interview.
- *Location, nature and address of the institution where the examination is being conducted.
- *Context of the interview (e.g. who informed, who requested the visit, by which documents, reason of being brought here or departure).
- *The name, affiliation of those present at the examination.
- *Relevant information about the circumstances at the time of the examination (such as any restraints on arrival, demeanour of those accompanying the prisoner, threatening statements, any difficulties, barriers during the examination).

- Investigators should carefully consider the context in which they are working, take necessary precautions and provide safeguards accordingly. If interviewing people who are still imprisoned or in similar situations in which reprisals are possible, the interviewer should use care not to put them in danger.
- Whether or not certain questions can be asked safely will vary considerably and depend on the degree to which confidentiality and security can be assured.

STORY OF DETENTION(S) AND TORTURE

The whole story starting from the outset of the apprehension or from the set of incidents until the interview should be taken and reported.

- Record narration in person's own words.
- Formulate the questions in a non-leading, open-ended manner.
- After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods.
- A method-listing approach may be counter-productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list.

Summary of detention and abuse: Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions.

Circumstances of apprehension: What time, from where, by whom (with details, if possible); other persons around witnesses/bystanders; interaction with family members; violence/threats used during the apprehension; use of restraints or blindfold.

Place and conditions of detention: What happened first, where, any identification process, transportation, distinctive features; other procedures; condition of the cell/room; size/dimensions, ventilation, lighting, temperature, toilet facilities, food; contact with third persons (family members, lawyer, health professionals); conditions of overcrowding or solitary confinement, etc.

Methods of torture and ill-treatment:

- Assessment of background: Where, when, how long, by whom; special features of the environment, perpetrators, devices/instruments; usual "routine", sequences and other information.
- For each form of abuse; body position, restraint, nature of contact, duration, frequency, anatomical location, the area of the body affected and how and other information.
- Sexual assaults.
- Deprivations (Sleep, food, toilet facilities, sensory stimulation, human contact, motor activities); threats, humiliations, violations of taboos, behavioural coercions and other methods.
- Previous medico-legal reporting process (if any).

COMPLAINTS

The patient's complaints should be ascertained in detail:

- Injured bodily areas; location, frequency and duration of each symptom; initial and late onset of symptoms; healing processes.
- Psychological problems, complaints, symptoms.
- Treatment or lack of treatment.

BACKGROUND INFORMATION

- General information (age, occupation, education, family composition, etc.)
- Past medical history
- Review of prior medical evaluations of torture and ill-treatment
- Previous detention and traumas
- Psychosocial history pre-arrest
- If the interviewee is still in custody, a limited psychosocial history regarding occupation and literacy might be sufficient
- Relevant story prior to apprehension
- Inquire about medication being taken (if s/he cannot receive it in custody, may cause adverse health consequences)
- Background information; this can be left to the end of the interview, to ask for it in the beginning may have a negative effect on the interview.
- The interviewer should take the circumstances into account and consider which parts of the background information should be acquired if the person is in custody, was recently released or if the time is limited

If the patient's clothes are the ones which s/he wore during torture, they should be gathered for examination and sent to the office of the prosecutor.

It is important to inform the patient clearly about the reason and importance of this process, receiving his/her consent to do so and providing adequate and appropriate clothing.

Source: IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)

INTERVIEW

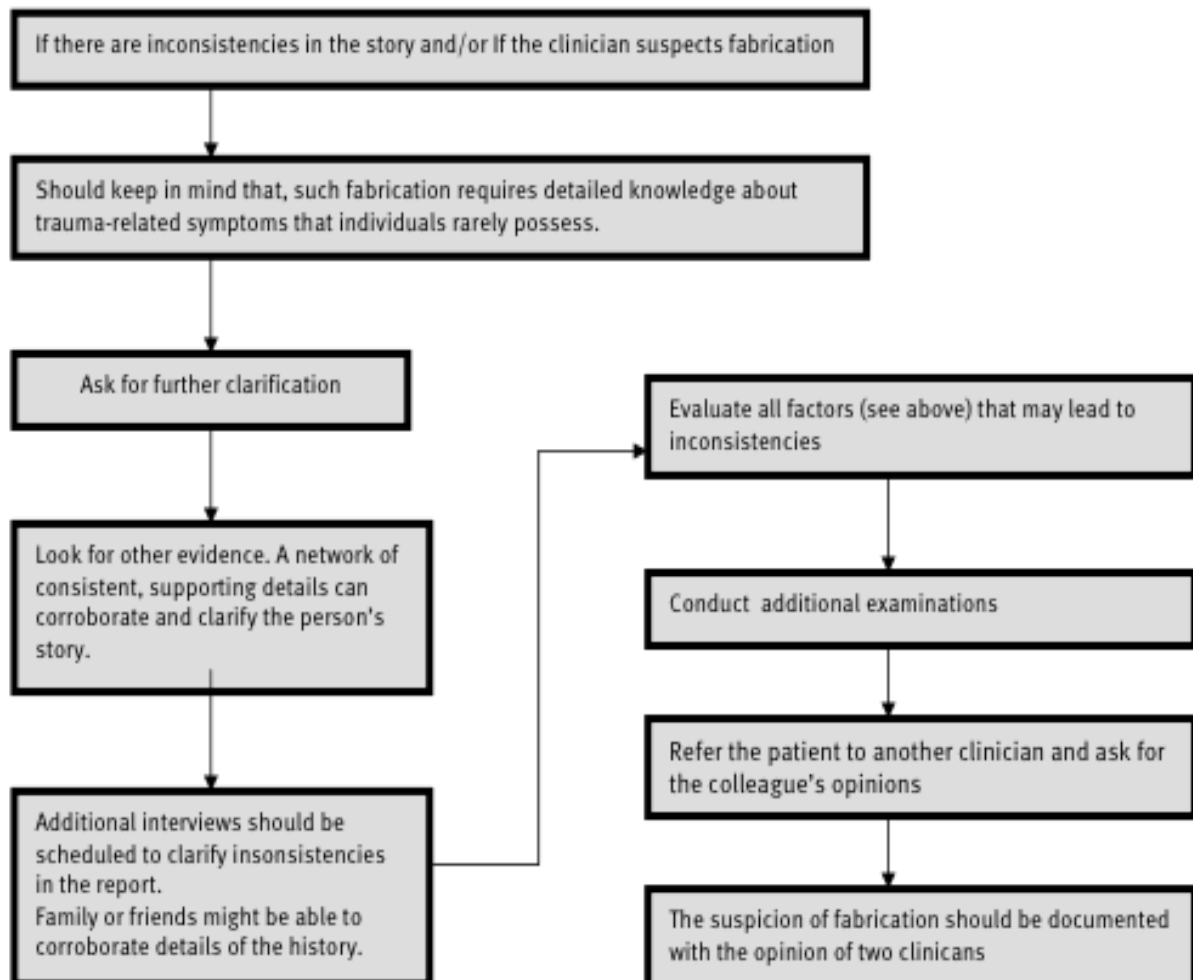
IF THERE ARE INCONSISTENCIES IN THE STORY

Be aware that inconsistencies do not necessarily mean that an allegation of torture is false.

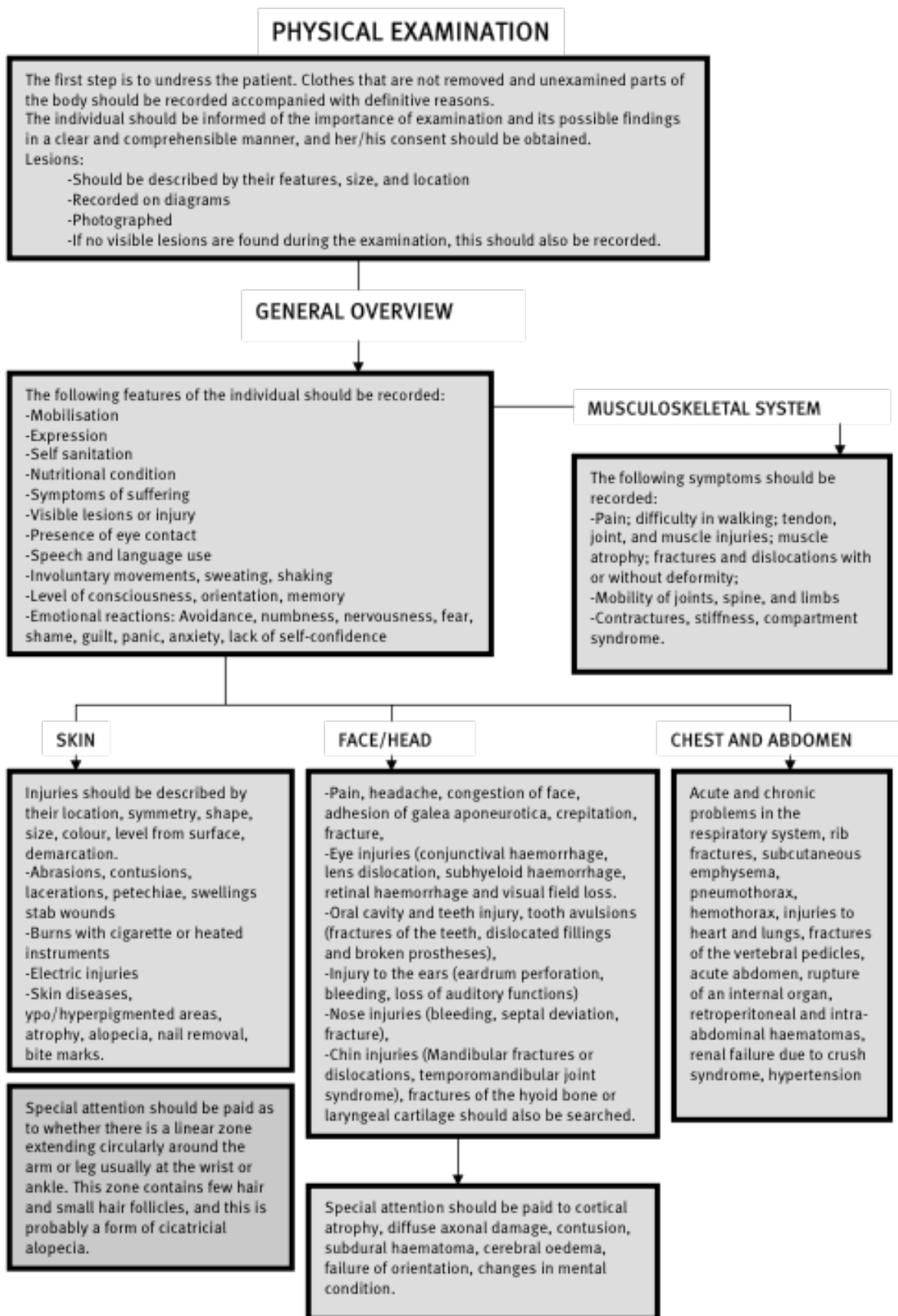
Torture survivors may have difficulties in recalling and recounting the specific details of the torture experience and other parts of the history which may cause some inconsistencies and blanks in the history.

Some factors which may cause difficulties in recalling and recounting the torture story:

- Torture experience itself (blindfolding, drugging, lapses of consciousness, disorientation in time and place during torture)
- Psychological impact of torture (PTSD-related memory disturbances, concentration difficulties; denial, avoidance; confusion, dissociation, amnesia)
- Neuro-psychiatric memory impairment (due to head injuries, suffocation, etc.)
- Cultural factors (feeling of guilt, shame, fear of stigmatization)
- Interview conditions or communicational barriers (lack of trust, lack of feeling safe, lack of privacy, inadequate time, pain)



Source: IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)



Source: IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)

For flow-charts of specific symptoms and suggested diagnostic tests for sexual torture, electric-heat appliance, asphyxiation, beating to the head, beating to the chest and back, beating to internal areas and back and suspension/positional torture, see [Annex Four of this manual](#). For model anatomical drawings for recording of injuries, see Appendix II of the Istanbul Protocol, reproduced as [Annex Three](#) of this manual.

For further specific guidance on the psychological/psychiatric evaluation see the Istanbul Protocol, paragraphs 260-315.

PSYCHOLOGICAL/PSYCHIATRIC EVALUATION

THE CENTRAL ROLE OF PSYCHOLOGICAL/PSYCHIATRIC EVALUATION

All investigation and evaluation of torture allegations should include a detailed psychological evaluation. Because:

- The extreme nature of torture is powerful enough to cause a wide range of psychological and mental problems.
- All kinds of torture inevitably comprise psychological processes. One of the main objectives of torture is to destroy the psychological and social integrity and functioning of the victim.
- Torture methods are often designed not to leave physical lesions. The psychological symptoms of torture, generally, are often more prevalent and persistent than physical ones.

GENERAL CONSIDERATIONS FOR PSYCHOLOGICAL/PSYCHIATRIC EVALUATION

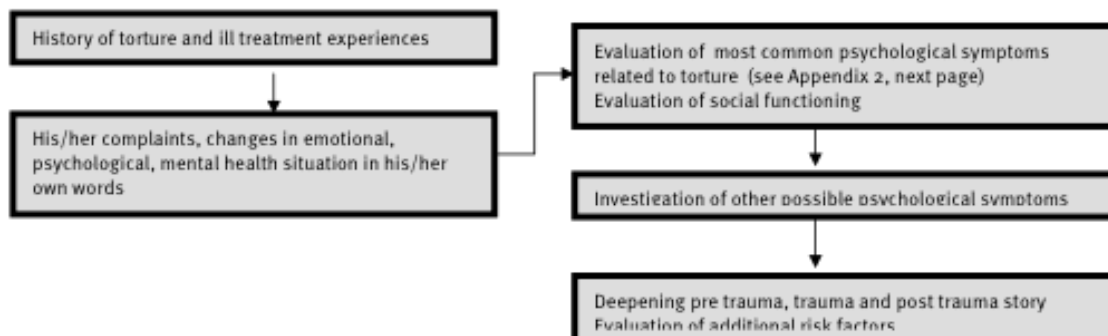
- Psychological evaluation and interpretation should always be made with an awareness of the cultural, political and social context as well as the conditions of the interview and assessment.
- It is important to recognise that not everyone who has been tortured develops a diagnosable mental illness. However, many victims experience profound emotional reactions and psychological symptoms.
- The psychological consequences of torture occur in the context of: personal attribution of meaning; personality development; social, political and cultural factors.
- General frames mentioned in the "medical examination place" and "interview" parts (above) should be taken into consideration.
- A diagnosis of a trauma-related mental disorder supports the claim of torture, but not meeting criteria for a diagnosis does not mean that the person was not tortured.

MAIN COMPONENTS OF PSYCHOLOGICAL/ PSYCHIATRIC EVALUATION

- History of torture and ill treatment: Every effort should be made to document the full history of torture, persecution and other relevant traumatic experiences.
- Current psychological complaints and symptoms: (not only the name of the symptoms, for each symptom; first emergence, triggers, durations, intensity, frequency, fluctuations over time should be evaluated and recorded also with examples and details)
- Post-torture history: Seek information about current life circumstances and also additional traumas, losses; social supports; coping styles.
- Pre-torture history: Family, educational, occupational history; cultural and religious background; also any history of past traumas.
- Medical history and psychiatric history: Pre-trauma health conditions.
- Mental status examination
- Assessment of social functioning
- Formulation of clinical impressions (see Appendix 1, next page)
- Recommendations: Can be further assessment, such as neuropsychological testing, medical or psychiatric treatment or a need for security or asylum.

PSYCHOLOGICAL/PSYCHIATRIC EVALUATION-Flow/Guide

The psychological evaluation starts at the beginning of the interview, at the very first contact. Dressing, posture, bodily expressions; not only the verbal content of the examinee (what he/she says), but also his/her manner of recalling, recounting, speaking (how he/she says it) has to be considered.



Source: IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)

PSYCHOLOGICAL/PSYCHIATRIC EVALUATION (cont.)

APPENDIX 1. INTERPRETATION OF THE FINDINGS AND FORMULATION OF THE CLINICAL IMPRESSION

- Medico-legal investigations of torture require understanding of the whole psychological phenomena, not only diagnosis.
- All the findings should be considered together; the relationship of individual components with each other should be taken into consideration.
- If the survivor has symptom levels consistent with a psychiatric diagnosis, the diagnosis should be stated. If not, the relationship and the consistency between the psychological findings and the torture history of the individual should be evaluated as a whole and stated in the report.
- Factors such as the onset of specific symptoms and content of the symptoms associated with the trauma, the specific characteristic of any particular psychological findings and patterns of psychological functioning should also be noted.
- The fluctuating course of trauma-related mental disorders over time should be taken into consideration during evaluation.
- The absence of the symptom at the time of the interview should be evaluated and interpreted very cautiously.

APPENDIX 2. MOST COMMON SYMPTOMS THAT CAN BE SEEN IN PEOPLE HAVING EXPERIENCED TORTURE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

- Re-experiencing the trauma (flashbacks, intrusive memories, recurrent nightmares, distress at exposure to cues of the traumatic event)
- Avoidance of the trauma related stimuli
- Hyper-arousal, hyper-vigilance, irritability, increased startle response, outburst of anger
- Physiological reactions to remembering the trauma
- Generalised anxiety
- Poor concentration
- Memory difficulties, narrowing the attention
- Sleep disturbances
- Emotional numbing
- Withdrawal, loss of interest or participation of activities
- The sense of social isolation, restriction of ability to be in contact with other people
- Sense of foreshortened future
- Damaged self-concept, reduced self-esteem
- Guilt feelings, shame feelings
- Depressed mood, anhedonia
- Feeling of hopelessness, helplessness
- Appetite disturbances or weight loss
- Fatigue and loss of energy
- Psychomotor agitation or retardation
- Thought of death and dying, suicidal ideation or suicide attempt
- Somatic complaints
- Sexual dysfunction
- Impulse control problems
- High-risk behaviour

Source: *IRCT, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Prepared by the Society of Forensic Medicine Specialists and revised through Prevention Through Documentation Project: IRCT (2007)*

10.5.5 Recording findings

The Istanbul Protocol provides a report following a medical/psychological evaluation should be produced promptly and must 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 story 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.

Article 20 of the Maldives' Anti-Torture Act 2013 requires that a medical report include (Art. 20):

- (1) Name, address, age and ID card number of the detainee.
- (2) The person's closest legal next of kin or closest legal guardian
- (3) The name and address of the person accompanying the detainee to the doctor.
- (4) The details of any inflicted wounds, or pains, or diseases, or health condition of the person, and the reasons believed by the doctor as the causes of such conditions.
- (5) The description and type of any inflicted wounds, or pains, or diseases, or health condition of the person.
- (6) The estimated time or period at which such wounds, or pains, or diseases, or health condition has been inflicted upon the person.
- (7) The suspected causes for and methods how and why such wounds, or pains, or diseases, or physical condition has been inflicted.
- (8) The date, time and the type and method of treatment given.

(9) What symptoms or signs the physician looked for, what symptoms or signs were found, and the medical prognosis for any symptoms, disease or signs that were found.

This article requires certain type of information different to the standards outlined in the Istanbul Protocol, but when both are read and applied together a report written under the Anti-Torture Act can be consistent with those standards.

10.5.6 Confidentiality of the report

The Istanbul Protocol provides (at para. 126) that:

- [t]he original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor.
- When a detainee or a lawyer acting on his or her behalf requests a medical report, the report must be provided.
- Copies of all medical reports should be retained by the examining physician.
- **Under no circumstances should a copy of the medical report be transferred to law enforcement officials.**

In this respect, Art. 20 of the Anti-Torture Act requires that a medico-legal report produced at the request of a detainee is to be placed on the detainee's detention file. **This provision must be interpreted in such a way that confidentiality of the medical record is maintained. In this regard, the recommendation of the Subcommittee on Prevention of Torture to the Maldives "that immediate measures are taken to establish and maintain confidentiality in the keeping of medical documents and records"¹¹⁹ remains an urgent priority.**

10.6 SYSTEMATIC MEDICAL EXAMINATION OF DETAINEES

Separately, as an important safeguard against torture and other ill-treatment, the Istanbul Protocol provides for **mandatory medical examination of detainees at the time of detention, and examination and evaluation upon release.**¹²⁰ This is in line with the Standard Minimum Rules for the Treatment of Prisoners, and recommendations of the Sub-Committee on the Prevention of Torture, including specifically in relation to the Maldives.¹²¹

In relation to the Maldives in particular, the SPT recommended systematic medical examinations, both in police custody and on transfer to prison.

In relation to police custody it said:

"The SPT recommends that the authorities introduce systematic medical examination of all persons in police custody and that these examinations

¹¹⁹ *Ibid.*, para. 159.

¹²⁰ Istanbul Protocol, para. 126.

¹²¹ Subcommittee on Prevention of Torture, 'Report on the Visit of the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment to the Maldives', CAT/OP/MDV/1, 26 February 2009, para. 108-112.

are carried out without using any restraints measures. The SPT also recommends that **medical examinations be conducted in accordance with the principle of medical confidentiality; non-medical persons, other than the patient, should not be present.** In exceptional cases, where a doctor so requests, special security arrangements may be considered relevant, such as having a police officer within call. The doctor should note this assessment in the records, as well as the names of all persons present. However, police officers should always stay out of hearing and preferably out of sight of a medical examination.

In addition to proper medical examination, **proper recording of injuries of persons deprived of their liberty by the police is an important safeguard,** contributing to the prevention of ill-treatment as well as to combating impunity. Thorough recording of injuries may well deter those who might otherwise resort to ill-treatment. **The SPT recommends that every routine medical examinations is carried out using a standard form that includes (a) a medical history (b) an account by the person examined of any violence (c) the result of the thorough physical examination, including a description of any injuries and (d) where the doctor's training so allows, an assessment as to consistency between the three first items.** The medical record should, upon request from the detainee, be made available to him/her or to his/her lawyer".¹²²

In relation to prisons, it said:

"The SPT recommends that medical screening of all prisoners should take place upon arrival. If the initial screening is performed by a nurse, the detainees should be offered the opportunity to be seen by a doctor as soon as possible. The medical examination should be thorough enough to reveal any injuries. The SPT further recommends that every routine medical examination is carried out using a standard form that includes (a) a medical history (b) an account by the person examined of any violence (c) the result of the thorough physical examination, including description of any injuries and (d) where the doctor's training so allows, an assessment as to consistency between the three first items. The report should be made available to the prisoner and to his or her lawyer.

The SPT further recommends that a procedure be established, with due consideration for medical confidentiality and the consent of the individual, for all cases of violence and alleged ill-treatment documented by doctors to be reported directly to the prison director for referral to the bodies responsible for monitoring of conditions in police detention facilities or in prisons and for complaints".¹²³

If there is evidence of torture or other ill-treatment, a fuller evaluation should be conducted and competent medical, administrative or judicial authorities should be

¹²² *Ibid.*, paras. 111-112.

¹²³ *Ibid.*, paras. 183-184.

informed, and should ensure that the person is removed from the site of the alleged other ill-treatment.¹²⁴

The Istanbul Protocol provides that access to a lawyer should be provided at the time of the medical examination. It also recognises that “[a]n outside presence during examination may be impossible in most prison situations. In such cases, it should be stipulated that prison doctors working with prisoners should respect medical ethics, and should be capable of carrying out their professional duties independently of any third-party influence”.¹²⁵

¹²⁴ Revised Standard Rules for the Treatment of Prisoners, Rule 34; Istanbul Protocol, para. 126.

¹²⁵ Istanbul Protocol, para. 126.



11. ISTANBUL PROTOCOL STANDARDS FOR INVESTIGATORS

Independent investigators are key in the fight against impunity for torture and in victims obtaining redress. They will usually have access to individuals, records and sites that lawyers and the individual themselves do not have, powers to compel witnesses to provide evidence, to access and preserve crime scenes and to require medical examination of those making complaints.

In the Maldives, investigators at the HRCM are given the primary responsibility under the Anti-Torture Act to investigate allegations of torture or other ill-treatment, and to forward cases to the Prosecution. The following are key standards and guidelines for investigators to follow as set out in the Istanbul Protocol.

11.1 NOMINATING AN INVESTIGATOR

The Istanbul Protocol states that a **primary investigator** should be identified for an individual case.¹²⁶ In deciding the investigator:

- special consideration should be given to the victim's preference for a person of the same gender, the same cultural background or the ability to communicate in his or her native language¹²⁷
- the investigator should have prior training or experience in documenting torture and in working with victims of torture; if they do not have such training they should "make every effort to become informed about torture and its physical and psychological consequences before interviewing the individual".¹²⁸

11.2 INVESTIGATORS' ROLE IN RELATION TO MEDICAL EVIDENCE

Medical evidence gathered using the Istanbul Protocol can be a vital tool in investigations, and an important part of any eventual successful prosecution and trial. Investigators therefore play a crucial role in ensuring that medical evidence is gathered at as early a stage as possible and that it conforms to Istanbul Protocol standards.

¹²⁶ Istanbul Protocol, para. 90.

¹²⁷ Istanbul Protocol, para. 90.

¹²⁸ Istanbul Protocol, para. 90.

In relation to medical evidence in particular, investigators should:

- Ensure that an independent medical and psychological evaluation is conducted where any allegation of torture or other ill-treatment is made¹²⁹
- If torture or other ill-treatment is alleged to have happened within the past six weeks, an examination should be arranged urgently¹³⁰
- Ensure that evaluations conform to established Istanbul Protocol standards
- Ensure that evaluations are carried out under the control of independent medical experts, not security personnel or other government officials¹³¹
- Ensure that they receive prompt and accurate written reports of medical evaluations¹³²
- Keep medical reports confidential, and communicate them to the subject or his or her representative
- Solicit the views of the subject of the report on the examination process, and record this in the report¹³³
- Have access to international expert advice and assistance throughout the investigation¹³⁴

As forensic expertise is limited in the Maldives, investigators may consider drawing on expertise from outside the country for the preparation of Istanbul Protocol compliant medico-legal evaluations in individual cases.

11.3 OTHER GENERAL GUIDELINES FOR INVESTIGATORS

More generally in their investigations, investigators should:

- Insist on the minimum standards of independence and access to information, witnesses and sites set out in the **Istanbul Protocol Principles for effective investigation and documentation** See further Chapter 5
- Carefully follow the guidance set out in above in relation to **general interview considerations**, and considerations in relation to interviewing in detention if relevant See further Chapter 8
- Be aware of methods of torture and other ill-treatment used, and their potential physical and psychological effects See further Chapter 7
- Be particularly aware of interviewee's safety, and keep records of identities safe to allow follow-up¹³⁵
- If possible, interview the alleged perpetrator, providing them with legal protections guaranteed under international and national law¹³⁶

¹²⁹ Istanbul Protocol, para. 104.

¹³⁰ Istanbul Protocol, para. 104.

¹³¹ Istanbul Protocol, para. 83.

¹³² Istanbul Protocol, para. 83.

¹³³ Istanbul Protocol, para. 84.

¹³⁴ Istanbul Protocol, para. 90.

¹³⁵ Istanbul Protocol, paras. 91-97.



- Gather as much physical evidence as possible, following the guidelines set out in Section 9.2 and 9.3
- Keep alleged victims of torture or other ill-treatment and their legal representatives informed of, and give access to, any hearing as well as to all information relevant to the investigation.¹³⁷


11.4 INFORMATION TO BE OBTAINED FROM AN ALLEGED VICTIM

The Istanbul Protocol states (at para. 99) that **the investigator should conduct an interview/s with the alleged victim and attempt to obtain as much of the following information as possible** (note that some of this will not be relevant if torture or other ill-treatment was carried outside a place of detention and questions should be adjusted accordingly):

- (i) “The circumstances leading up to the torture, including arrest or abduction and detention;
- (ii) Approximate dates and times of the torture, including when the last instance of torture occurred. Establishing this information may not be easy, as there may be several places and perpetrators (or groups of 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. 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;
- (iii) A detailed description of the persons involved in the arrest, detention and torture, including whether he or she knew any of them prior to the events relating to the alleged torture, clothing, scars, birthmarks, tattoos, height, weight (the person may be able to describe the torturer in relation to his or her own size), anything unusual about the perpetrator’s anatomy, language and accent and whether the perpetrators were intoxicated at any time;
- (iv) Contents of what the person was told or asked. This may provide relevant information when trying to identify secret or unacknowledged places of detention;
- (v) A description of the usual routine in the place of detention and the pattern of ill-treatment;
- (vi) A description of the facts of the torture, including the methods of torture used. This is understandably often difficult, and investigators should not expect to obtain the full story during one interview. It is important to obtain precise information, but questions related to intimate humiliation and assault will be traumatic, often extremely so;

¹³⁶ Istanbul Protocol, para. 101.

¹³⁷ Istanbul Protocol, para. 81.

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- (vii) Whether the individual was sexually assaulted. Most people will tend to answer a question on 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. 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 culture and personality, that more of the story will come out;
 - (viii) Physical injuries sustained in the course of the torture;
 - (ix) A description of weapons or other physical objects used;
 - (x) The identity of witnesses to the events involving torture. The investigator must use care in protecting the safety of witnesses and should consider encrypting the identities of witnesses or keeping these names separate from the substantive interview notes".

12. LAWYERS AND THE ISTANBUL PROTOCOL

Lawyers are both advocates for their clients, and may also “play a vital role in persuading governments to comply with their international obligations to refrain from acts of torture and to implement preventative measures”.¹³⁸

When lawyers are familiar with international law, including the standards set out in the Istanbul Protocol, they can use these standards to interpret and apply domestic law in light of them in their legal arguments, and can advocate that they are applied both in individual cases and more generally.

Note that this section draws heavily on the following: IRCT/REDRESS (2009) ‘Action Against Torture: A practical guide to the Istanbul Protocol – for lawyers’, IRCT and IRCT/REDRESS, ‘Checklist for Lawyers’. These are useful resources for lawyers and can be found online at: <http://www.irct.org/media-and-resources/library/other-irct-key-publications.aspx>.

For further detailed guidance on documenting allegations of torture see Camille Giffard, ‘The The Torture Reporting Handbook: How to document and respond to allegations of torture within the international system for the protection of human rights’, Human Rights Centre, University of Essex, Part II – Documenting Allegations.

<http://www.essex.ac.uk/torturehandbook/english.htm>.

12.1 KEY ROLES OF LAWYERS IN DOCUMENTATION AND INVESTIGATION

Lawyers can play the following key roles in the documentation and investigation of torture:

- Documenting torture for use in legal or other proceedings, including future proceedings where national mechanisms at the time are unavailable or ineffective
- Collecting evidence of torture that may prompt authorities to open or reopen an investigation
- Providing evidence of torture that supports ongoing investigations or prosecutions at the national or international level
- Recording the failure to investigate in spite of the availability of evidence or the shortcomings of any investigations undertaken with a view to prompting further investigations, including by taking cases to regional or international human rights bodies
- Collecting evidence to support reparation claims brought at the national or international level before judicial or administrative bodies.

From IRCT/REDRESS (2009) ‘Action Against Torture: A practical guide to the Istanbul Protocol – for lawyers’, IRCT, p. 8.

¹³⁸ IRCT/REDRESS (2009) ‘Action Against Torture: A practical guide to the Istanbul Protocol – for lawyers’, IRCT, p. 7.

12.2 LAWYERS AND MEDICAL EVIDENCE

It is very important “for lawyers working with torture survivors to know how torture can be medically documented and how to recognise the physical and psychological symptoms of torture. This will not only help them to better understand their clients and assist them but equally, such insights are extremely important when lawyers lodge complaints of torture or other forms of ill-treatment on the survivors’ behalf”.¹³⁹

Medical evidence can help lawyers in two particular ways, by:

- Helping to prove that torture has occurred, and
- Assisting in the determination of claims for reparation (ie. what is necessary for restitution, compensation and rehabilitation)

Understanding the information and standards set out in the Istanbul Protocol is important for lawyers in a number of respects:

- Lawyers may often need to work together closely with doctors to effectively document torture and other ill-treatment. They may do so by directly instructing a doctor or mental health professional to carry out an evaluation and provide a report for their client, or by obtaining an official medical evaluation of their client under relevant legislation (such as the Maldives Anti Torture Act) or by court order.
- Lawyers need to be aware of the proper standards for a medical report “to assess whether the official investigation undertaken by the police or other competent body took into account proper medical evidence”, and if not, to obtain their own independent evidence.¹⁴⁰
- Lawyers need to understand the physical and psychological effects of torture when they are interviewing victims (i) to make sure they are asking the right questions and collecting the right evidence; (ii) to help them understand the psychological consequences that torture might cause and to avoid to the extent possible retraumatising the individual during the interview; and (iii) to help them to understand and to respond to unexpected ‘reactions’ or ‘answers’ from victims.¹⁴¹

Lawyers can play a key role in ensuring that medical evidence is obtained and used appropriately by:

- requesting independent medical evaluations for their clients under the Anti-Torture Act 2013 if applicable, and ensuring that the appropriate safeguards are in place and are followed applied
- reviewing such evaluations for consistency with Istanbul Protocol standards, and obtaining independent medical evaluations if required

¹³⁹ *Ibid.*, p. 9.

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*

- challenging substandard medical evaluations and reports carried out as part of police investigations or investigations by other bodies
- educating judges through their legal arguments as to the domestic and international standards concerning the usefulness of and standards for medical evidence and through expert evidence on the medical and psychological effects of torture and other ill-treatment
- advocating for changes in legislation, regulation and practice to allow independent medical evaluations of those alleging torture and other ill-treatment in line with Istanbul Protocol standards.

In relation to their own clients, lawyers should insist that:

- independent medical and psychological evaluations are carried out where an allegation of torture or other ill-treatment has been made (and paid for by the State if the conditions under the Anti-Torture Act are satisfied)
- the lawyer is allowed to be present at the independent medical evaluation
- security forces are not present at the independent medical evaluation
- other safeguards set out in the boxed text in Section 10.5.2 are followed
- the medical professionals carrying out the evaluation adhere to the highest ethical standards
- a prompt report is provided in line with the requirements of the Istanbul Protocol

12.3 ENSURING EFFECTIVE INVESTIGATIONS

The following are a number of practical steps that lawyers may take to enhance the effectiveness of investigations at the national level:

- Obtain a detailed statement of the victim, which includes information regarding the facts possible evidence in relation to the act of torture and any proceedings
- Record any complaints made by the victim about his or her health condition; view injured parts of the body with the consent of the victim and indicate injuries on the body diagram contained in the Istanbul Protocol
- Examine the medical report for any inconsistencies. Compare the following: medical reports if there are more than one; medical report(s) with the records of relevant health units; all the existing documents/reports with victim's statement. If you note any inconsistencies, inform the judges about your findings and any possible misconduct. Having sought prior instruction from the client (to avoid putting him/ her at any risk), alert investigators to any information pertinent to the investigation and where there might be a possibility of sources of evidence being overlooked, to ensure that the investigation produces evidence that is admissible in court
- Submit the victim's statement as well as the record on the health condition together with the body diagram to the investigative authorities with the consent of the victim

- Request the authorities to undertake the necessary steps to investigate allegations of torture based on the information provided in the victim's statement
- In parallel, if possible, collect and submit any evidence referred to by the victim and submit it to the investigating body
- Assess the thoroughness of an investigation by checking if investigators have sought all relevant sources of evidence before injuries disappear or witnesses are no longer available, including medical evidence (of both physical and psychological damage)
- If possible, promptly submit any concerns with the thoroughness of the investigation, such as delays in conducting medical evaluations, in writing and request second medical evaluations if the competence or impartiality of the examining health professional is called into question
- Use the record of the health condition and the body diagram to ask for a (second) medical report and, as appropriate, submit it to medical chambers, universities or other institutions for an independent report
- Challenge any report issued by the investigative mechanism that is not sufficiently comprehensive and reasoned, including information on why certain lines of enquiry were pursued and others not and highlighting any irregularities found in the course of the investigation; cite international and national guidelines/rules on collecting evidence and principles on investigations, including the Istanbul Protocol
- Collect secondary documentation (such as reports of human rights organisations, research studies, press articles) to support a case that an existing investigation is ineffective or that the particular circumstances of the case (e.g. highly political) require an independent investigation or re-investigation of the allegations
- Intervene with the relevant authorities where public officials (who may or may not have been charged with perpetrating torture but are implicated in the allegations) have not been suspended from their positions during the period of investigation
- Seek safeguards for health professionals undertaking medical examinations to ensure they have sufficient time and privacy and to avoid any sanctions, in case their examinations confirm that torture was inflicted
- Develop a database that fully documents all torture-related complaints and investigations using a sound and consistent methodology, and undertake regular reviews and analyses with a view to identifying legislative and institutional shortcomings
- On the basis of such findings, advocate for requisite legislative, institutional and practical changes, including the setting up of independent complaints mechanisms.

From: IRCT/REDRESS (2009) 'Action Against Torture: A practical guide to the Istanbul Protocol – for lawyers', IRCT, pp. 34-35.

12.4 LAWYERS AND DOCUMENTATION MORE GENERALLY

As set out above, lawyers often also play a very important role in documentation of a case more generally.

In carrying out such documentation they should:

- Be aware of and uphold their professional ethics obligations
- be very careful to take into account and follow the **interview considerations set out in Chapter 8** and **considerations for obtaining other evidence in Chapter 9**.
- not usually be involved in the collection of **real evidence** (see further above, Section 9.2)
- be very aware of the **safety and security of their clients**, and the risk that legal action may pose
- consider **creative strategies to obtain further documentation**, such as Freedom of Information requests for official records

See further
Chapter 6

See further
Chapters 8 & 9

In interviewing alleged victims of torture and other ill-treatment to compile a witness statement, lawyers will usually need to obtain the same information as the Istanbul Protocol sets out for investigators, as set out above in the [boxed text at 11.4](#).

12.5 LAWYERS AND THE PROMOTION OF INTERNATIONAL STANDARDS

Lawyers can also promote the implementation of international standards through their casework, lobbying, and participation in training of security officials. This can include:

- Using international human rights arguments in pleadings and case submissions and referring to positive jurisprudence of neighbouring countries to encourage judges to accept new or novel arguments
- Developing casework strategies that seek progressive changes in the approaches of judges to the question of torture. Always start with more straightforward constitutional arguments that are well entrenched in the national legal culture before moving to other concepts. If possible, select the most “sympathetic” and clearest of cases, where for example most medical evidence is available to prove both physical and psycho- logical injury to make sure both types of torture become part of national jurisprudence
- Making sure that domestic litigation strategy are consistent with the possibility to submit a petition to an international human rights body or court
- Lobbying for amendments to the Rules of Court, Procedural Codes and/or other relevant evidentiary principles to shift the burden of proof to the custodial authority when it is reasonably alleged that torture took place during detention (eg. injury has occurred), and to allow for the receipt of expert medical evidence.
- Object in individual cases and lobby for amendments to regulations or procedures that violate the procedural safeguards of their clients, including the right of access to a lawyer and the right of access to a doctor.

Summarised from: IRCT/REDRESS (2009) 'Action Against Torture: A practical guide to the Istanbul Protocol – for lawyers', IRCT, pp. 14-16.

13. COMPLEMENTARY ROLES OF OTHER PROFESSIONALS

13.1 PROSECUTORS

Prosecutors may play an important role in ensuring allegations of torture or ill-treatment are properly documented. Where such allegations are made in cases the prosecutor is handling (whether by the accused, such as a forced confession, or by a complainant), the prosecutor must ensure that an effective investigation is carried out, and such an investigation should include examination by an independent medical professional.

As for lawyers and investigators, it is important that public prosecutors understand the potential medical and psychological effects of torture and other ill-treatment, and ways in which this evidence may be effectively documented and presented to the Court. They should ensure that alleged victims of torture or other ill-treatment are interviewed in an appropriate manner, and that other evidence, including medical evidence, is properly collected. In this regard, it is important that prosecutors are familiar with the information set out in the following chapters of this Manual:

- [Chapter 5 \(Minimum standards for investigation and documentation\)](#)
- [Chapter 6 \(Key principles of professional ethics\)](#)
- [Chapter 7 \(Torture and Ill-treatment and their medical and psychological effects\)](#)
- [Chapter 8 \(General interview considerations\)](#)
- [Chapter 9 \(General considerations for other types of evidence\)](#)


The Istanbul Protocol Principles make it clear that investigations into alleged torture and other ill-treatment must be strictly independent and impartial (see further above [Chapter 5](#)). Because of their often close working relationship with the police “there may be a real or perceived reluctance on the part of the prosecution service to investigate allegations against police officers”.¹⁴² It has been suggested that “[t]o help prevent a deferential attitude towards the police when investigating torture, there should be a separate department within the public prosecutor’s office mandated to investigate complaints against the police or other public officials. This department would require sufficient resources and training to fulfil the specialist nature of the work”.¹⁴³

13.2 JUDGES

Judges have the ultimate oversight of detention, investigations and prosecutions, and it is therefore crucial that they have an understanding of the nature of torture and other ill-treatment, and how it may manifest in medical and psychological ways.

¹⁴² IRCT/REDRESS (2009) ‘Action Against Torture: A practical guide to the Istanbul Protocol – for lawyers’, IRCT, p. 32.

¹⁴³ *Ibid.*



Judges have a very important role to play in ensuring that those facing criminal trial and those held in detention are given their rights, which should include the right to an independent medical examination if requested.

Where individuals are brought before them to determine whether they should be held in custody, judges should pro-actively ask detainees if they have been examined by a doctor, and if they have any complaints to make about their treatment. The same should occur at trial for those in detention. Following its visit to the Maldives in 2009, the Subcommittee on the Prevention of Torture recommended that:

detainees should not only be present in the court hearing regarding detention and its continuation, but ... the court should afford them an opportunity to speak and to report any ill-treatment. It should always be open to the court to make a referral for medical examination if there are reasons to believe that ill-treatment may have occurred, and to take steps to ensure that any allegations of ill-treatment are promptly investigated by a competent body.

Where allegations of torture or other ill-treatment are raised judges should order that these are investigated, including ordering an independent medical examination reasonable suspicion that a person has been tortured or otherwise ill-treated, as detainees may be afraid to complain directly.

If there is a reasonable suspicion that torture or other ill-treatment has occurred, judges should have the power to open or order the opening of an independent investigation,¹⁴⁴ and should order the removal of an individual from the site of alleged torture or other ill-treatment if it is ongoing.

Judges should also be familiar with the Istanbul Protocol and the information contained in it about the physical and psychological effects of torture and ill-treatment. It is important for judges to understand the importance of medico-legal evidence in relation to allegations of torture and other ill-treatment (whether to exclude evidence or for redress) and to be familiar with methods of evaluating medico-legal reports presented to the Court. In this, the Istanbul Protocol provides a helpful guide for Judges.

13.3 POLICE AND STAFF OF PLACES OF DETENTION

There are two aspects to the role of police and staff at places of detention (including prisons, drug rehabilitation centres and mental health facilities) in relation to documentation of torture and other ill-treatment. First, they must allow access to lawyers as required by law and enable independent medical examinations to be carried out promptly when requested. State officials and police officers should not insist on being present during interviews with lawyers and medical examinations of detainees; if internal regulations require this, those regulations should be reviewed and changed.

Second, police and other officials must act swiftly where allegations of torture and other ill-treatment are made to ensure that those allegations are documented and investigated. As set out in the Istanbul Protocol Principles, the investigators must be

¹⁴⁴ *Ibid.*, p. 33.

independent of the suspected perpetrators or the agency they work for. Where the police are involved in investigating allegations of torture and other ill-treatment they should follow the guidance set out for investigators, above.

13.4 RELEVANT MINISTRIES

Relevant ministries – including those concerning justice, health, and law enforcement – have an important role to ensuring the right environment for effective investigations and documentation. This includes:

- Providing adequate training for law enforcement personnel, judges, lawyers and doctors
- Sufficient budget allocation for effective independent medical documentation and effective investigations
- The creation of an appropriate protocol, based on the Istanbul Protocol, for medical evaluations and reports in relation to allegations of torture and other ill-treatment
- Review of systems and legislation to ensure that domestic and international standards for effective investigation and documentation are being met, and that the justice and health sectors work together in this regard
- Considering establishing a system of independent audit of medico-legal evaluations to ensure quality control
- Collect statistics including on number of complaints made, medical examinations carried out, investigations started, cases sent for prosecution, cases resulting in conviction

13.5 CIVIL SOCIETY

NGOs or other civil society may often be the first point of contact for an individual who complains of having been torture or otherwise ill-treated. They can assist individuals to obtain advice, services and treatment, including from the legal and medical professions, and may often be involved in documenting allegations made to them, by taking statements, photographs and gathering supporting evidence.

Staff from NGOs may be present at sites of alleged torture or other ill-treatment, for example when observing protests, and may be able to document such treatment directly through photographs, videos and witness testimony. The information held by the NGO on other similar cases and the research conducted on torture and other ill-treatment domestically and internationally, can also provide valuable support to the case of the individual.

Similar considerations apply to civil society as to lawyers for documentation. It is important for civil society actors to be aware of the potential medical and psychological effects of torture and other ill-treatment, and to refer individuals to support as appropriate.

As for all actors, in documenting torture or other ill-treatment, civil society should be very mindful of:

See further
Chapter 7



- The considerations set out in **general interview considerations, including obtaining informed consent for any action on individual cases, and general considerations for other evidence**
- The **safety, security and confidentiality** of individuals they are in contact with

See further
Chapters 8 & 9

See further
Chapter 6

Civil society can also play an important role, along with lawyers, in promotion of international standards through lobbying for transparency, accountability, and legislative reform. For further information on the relevant international standards see:

- [Chapter 3 \(International Laws on Torture and Other Ill-treatment\)](#)
- [Chapter 5 \(Minimum standards for investigation and documentation\)](#)
- [Chapter 10 \(Documentation of torture and other ill-treatment by medical professionals\)](#)

Civil society can also be an important support for doctors and lawyers who face difficulties after living up to their ethical standards in documenting allegations of torture and other ill-treatment.

See further
Chapter 6

PART D: NEXT STEPS



14. DEVELOPING AN ACTION PLAN FOR THE MALDIVES

Training and meetings conducted in conjunction with the HRCM in 2015 demonstrated that there is enthusiasm in the Maldives for implementing standards of the Istanbul Protocol to improve investigation and medical documentation of torture and other ill-treatment. There are a number of practical steps that can be taken now to bring practices closer into line with those of the Istanbul Protocol, and a number of other longer term reforms that should be undertaken.

Participants at meetings identified the importance of developing a roadmap for implementation, and set out a number of issues that should be addressed in it. It has been suggested that this action plan be discussed further and agreed among stakeholders, and adopted with defined timelines for achievement.


The following are a number of issues that have been identified as being particularly important for consideration in the Action Plan.

Legal framework

- Review of regulations and rules relevant to medico-legal documentation (including police and correctional services regulations and rules), and amendment as necessary to ensure safeguards required by the Istanbul Protocol are followed
- Review of practices making documentation by lawyers difficult, including restrictions on taking photographs in detention, masking of police officers and lack of use of police identification numbers, delays in access to detainees
- Development of Commentary to the Anti-Torture Act 2013

Forms and protocols

- Review and amendment of medico-legal documentation forms used by medical professionals, incorporating informed consent procedures, to include both medical and psychological examination, and to require the taking of photographs
- Review and amendment of investigation forms used by HRCM
- Development of protocols in prisons, hospitals and private clinics for:
 - examination of patients held in detention, including ensuring that police or other officials are not present except in the limited circumstances defined in the Istanbul Protocol
 - maintaining confidentiality of medical records, including of those held in detention
 - access to medical records by the individuals concerned and their legal representatives
 - reporting of suspected torture or other ill-treatment to appropriate authorities, while respecting safety and security of the individual, including sharing of statistical information gathered by main government hospital

- 
- Development of procedure for requesting medical examination under the Anti-Torture Act 2013, and for provision of examination and funding within 24 hour deadline

Medical professionals

- Development of understanding of difference between medical records and forensic medical evaluation, and what medical professionals in private clinic and hospital settings are properly trained and able to provide
- Hospitals to retain medical records (discharge summaries and copies of prescriptions) for any detainee treated
- Provision of basic training to medical professionals from state hospitals and private clinics on medico-legal documentation of torture and other ill-treatment, and use of the revised medico-legal form, and training of new doctors as they are recruited
- Development of a specialised “one-stop” unit at the main government hospital for examination, evaluation, treatment and referral of all sexual and gender-based violence and torture or other ill-treatment cases
- Continued development by the Ministry of Health of a monitoring and evaluation mechanism for medico-legal documentation conducted in state hospitals
- Development of support for doctors who have dual obligations to ensure that they have adequate support and protective mechanisms to report torture and ill-treatment when it is encountered
- Development of forensic expertise within the Maldives, including by:
 - Further specialised training of medical professionals in forensic medicine
 - Further detailed training for doctors without forensic expertise on medico-legal documentation of torture and other ill-treatment
 - Consulting with forensic experts from a number of countries about development of forensic expertise within particular country settings
 - Funding position for outside forensic expert/s to come to the Maldives for individual cases at short notice, and developing a program for local doctors to shadow examinations

Investigations

- Further dialogue between HRCM and medical professionals on extent to which assessments of consistency can be made in medico-legal evaluations, given doctors’ training
- Funding for outside forensic expert to come to the Maldives for individual cases at short notice, to conduct full medico-legal evaluation and produce expert report, or to consider and provide opinion on information provided in medical records and medico-legal reports completed in the Maldives



Police and Staff at Places of Detention

- Training of Police and Correctional services personnel on role of medico-legal documentation and protocols put in place for medico-legal documentation and confidentiality of medical records
- Improvement of procedures for medical examination of detainees on admission to places of detention and development of procedures for examination by medical professionals of individuals in police custody

Judges and Prosecutors

- Training of Prosecutors and Judges on role of medico-legal documentation and Istanbul Protocol standards

Lawyers and NGOs

- Sensitisation for lawyers and NGOs on the existence of provisions in the Anti-Torture Act 2013 for medico-legal evaluation, and the procedure for requesting this
- Provision of training on the Anti-Torture Act 2013 and the Istanbul Protocol

Victims

- Provision of information to detainees on right to an independent medical examination and procedure for requesting this
- Provision of information in hospitals and other settings on procedure to make a complaint of torture or other ill-treatment

Achieving these reforms will take political commitment, budgetary and human resources and cooperation between the HRCM, medical profession, government ministries, and legal professionals. However, early signs – including a process currently underway for amendment of the medico-legal form used across the Maldives to take Istanbul Protocol standards into account – are encouraging. Although some of these reforms will require long-term commitment, a number of them can be achieved immediately. A number of them – including instigating measures to ensure the confidentiality of medical records, ensuring there is informed consent for any medico-legal examination, and instituting procedures for reporting of allegations by medical professionals – were identified as immediate priorities by the Subcommittee on Prevention of Torture during its visit in 2009, and should be addressed urgently.

Steps should now be taken to agree a detailed road map between stakeholders, and to agree on responsibilities and timelines. This will allow the professionals involved to move towards effective investigation and documentation of torture and other ill-treatment, leading ultimately to preventing it from happening at all.

ANNEXES



ANNEX ONE: EXTRACT FROM THE REVISED UNITED NATIONS STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS (THE MANDELA RULES)

Health Care Services

Rule 24

1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
2. Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

Rule 25

1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.
2. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner.

Rule 26


1. The health-care service shall prepare and maintain accurate, up-to-date and confidential individual medical files on all prisoners, and all prisoners should be granted access to their files upon request. A prisoner may appoint a third party to access his or her medical file.
2. Medical files shall be transferred to the health-care service of the receiving institution upon transfer of a prisoner and shall be subject to medical confidentiality.

Rule 27

1. All prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care.
2. Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.

Rule 28

In women's prisons, there shall be special accommodation for all necessary prenatal and postnatal care and treatment. Arrangements shall be made wherever



practicable for children to be born in a hospital outside the prison. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

Rule 29

1. A decision to allow a child to stay with his or her parent in prison shall be based on the best interests of the child concerned. Where children are allowed to remain in prison with a parent, provision shall be made for:

(a) Internal or external childcare facilities staffed by qualified persons, where the children shall be placed when they are not in the care of their parent;

(b) Child-specific health-care services, including health screenings upon admission and ongoing monitoring of their development by specialists.

2. Children in prison with a parent shall never be treated as prisoners.

Rule 30

A physician or other qualified health-care professionals, whether or not they are required to report to the physician, shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary. Particular attention shall be paid to:

(a) Identifying health-care needs and taking all necessary measures for treatment;

(b) Identifying any ill-treatment that arriving prisoners may have been subjected to prior to admission;

(c) Identifying any signs of psychological or other stress brought on by the fact of imprisonment, including, but not limited to, the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol; and undertaking all appropriate individualized measures or treatment;

(d) In cases where prisoners are suspected of having contagious diseases, providing for the clinical isolation and adequate treatment of those prisoners during the infectious period;

(e) Determining the fitness of prisoners to work, to exercise and to participate in other activities, as appropriate.

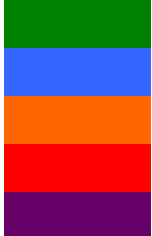
Rule 31

The physician or, where applicable, other qualified health-care professionals shall have daily access to all sick prisoners, all prisoners who complain of physical or mental health issues or injury and any prisoner to whom their attention is specially directed. All medical examinations shall be undertaken in full confidentiality.

Rule 32

1. 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, in particular:

(a) The duty of protecting prisoners' physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only;



(b) Adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship;

(c) The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others;

(d) An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation that may be detrimental to a prisoner's health, such as the removal of a prisoner's cells, body tissues or organs.

2. Without prejudice to paragraph 1 (d) of this rule, prisoners may be allowed, upon their free and informed consent and in accordance with applicable law, to participate in clinical trials and other health research accessible in the community if these are expected to produce a direct and significant benefit to their health, and to donate cells, body tissues or organs to a relative.

Rule 33

The physician shall report to the director whenever he or she considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

Rule 34

If, in the course of examining a prisoner upon admission or providing medical care to the prisoner thereafter, health-care professionals become aware of any signs of torture or other cruel, inhuman or degrading treatment or punishment, they shall document and report such cases to the competent medical, administrative or judicial authority. Proper procedural safeguards shall be followed in order not to expose the prisoner or associated persons to foreseeable risk of harm.

Rule 35

1. The physician or competent public health body shall regularly inspect and advise the director on:

(a) The quantity, quality, preparation and service of food;

(b) The hygiene and cleanliness of the institution and the prisoners;

(c) The sanitation, temperature, lighting and ventilation of the prison;

(d) The suitability and cleanliness of the prisoners' clothing and bedding;

(e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

2. The prison director shall take into consideration the advice and reports provided in accordance with paragraph 1 of this rule and rule 33 and shall take immediate steps to give effect to the advice and the recommendations in the reports. If the advice or recommendations do not fall within the prison director's competence or if he or she does not concur with them, the director shall immediately submit to a higher authority his or her own report and the advice or recommendations of the physician or competent public health body.




ANNEX TWO: TYPES OF PHYSICAL AND PSYCHOLOGICAL TORTURE LISTED IN THE ANTI TORTURE ACT 2013

Physical Torture

13. (a) "Physical torture" shall be considered any physical action by a state official under whose care a person is or upon the order of such an official or with the consent of such an official, or with the knowledge of such an official, which results in the infliction of the sensation of pain, or to bring tiredness to the body, or to weaken the body, or an action resulting in the body or part of the body to not function in its normally.

(b) The following, by their very nature, shall be considered physical torture. Yet, the definition of physical torture is not limited to the following. Other actions of a similar nature are also to be considered as physical torture.

- (1) The beating of a person's body in an organized or systematic fashion.
- (2) Banging of a person's head in a certain way at a certain place.
- (3) Hitting a person with the fists or kicking a person with the legs.
- (4) Hitting a person with the butt of a gun, or a baton, or a stick, or a plastic tube, or a brick, or a chair, or a piece of wood, or with any such hard object.
- (5) Jumping on or kicking a person's stomach.
- (6) Hitting a person's genitals.
- (7) Applying a heated rod or any such object to a person's body.
- (8) Restricting a person of daily meals or not providing a person's daily meals or feeding of rotting food, or the forceful feeding or feeding something unfit for human consumption.
- (9) The forceful feeding or swallowing or applying a person's own or another person's excrement on his body or on applying a person's own or another person's excrement on his belongings.
- (10) Infliction of electric shocks.
- (11) Applying a lit cigarette to a person's body.
- (12) Pouring or spraying of heated oil on a person's body.
- (13) Pouring or spraying of acid.
- (14) The pouring of chili, salt or any such substance on a wound on the body or pouring any chemical that would further increase the sensation of burning of the wound or torturing the wound in any other way.
- (15) The forceful pushing of a person's head into water, or the pouring of water on the face of a person resting on a horizontal surface (water boarding).
- (16) The tying of a person in a manner where the person is unable to move or in a manner that puts strain on the body.
- (17) Tying of a person in a manner that the person cannot adjust his position.

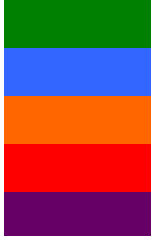
- 
- (18) Suspending a person vertically upside down, or suspending a person from an angle.
 - (19) Performing an action of sexual nature.
 - (20) The act of performing sexual intercourse.
 - (21) Performing asexual act which is deemed unacceptable by society.
 - (22) Subjecting a person's genitals to electric shock.
 - (23) Insertion of an object into a person's genitalia.
 - (24) Sodomy.
 - (25) Detaining in a way that may cause suffocation.
 - (26) Forceful tearing of nails or teeth or hair or shaving a person's hair.
 - (27) Subjecting a part of the body to cuts, or the mutilation of a part of the body or amputation.
 - (28) Subjecting a person to extreme heat or extreme cold.
 - (29) Subjecting a person to sit on ice.
 - (30) Covering a person's head and face with a polythene bag.
 - (31) Subjecting a person to any medication which might affect a person's mental state, consciousness or memory.
 - (32) Subjecting a person to medication in order to mimic symptoms particular to a certain disease.
 - (33) Subjecting a person to the fall of drops of water onto to person's head in a certain manner and at a certain rate.

Psychological Torture

14. (a) "Psychological torture" shall be considered as any act or actions to subject a person to anxiety, or to deprive a person from natural process of thought, or to frighten, or to force something upon a person, or to subject a person to degrading treatment, or to humiliate a person in the care of a government official, or by the orders of such official, or with the consent of such official, or with the knowledge of such an official.

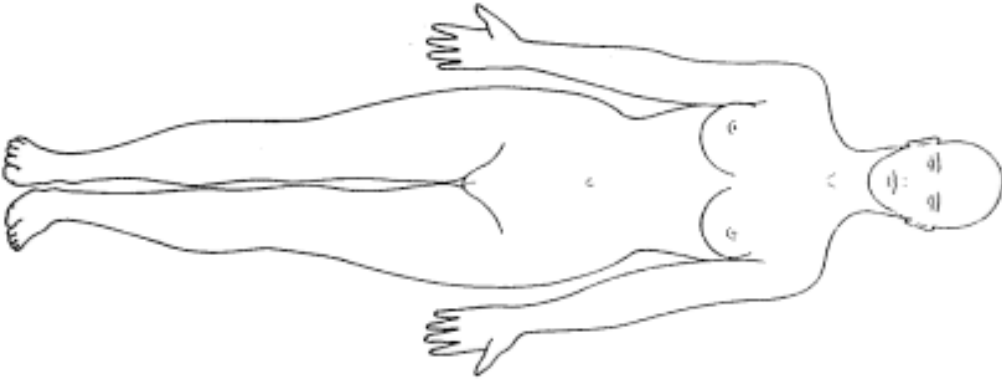
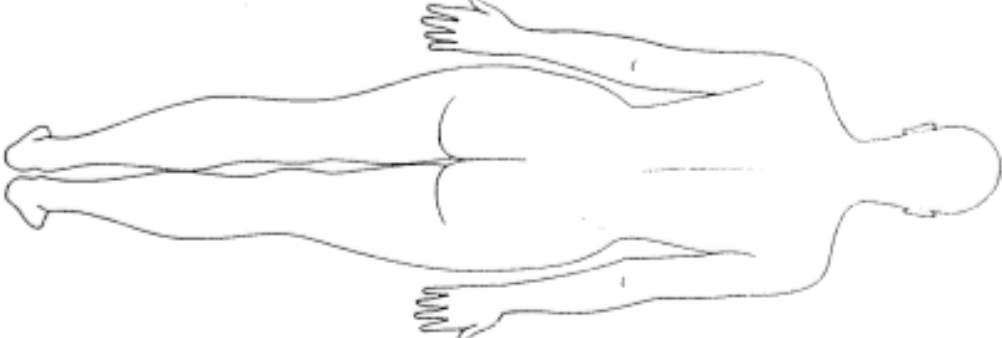

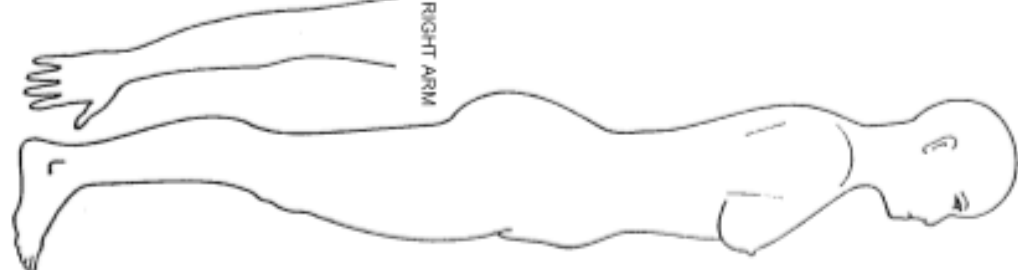
(b) The following, by their very nature, shall be considered psychological torture. Yet, the definition of psychological torture is not limited to the following. Other actions of similar nature are also to be considered as psychological torture.

- (1) Blindfolding.
- (2) Threatening to harm a member of one's family.
- (3) Solitary confinement (detention in a manner where no other human can interact with that person and in a manner where he cannot see any other person).
- (4) Detaining a person in a secret centre that is not registered as a place of detention.
- (5) Long continuous durations of interrogation.

- 
- (6) Forcing a person to walk or ordering a person to perform certain actions in front of other people with the intention of humiliating the person.
 - (7) The transportation of a person from the facility in which he is being detained to another facility or place that has not been previously arranged in order to make the person believe that the purpose for the change in location is to subject the person to torture.
 - (8) Committing actions of degradation against a member of a person's family.
 - (9) To physically abuse a family member, friend, relative or another third person in the presence and view of that person.
 - (10) Depriving a person from rest or sleep.
 - (11) Forcing a person to strip nude in the presence of another person or other people.
 - (12) Shaving of one's head.
 - (13) Branding a person skin in a particular form to cause shame and humiliation.
 - (14) Prohibiting a person from talking with a family member or a lawyer.

ANNEX THREE: ANATOMICAL DRAWINGS FOR DOCUMENTATION OF TORTURE AND OTHER ILL-TREATMENT (IP, ANNEX III)

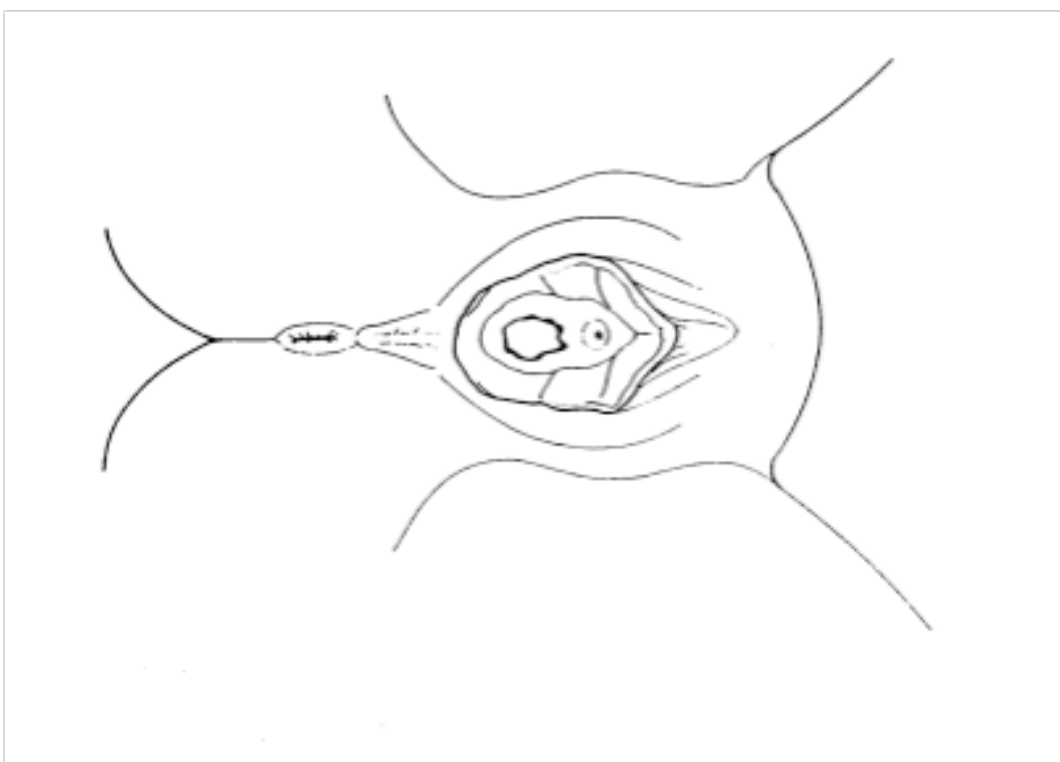
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|--|---|--|--|
|  |  |  |  |
| | | LEFT ARM | RIGHT ARM |

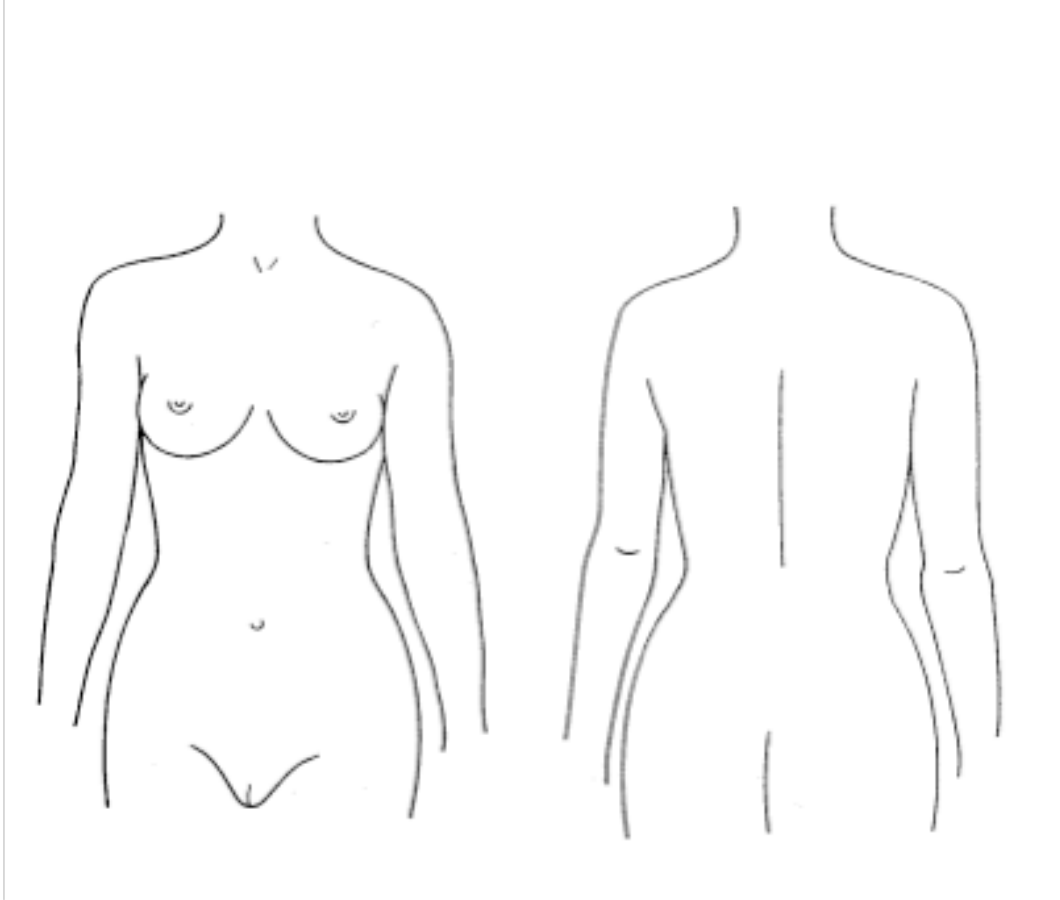
FULL BODY, FEMALE—ANTERIOR AND POSTERIOR VIEWS

FULL BODY, FEMALE—LATERAL VIEW

PERINEUM—FEMALE

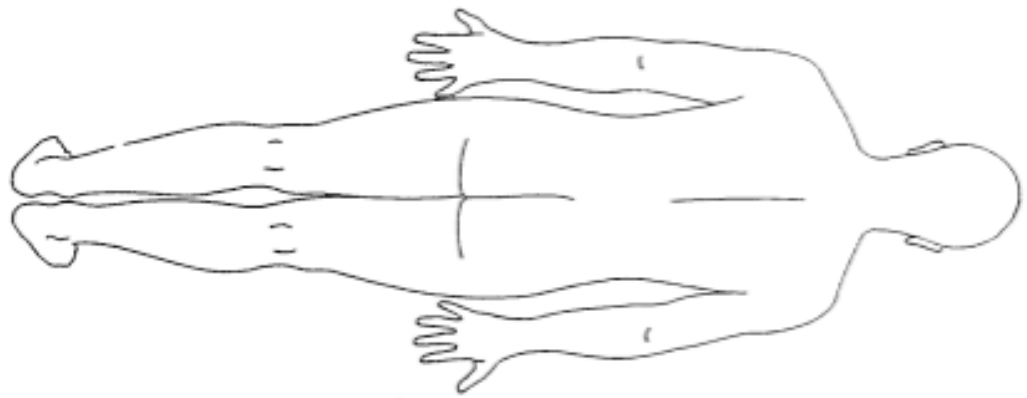
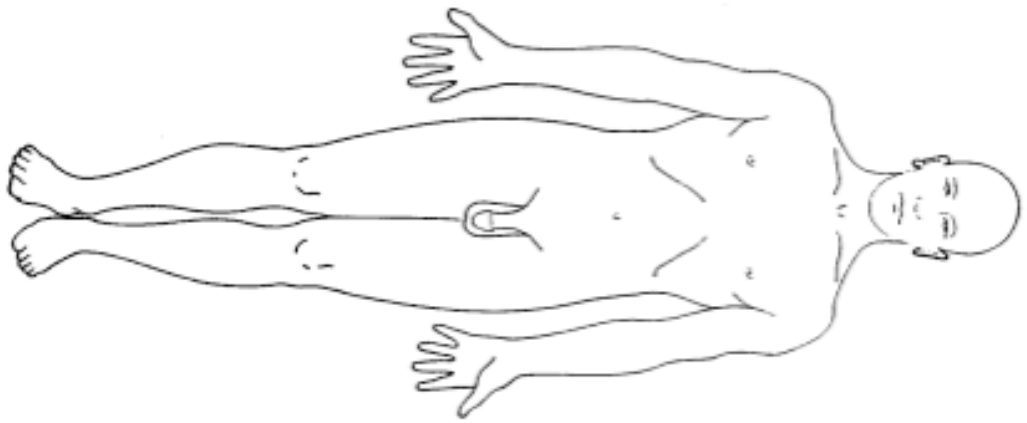


THORACIC ABDOMINAL, FEMALE—ANTERIOR AND POSTERIOR VIEWS



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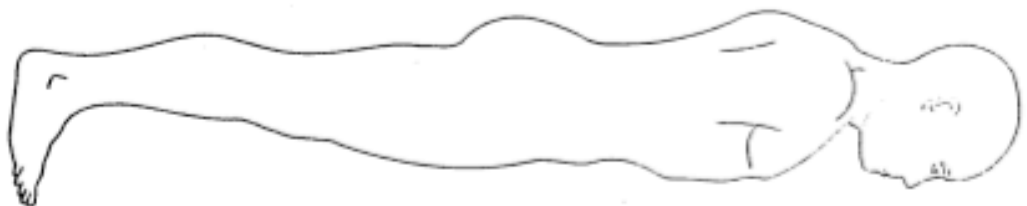
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LEFT ARM



RIGHT ARM



Name _____

Case No. _____

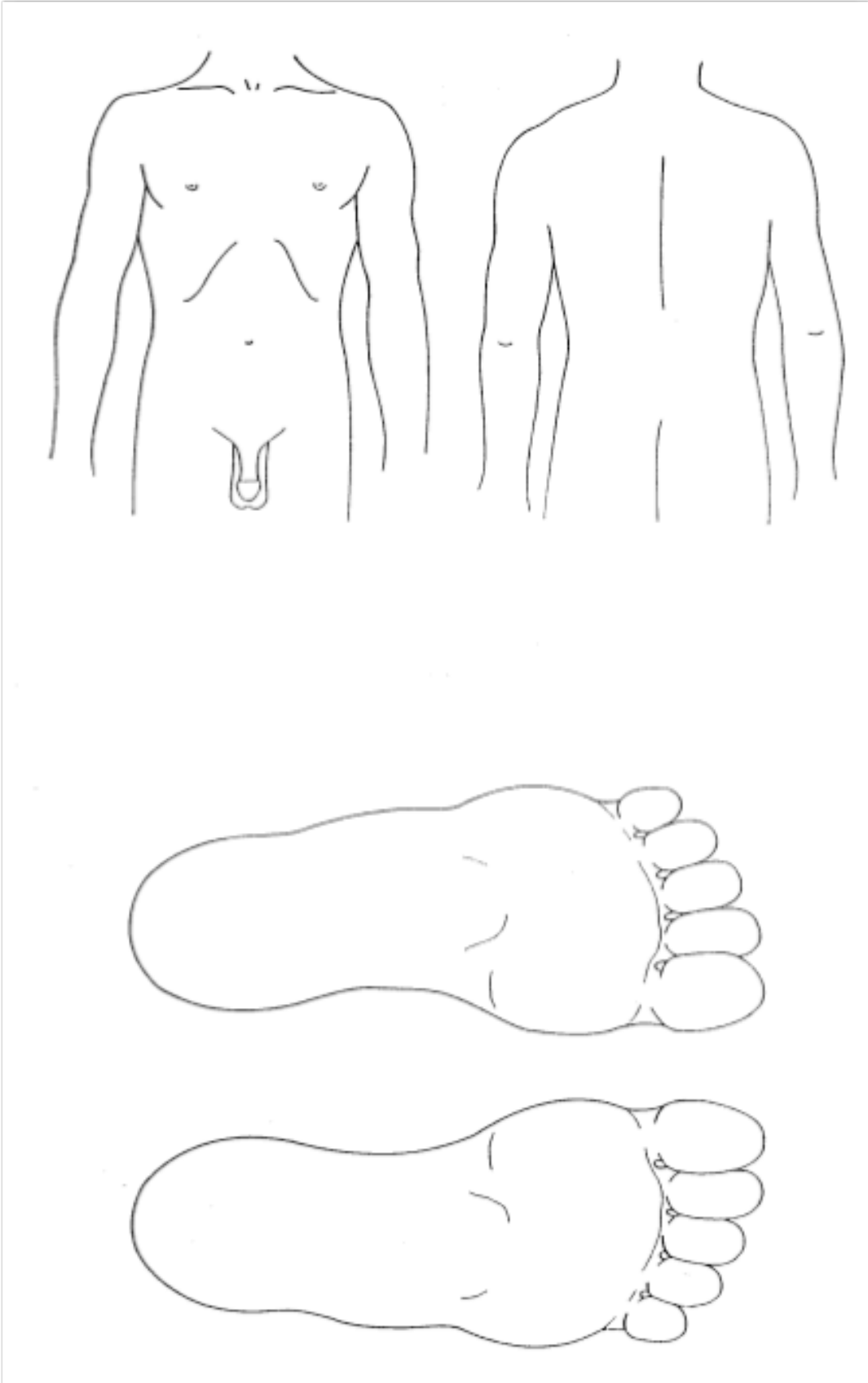
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THORACIC ABDOMINAL, MALE—ANTERIOR AND POSTERIOR VIEWS

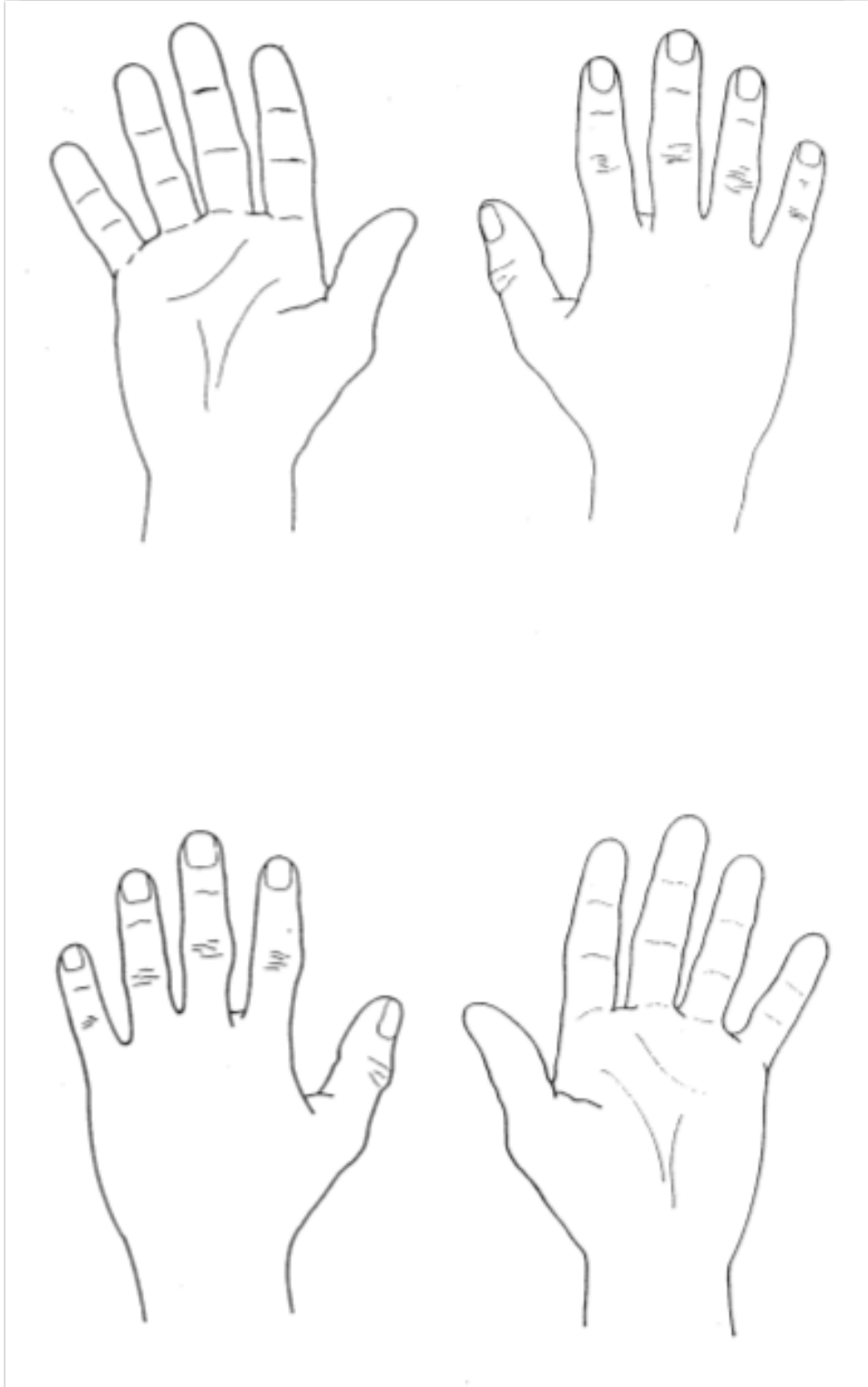


FEET—LEFT AND RIGHT PLANTAR SURFACES

Name _____
Case No. _____
Date _____

Name _____
Case No. _____
Date _____

RIGHT HAND—PALMAR AND DORSAL



LEFT HAND—PALMAR AND DORSAL

Name _____

Case No. _____

Date _____

Name _____

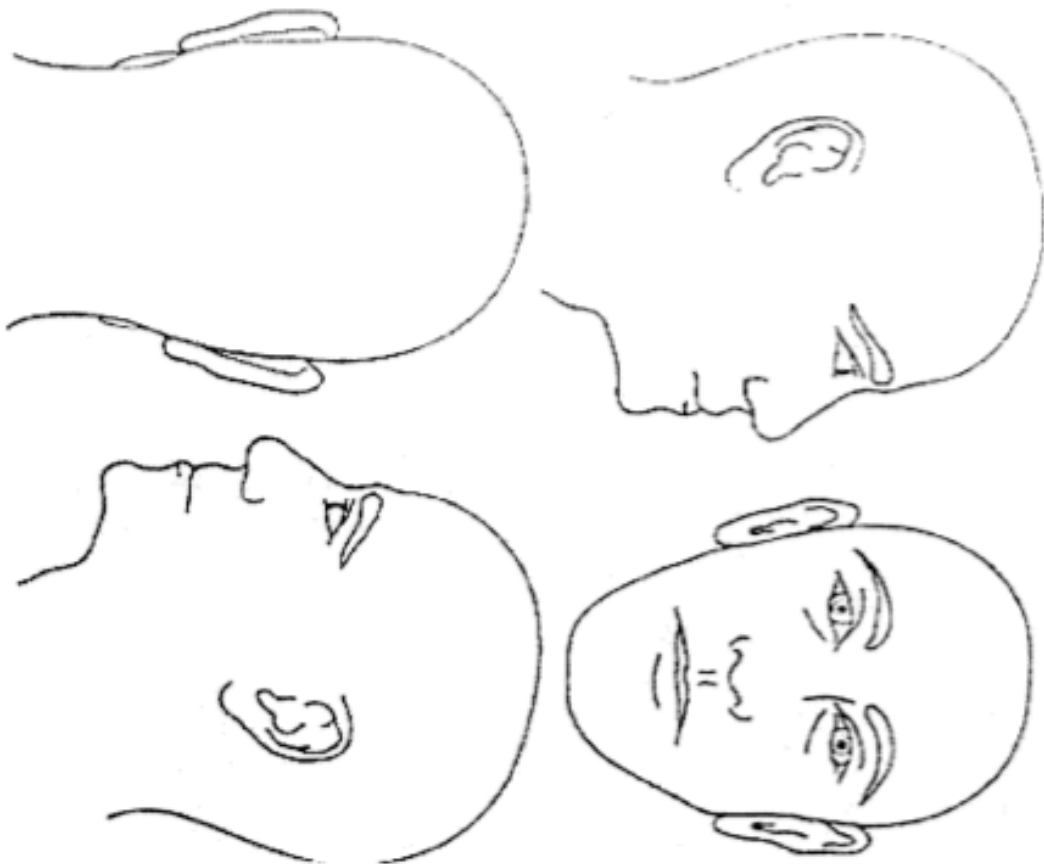
Case No. _____

Date _____

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



HEAD—SURFACE AND SKELETAL ANATOMY, LATERAL VIEW



Name _____

Case No. _____

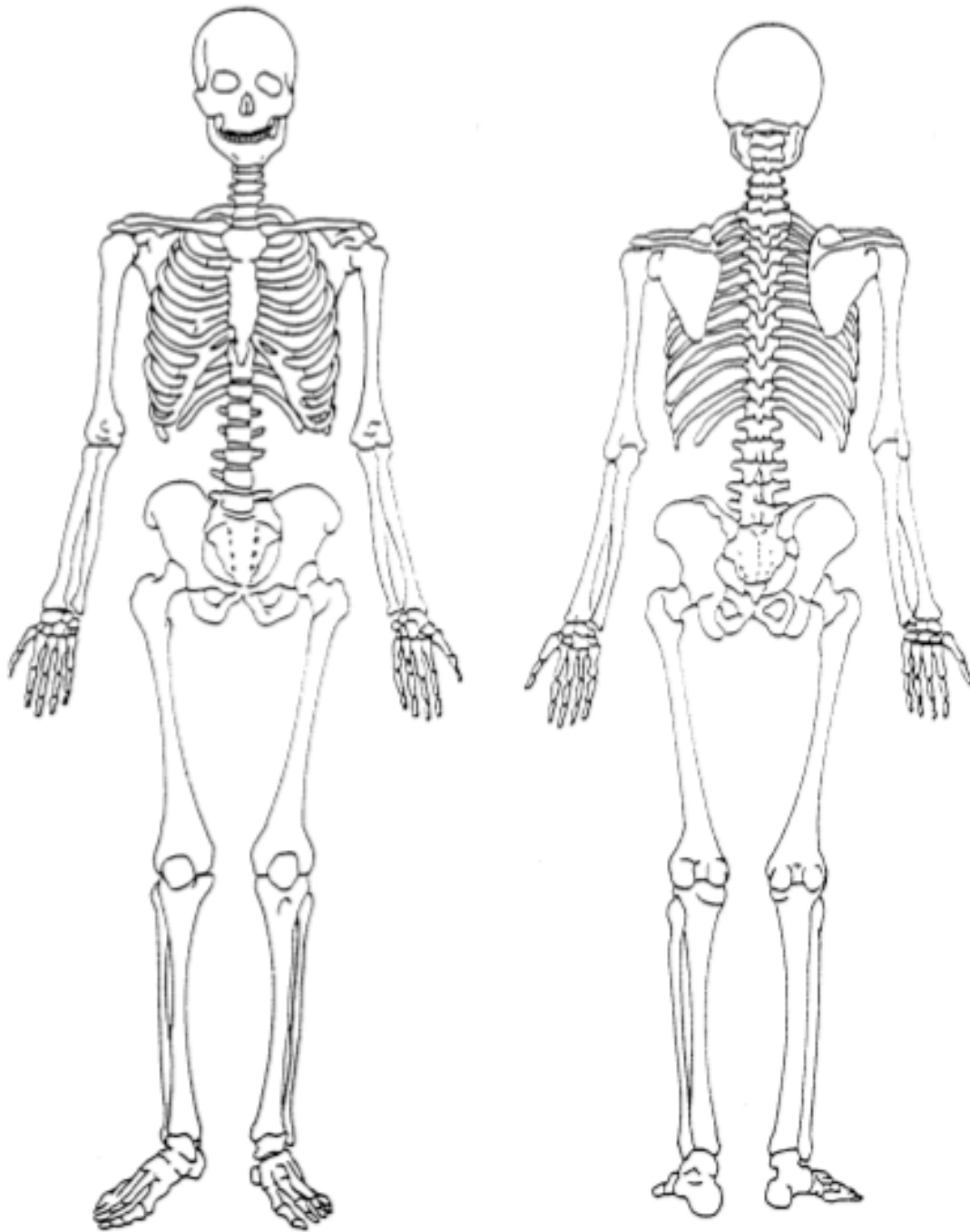
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Name _____

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SKELETON—ANTERIOR AND POSTERIOR VIEWS



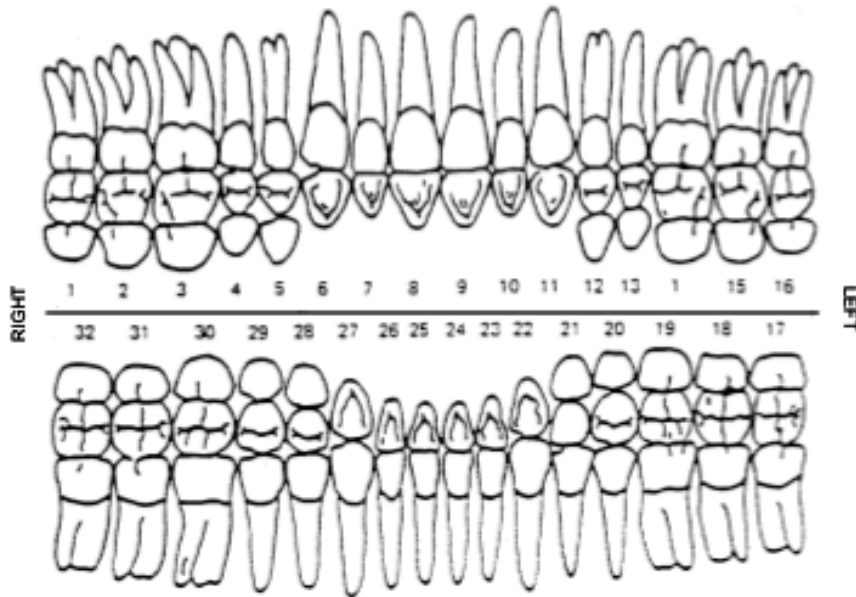
Name _____

Case No. _____

Date _____

MARK ALL EXISTING RESTORATIONS AND MISSING TEETH ON THIS CHART

Estimated Age _____
 Sex _____
 Race _____



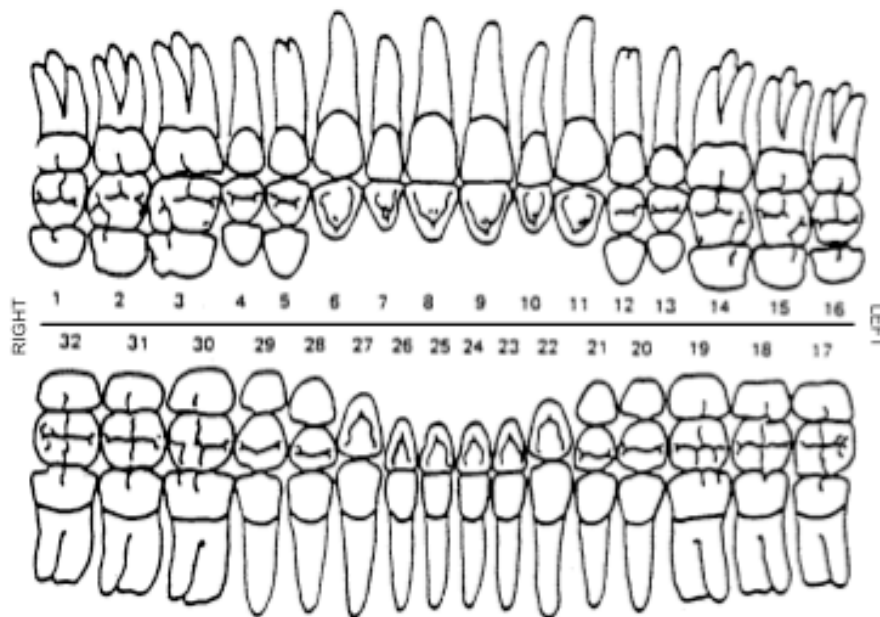
Circle descriptive term
 Prosthetic appliances present
 Maxilla
 Full denture
 Partial denture
 Fixed bridge

Mandible
 Full denture
 Partial denture
 Fixed bridge

Describe completely all prosthetic appliances or fixed bridges _____

Stains on teeth
 Slight
 Moderate
 Severe

MARK ALL CARIES ON THIS CHART
 Outline all caries and 'X' out all missing teeth

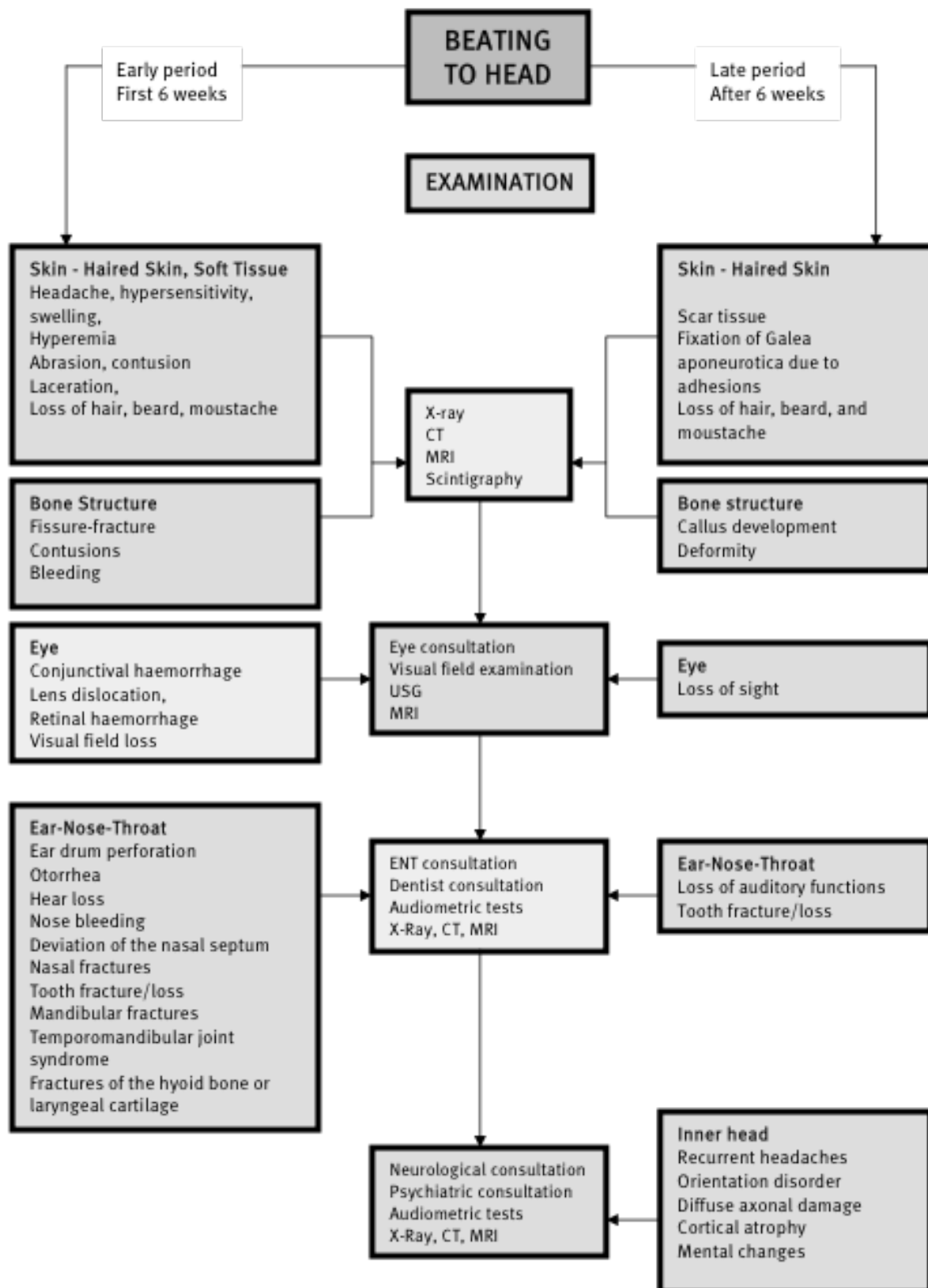


Circle descriptive term
 Relationship
 Normal
 Undershot
 Overbite

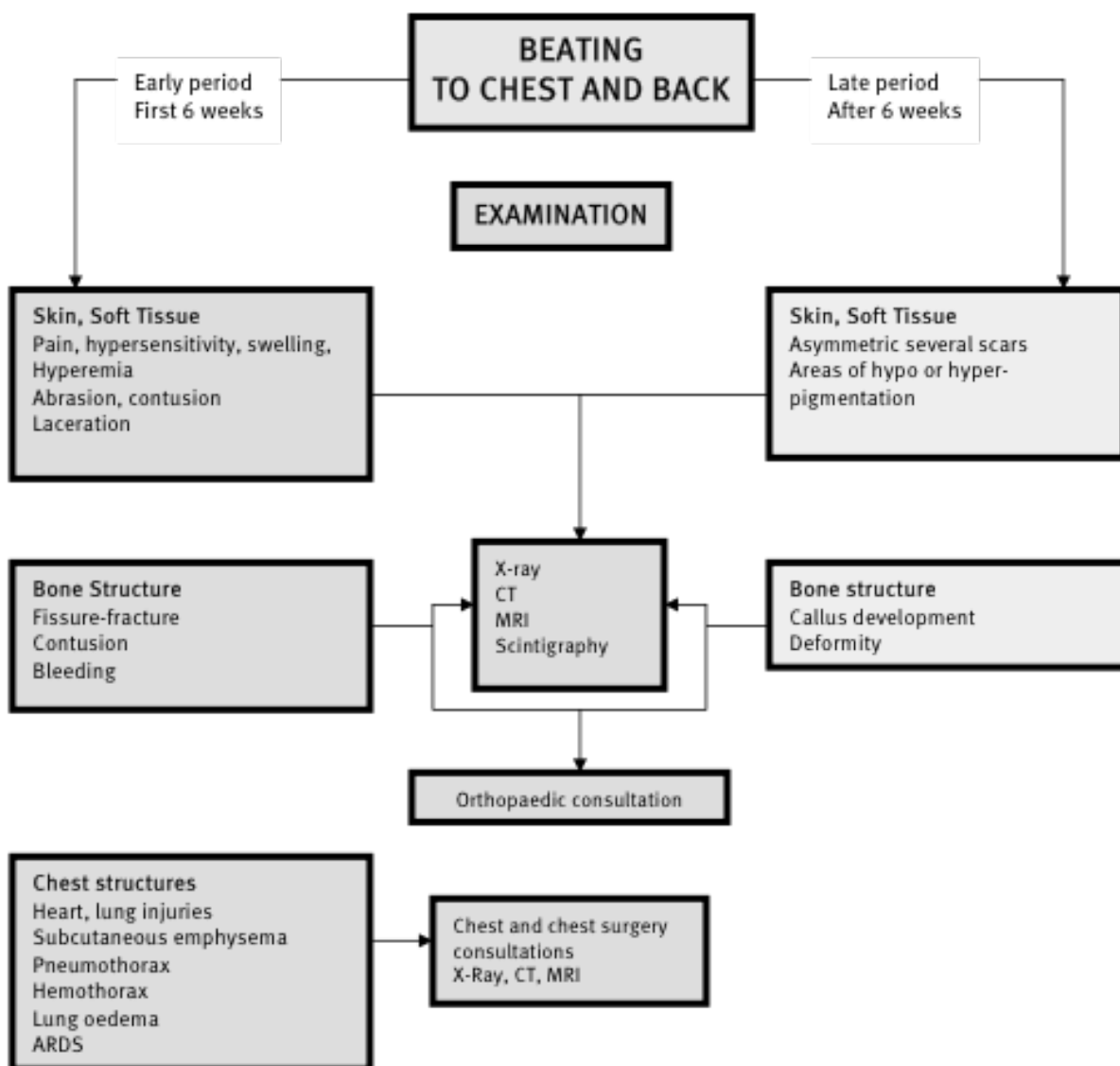
Periodontal Condition
 Excellent
 Average
 Poor

Calculus
 Slight
 Moderate
 Severe

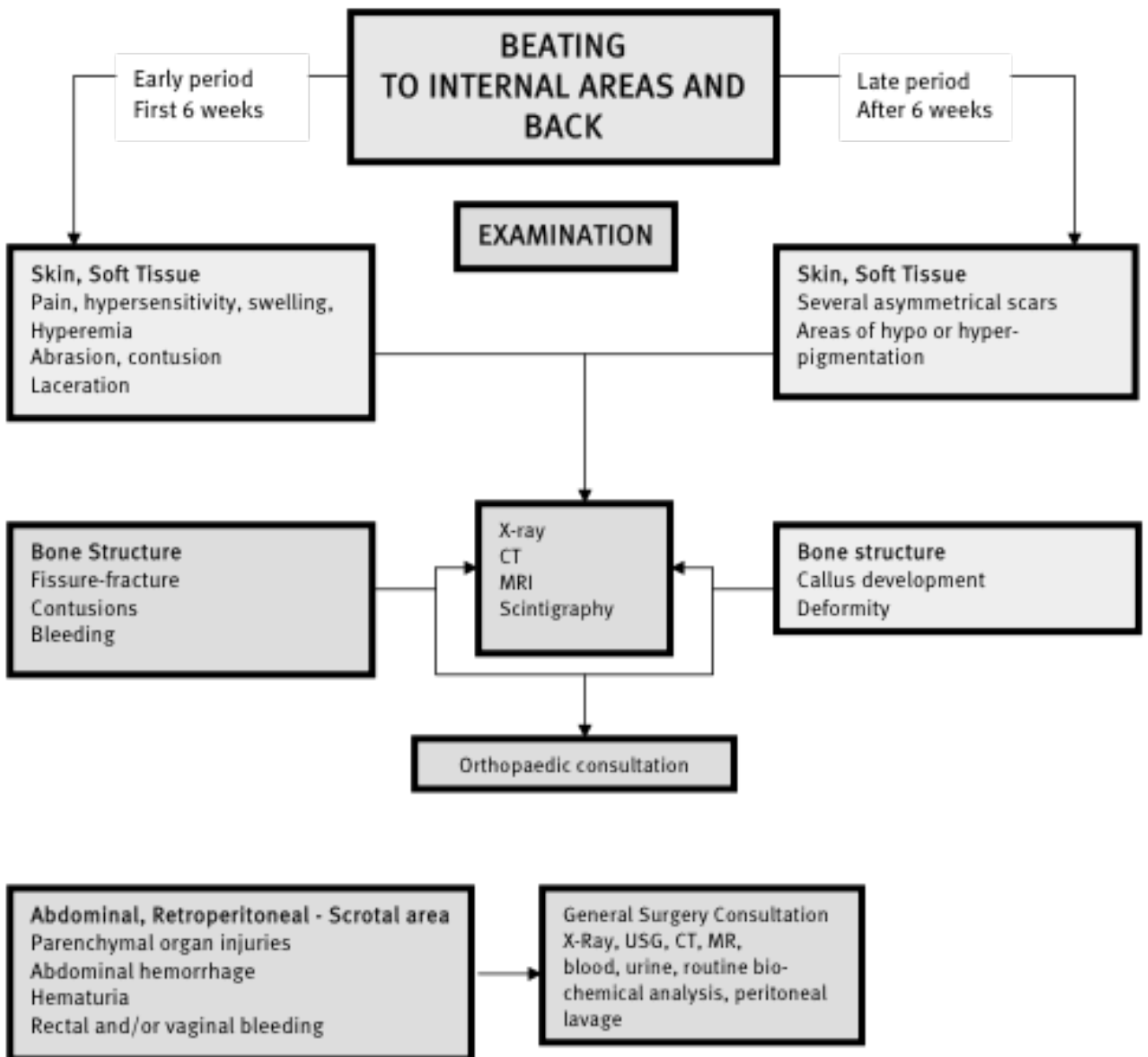
ANNEX FOUR: PHYSICAL SYMPTOMS & FURTHER INVESTIGATIONS FOR CERTAIN TYPES OF TRAUMA



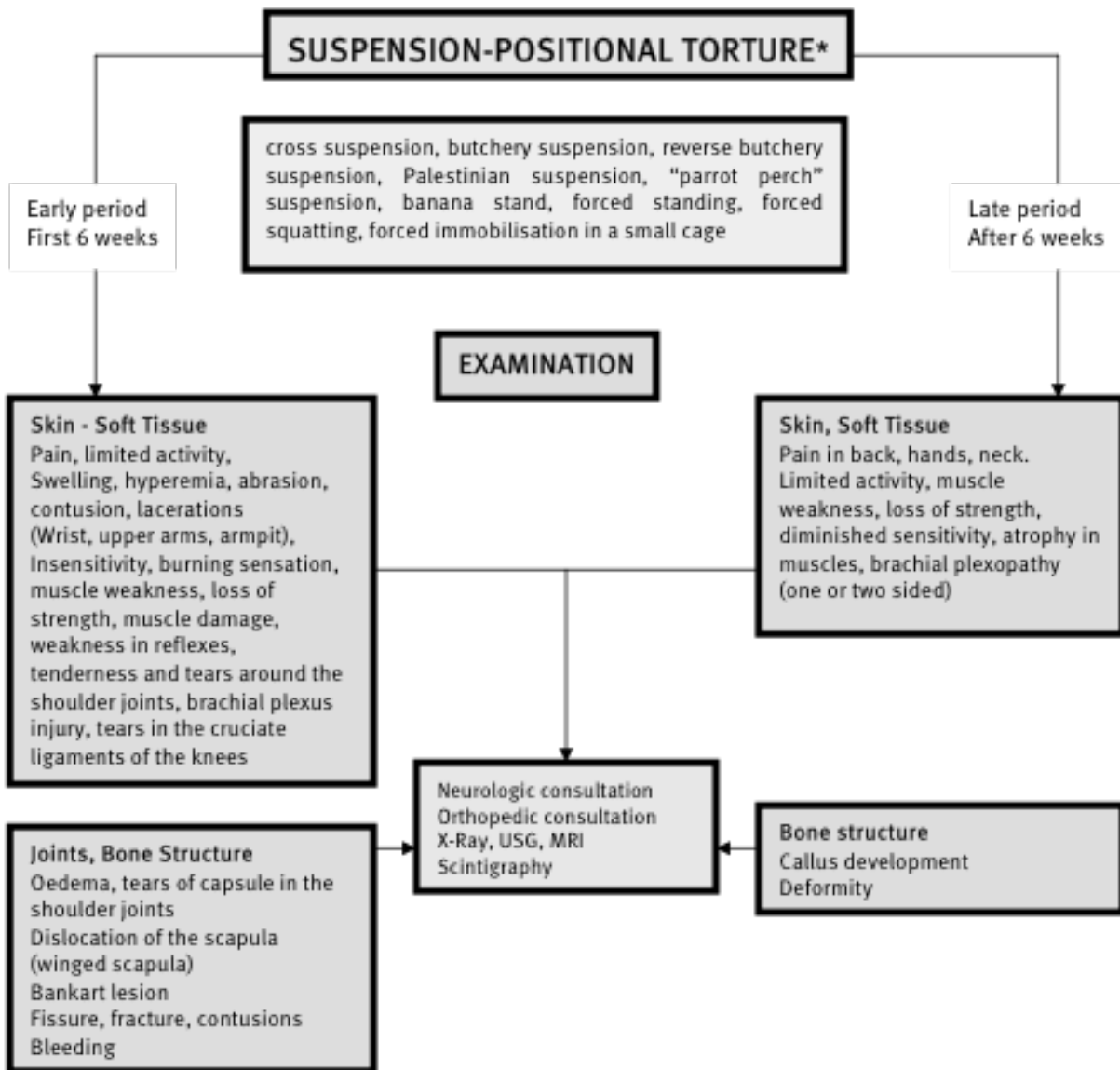
Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)



Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)

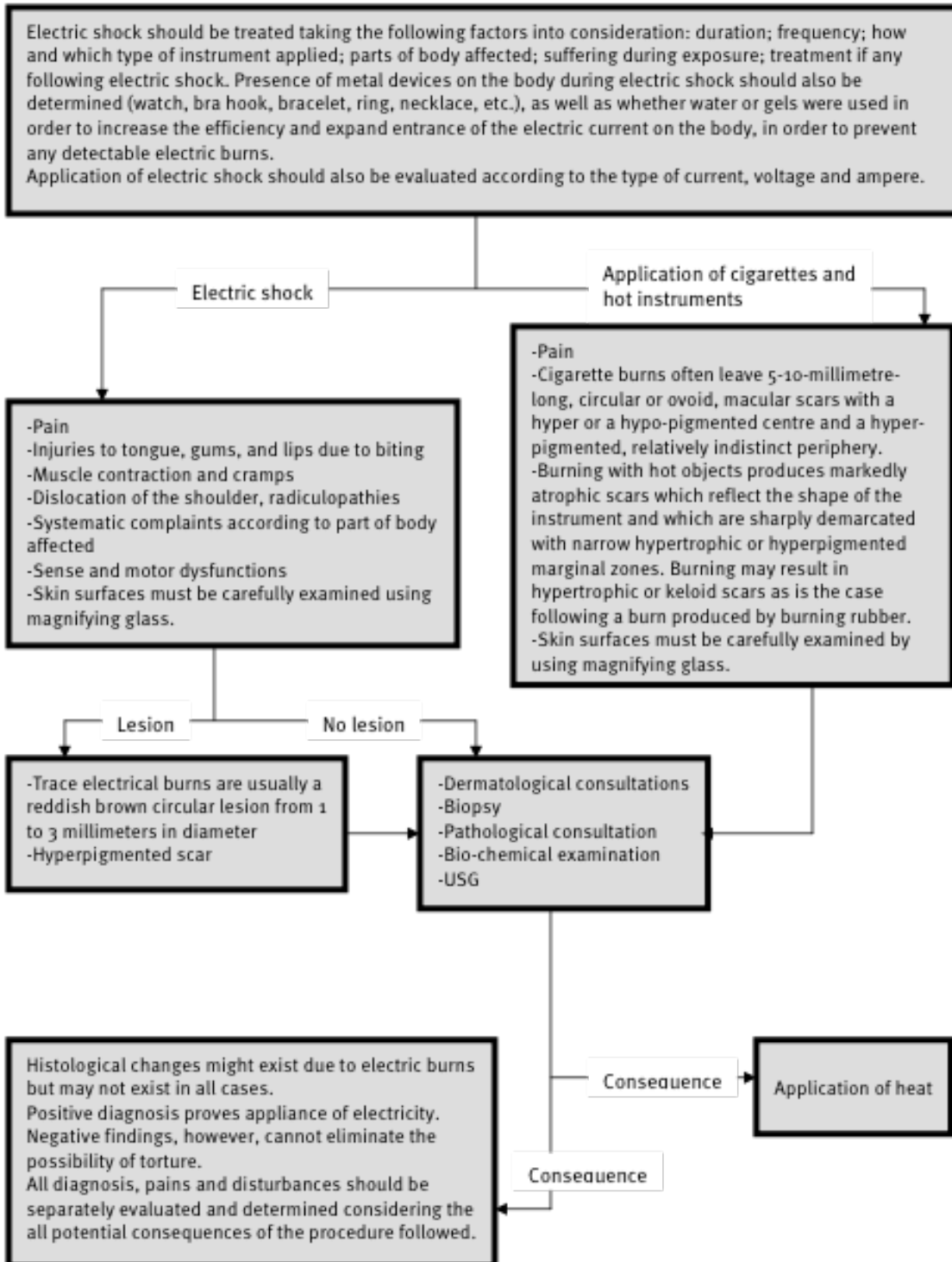


Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)



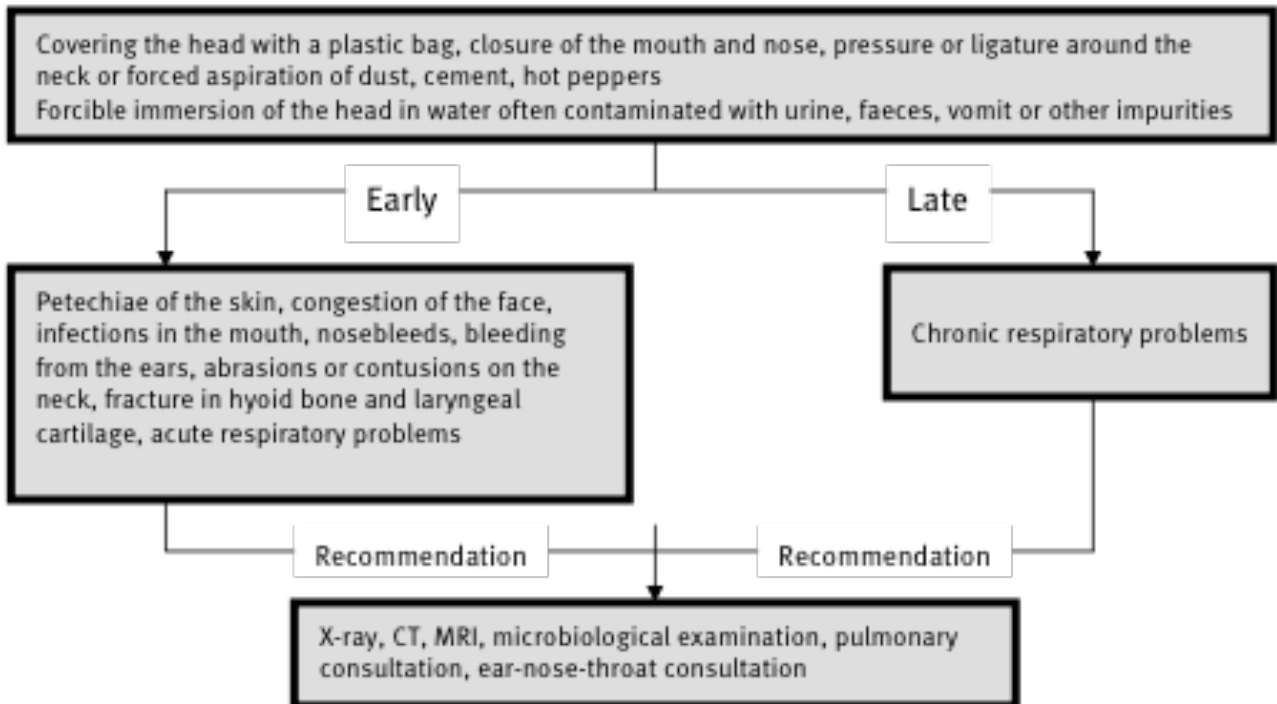
Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)

ELECTRIC-HEAT APPLIANCE

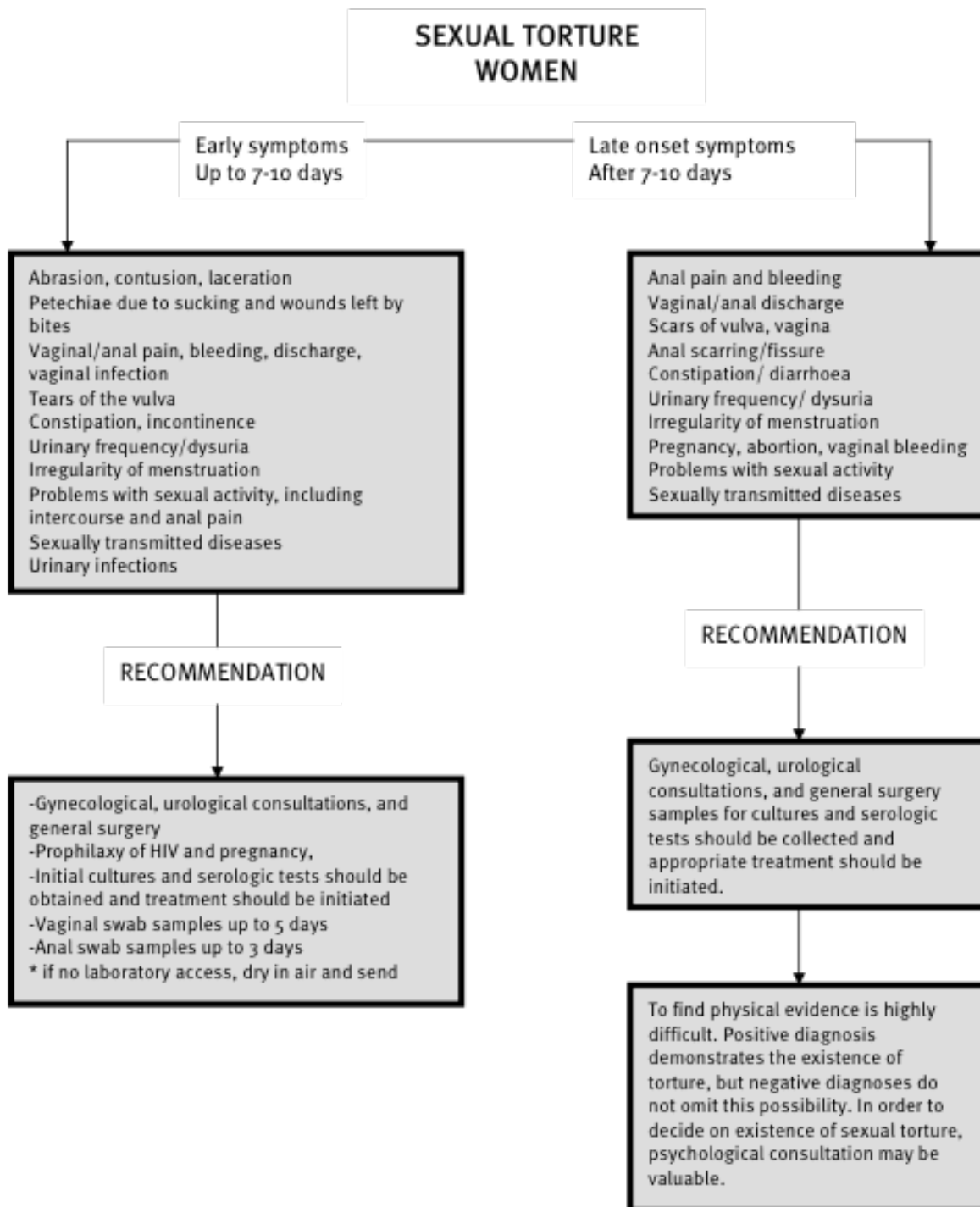


Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)

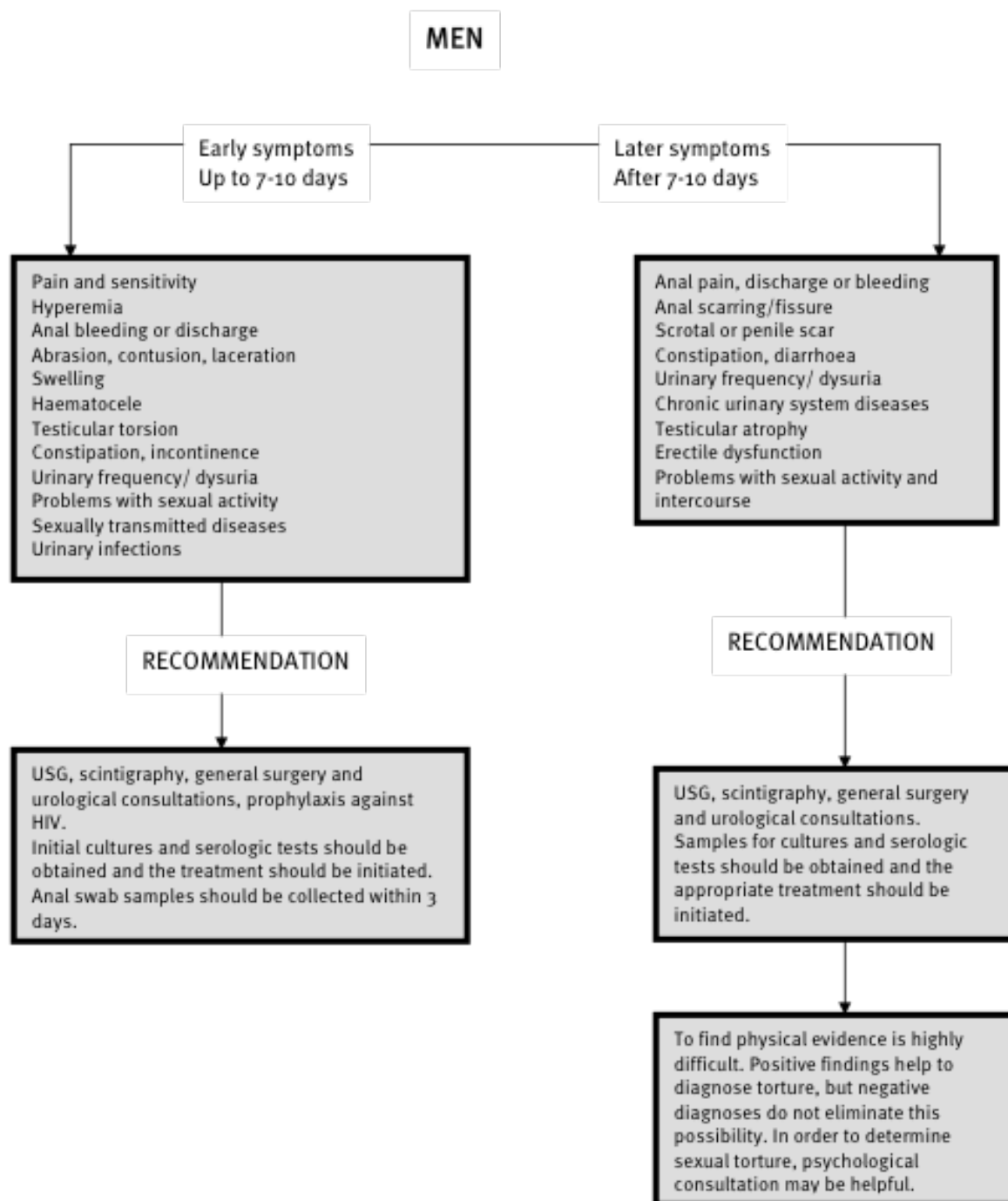
ASPHYXIATION



Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)



Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)



Source: Society of Forensic Medicine Specialists, 'Medical Checklist/Guide for Effective Documentation and Investigation of Torture and Other Forms of Ill-treatment', Revised through Prevention Through Documentation Project: IRCT (2007)