

Implementing the Istanbul Protocol

PRAXIS PAPER NO. 3



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Introduction

With the aim of exploring possibilities of adding a medico-legal documentation component to the rehabilitation of torture victims performed at the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, a pilot study was performed in the fall of 2005. This report describes the process and results of the RCT pilot study on implementing medico-legal documentation in a rehabilitative setting.

As means of preventing torture, documentation is believed to be a highly effective strategy and is applied in different variations by institutions ranging from the International Committee of the Red Cross (ICRC) to small local NGOs. By documenting abuse and maltreatment, facts can be presented to political leaders, prison wards and others with power to change practice. Likewise, documentation is essential for persecuting perpetrators legally, another strategy believed to be highly preventive. Persecuting perpetrators of torture is also a way of offering redress and compensation and can thus play an important part in the rehabilitation of the individual and the torture-struck society.

As a way of streamlining and improving documentation methods, a group of experts within law, medicine, health care, psychology and social sciences created a manual, which has become the authoritative document on the subject: *“Istanbul Protocol – Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment”*. The protocol, however, is not widely applied.

There are many explanations for the lack of implementation. The volume and extent of the protocol no doubt plays an important part, but another explanation may be that most approaches to victims of torture are rehabilitative in their scope. The rehabilitative and documentary strategies are seldom applied simultaneously. Documenting torture is not necessarily a logical consequence of rehabilitating torture victims – quite contrary, important ethical principles such as doctor-patient confidentiality and the therapeutic approach to victims inscribed in various ethical codes of health care personnel inhibit a combination of the two approaches. Moreover resources are often scarce, and performing documentation represents an additional cost.

However, there are many arguments for adding a logical component to rehabilitation. Rehabilitation is extremely important for the individual victim, the family and the torture-struck society, but in order to get to the root of the problem, torture must be prevented from occurring altogether. The primary source of information about a stealth phenomenon like torture is the individual victim in the rehabilitation process and the rehabilitation process is thus an important source of information for improving and developing preventive strategies.

The synergies between rehabilitation and documentation are noticeable - a large part of the information is essentially similar. This is especially true for the medical and psychological part of the Istanbul Protocol, but also legal and practical information typically surface in the course of rehabilitation¹. For instance, the victim often describes the type of torture in connection with the treatment process. Such information is

¹ RCT pilot study (section 3).

recorded in the medical journal of each client, but inaccessible for other purposes due to the way it is collected, recorded and administered.

Where medico-legal documentation *is* gathered, it is rarely on the basis of the Istanbul Protocol, a likely reason being the high level of detail and the time required to perform a full examination, which in the RCT pilot study was estimated to take several hours if not combined with obtaining information for rehabilitation². A similar study by the Archbishop's Human Rights Office (ODHAG) in Guatemala estimated as much as seven hours to perform a full examination according to the Istanbul Protocol³.

With the overall aim of assessing *how a rehabilitation centre like The Rehabilitation and Research Centre for Torture Victims (RCT) can contribute to the fight against impunity* the purpose of this report is to *explore to what extent medical documentation can be added to the rehabilitation process already in place*. The report proposes the construction of a joint database system, where the information gathering and registration for rehabilitation and documentation are combined, thus realizing the synergies in the data collection process. Such a system would allow a rehabilitation facility such as the RCT to add medico-legal documentation at a minimum cost and would improve RCT's ability to:

- Contribute to the fight against impunity
- Perform medical documentation in asylum cases
- Conduct research on the consequences of and strategies against torture
- Substantiate lobbying activities
- Substantiate advocacy activities
- Develop methods of documentation further

Section 2 of this report outlines the background for performing medical documentation at a rehabilitation centre by reviewing literature on the subject and attempts to extract lessons from others already performing medico-legal documentation. Section 3 is a description of the RCT pilot study on the implementation of the Istanbul Protocol, while Section 4 draws up some general considerations on implementing medico-legal documentation in a rehabilitative setting. The methods of documentation outlined in the Istanbul Protocol and other literature will not be discussed in this report, since the aim is not to evaluate these methods but to find out how they can be implemented in a rehabilitative setting.

Setting the scene and learning from others

Performing medico-legal documentation in the safe and comparatively well-resourced setting of the RCT is quite different from conducting prison visits with scarce resources in a violent environment, as is the case for many NGO's. As explained in the Istanbul Protocol and other literature on the subject, a variety of factors affect implementation. Likewise, the experiences and strategies of other organizations in the field can provide lessons and ideas for the implementation at RCT. This section summarizes some of the

² The pilot-study of applying the Istanbul Protocol to five RCT clients estimated this amount of time to apply it completely and during one session (section 3).

³ ODHAG (2005).

important considerations on implementation listed in the Istanbul Protocol and other literature and reviews the experiences of other organizations in the field.

Summary of Review of Literature and Current Practices

In the following section the various materials on the subject of medico-legal documentation – typically in the form of handbooks and manuals, but also a number of articles⁴ – is discussed on the basis of the Istanbul Protocol and alongside a review of current practices of NGOs and organizations such as the ICRC and the Committee for the Prevention of Torture (CPT).

It is widely agreed that the method of medico-legal documentation can be instrumental in fulfilling a range of *legal* obligations within the UN human rights system and the Geneva Conventions, including the UN Convention against Torture and its Optional Protocol (OPCAT)⁵. Notably, the principle of non-refoulement and the many principles to ensure the persecution of perpetrators can hardly be fulfilled without some sort of medico-legal documentation.

The professional *ethical codes* for physicians and health care personnel⁶ have more ambiguous implications for medico-legal documentation. On the one hand, the ethical codes are in line with the UN human rights in stipulating that all must be done to prevent torture and relieve the consequences, but on the other hand some of the most fundamental principles of the doctor-patient relationship – confidentiality, therapeutic focus, etc. – do not adjust easily to medico-legal documentation. With documentation, the doctor's role changes from being purely therapeutic to becoming more investigative since the doctor has to judge whether the patient's story is legitimate, a concern which is irrelevant for treatment and rehabilitation. There are circumstances where documentation is detrimental to treatment or the doctor has to choose between the two. Should the doctor then prioritize documentation and thus possibly help prevent torture in the long run or should the doctor focus on treating fewer victims thoroughly? The doctor should always act according to the best interest of the patient, but the dilemma is significant. Documentation must thus never compromise the best interest of the patient. Likewise, the principle of anonymity, which cannot be compromised by the doctor, requires careful consideration when performing medico-legal documentation.

In practice, a wide range of factors affects medico-legal documentation. The *aim* of the investigation for one (i.e. gathering evidence for a trial or screening large prison populations) largely determines the process since the level of detail and resources per

⁴ See the list of literature for a complete overview.

⁵ Bernath (1999): 40; Vedel Kessing (2003): 160; ICRC (2002a): 6; RCT (2005): OPCAT Conference Report (2005).

⁶ *Ethics for the legal profession*: UN Basic Principles on the Independence of the Judiciary (1985), The UN Guidelines on the Role of Prosecutors (1990), and UN Basic Principles on the Role of Lawyers (1990).

Ethics for the health care professions: UN Principles of Medical Ethics (1989), WMA Declaration of Tokyo - Guidelines for Physicians Concerning Torture and Ill-treatment (1975), World Psychiatric Associations Declaration of Hawaii (1977), The Islamic Conference of Islamic Medicine's Declaration of Kuwait (1981). and the International Council of Nurses (1975).

victim varies accordingly⁷. Also *security* issues affect the process. In Denmark, where torture victims are mainly refugees who have fled the country where the torture occurred, security measures play a small role although measures are in place to make the clients feel safe. Security issues play a dominant role for almost all of RCT's partners, since both the investigative team and the alleged victims risk violent repercussions from authorities attempting to silence accusations of torture and abuse. The proximity to perpetrators affects both the victim who might be afraid or nervous and the investigator who has to rely on the goodwill of the authorities. Applying the security measures listed in the Istanbul Protocol and in the ICRC guidelines involves securing access to all prisoners, always speaking to prisoners in private, the ability to conduct follow-up visits and to record the identity of the alleged victim⁸. Securing these measures can be both costly and impossible, but if they're not in place, the victim may be better off not being documented.

A number of practical issues, such as the *time* and *resources* available and the *composition of the investigation team and their level of expertise* also affect implementation. The time available for medico-legal documentation basically sets the limits. At RCT, a client typically undergoes a thorough rehabilitation process lasting up to one year involving a wide range of doctors, psychologist, nurses, physiotherapist and social workers. The time spent on one client equals time away from a new one, and time is thus still an issue at a comparatively well-resourced establishment as the RCT. For many of RCT's partners and organizations such as the ICRC and the Committee for the Prevention of Torture (CPT) which are involved in prison visits, the time spent on each inmate or client has to be carefully measured against seeing as many as possible. To cope with this problem, some organizations such as the International Rehabilitation Council for Torture Victims (IRCT), propose a screening methodology whereby a large prison population can be screened. In addition to identifying victims for further investigation, this method renders a large data set, which allows the investigative team to speak for the entire population⁹. Similarly, the resources available affect the documentation process. A well-resourced team will, for instance, be able to photograph and videotape injuries and store data in an advanced data-system, while a team with fewer resources will have to rely on descriptions of injuries. Similarly, the type of experts available and their professional skill and experience with torture affects the investigation.

There are also several different methods for *collecting data*. The interview is the core of the documentation process and all observers emphasize the need to adopt an open questioning technique, which allows the alleged victim to describe events in his/her own words, without suggesting answers¹⁰. The interview can take the form of a narrative/story, where the victim tells anything that comes to mind. The narrative can be an important element in assessing the credibility of the victim and guiding the interview¹¹. The use of questionnaires is debated, since they tend to oversimplify, but it is widely recognized that the investigator needs some sort of checklist or questionnaire to lead the investigation¹². Photographs and videotaping is recommended by all observers as

⁷ Istanbul Protocol (1999): 18.

⁸ Istanbul Protocol (1999): 18-19, 25; Reyes (2002): 81-86; Staiff (2000a); Perreira (2005)

⁹ IRCT short Medical Detection Format.

¹⁰ Istanbul Protocol (1999): 20; Iacopino: 128; Vedel Rasmussen (1990): 3; Physicians for Human Rights (2001): 25.

¹¹ Istanbul Protocol (1999): 71; Iacopino (2002): 102-103.

¹² Vedel Rasmussen (1999): 3; Istanbul Protocol (1999): 70-72; Giffard (2000): 37; Reyes in the RCT OPCAT-Conference Report (2005).

a good way of documenting injuries. Self-reporting methods where the main source of data is the alleged victims own report were generally discarded due to low credibility, while data of a more general nature – country reports, crime and health statistics – were recommended by some observers as a way of contextualizing the individual case.

Throughout the data collection process, the investigator should be aware that torture victims typically experience memory lapses and confusion¹³. The victim also risks retraumatization when describing the torture incidence and the investigator should carefully observe the victim to avoid this¹⁴. Cultural differences between the investigator and the victim can also affect the data collection, since they may be speaking within different regimes of truth and understanding¹⁵. A victim may have a different perception of pain and suffering than the investigator and thus perceive some torture methods differently from the investigator. The investigator should also pay attention to him/herself and any interpreters involved. Counter transference, i.e. feelings of guilt, rage, sadness, helplessness or an exaggerated identification with the victim, can seriously affect both and impede the investigation and should be dealt with accordingly¹⁶.

The medical and psychological components of the medico-legal investigation as well as the special character of sexual torture are thoroughly described in the Istanbul Protocol and other literature on the subject. The procedures resemble those applied in the rehabilitation process. There are, however, significant differences between examining for rehabilitative and documentary purposes. First of all, medico-legal documentation represents an alteration of focus: the physician is no longer only concerned with treatment but has to assess the degree of consistency between the allegations of torture and the objective findings. At the end of the process, the investigator has to put forward an interpretation of the degree of consistency between the objective findings of the investigation and the allegations of torture thus assuming an entirely new and more judgmental role. Moreover, in documentation, injuries that have healed or are otherwise unimportant for the ongoing treatment – typically scars – are also important and should be thoroughly described and perhaps photographed¹⁷.

The *legal* component of documentation is generally new to the rehabilitation process. The aim of documenting for legal purposes is generally the same as in other criminal investigation, i.e. to establish the course of events and gather evidence. The literature offers many opinions on what information is most important to obtain from the victim, the main point of disagreement being the level of detail. Some emphasize that every little detail is important since it can be corroborated with other evidence. Others are more concerned with recording key points such as the place and date of torture and recommend leaving the specific details for later. The aim of medico-legal documentation is to prove that an incident amounts to torture or ill-treatment and the investigator must seek to prove by facts that all elements in the definition of torture were present in the incident. Useful documentation thus mirrors the torture definition¹⁸:

¹³ Istanbul Protocol (1999): 28-29; Physicians for Human Rights (2001): 28; Iacopino (2002): 106; Alden (2002): 121.

¹⁴ Alden (2002): 123; Istanbul Protocol (1999): 19, 27-30; Reyes (2002): 79, 97.

¹⁵ Istanbul Protocol (1999): 28-29; Physicians for Human Rights (2001): 28; Iacopino in Peel & Iacopino (2002): 106; Alden (2002): 121.

¹⁶ Istanbul Protocol (1999): 19, 48-49; Iacopino (2002): 105.

¹⁷ Istanbul Protocol (1999): 33; Danielsen & Rasmussen (2005); IRCT 2005; Danielsen (2002); Kirschner & Peel (2002): 151-155; Ozkalipci 134-146.

¹⁸ Giffard (2000): 13.

What was done?
Who did it?
Why was it done?
Where was it done?¹⁹

The individual case is normally the basis of any useful documentation, but general reports about the situation in a country can also be valuable in identifying torture patterns. The combination of individual cases, general reports and – if possible – a compilation of similar cases all strengthens each case individually since many similar cases can support the individual complaint and point to a pattern of abuse. Documentation in the form of photos of injuries, medical records, testimonies, prison records etc. should be sought as supporting evidence, since mere claims of being subjected to torture can seldom be proved conclusively. Accusations of torture tend to occur in contexts where emotions and allegiances are very strong, and the possibility of false accusations being put forward as well as true allegations being discarded should be acknowledged²⁰.

Learning from Others

Although medico-legal documentation is a relatively new strategy of prevention and few apply the Istanbul Protocol in extenso, there are a number of organizations that have obtained know-how and experience in the field. The organizations vary in size, aim, resources available, and methods; but there are common denominators in their work: Almost all of the NGOs use medico-legal data proactively for advocacy and lobbying purposes, but have had a more difficult time in assisting victims in bringing perpetrators to trial due to the legal and political systems in their countries.

The International Committee of the Red Cross (ICRC) and Committee for the Prevention of Torture (CPT) under the Council of Europe are examples of international organizations that have specialized in prison visits and been instrumental in developing methods of medico-legal documentation. Both organizations use the data obtained as a basis for entering into dialogue with the authorities and have found this to be an effective strategy of prevention. The experiences of these organizations are included in the Istanbul Protocol, but since they are prison visiting mechanisms and not rehabilitation centres, the implementation issues are different from those of the RCT.

Many of RCT's partners and similar organizations – typically rehabilitation clinics and human rights organizations working at a grass root level in violent societies – have experience with medico-legal documentation. The Centre for the Prevention and Rehabilitation of Torture Victims and Their Families (CPTRT) in Honduras have developed "La Pesquisa", a screening system where the health status and story of all new prisoners are attempted recorded through visits. The data is used for both lobbying, advocacy and for research. The CPTRT has, for instance, studied police conduct on the basis of medico-legal documentation. The Asian Human Rights Commission (AHRC) in Sri Lanka as well as the Centre for Victims of Torture (CVICT) in Nepal have gained

¹⁹ SAIS (2004)

²⁰ Pounder, The RCT OPCAT Conference Report (2005).

experience in applying medico-legal documentation for legal purposes. Both have succeeded in bringing cases of torture to court, and medico-legal documentation has played an important role although results have been mixed due to the lack of an efficient legal system in both countries.

The Bangladesh Rehabilitation Centre for Torture Victims (BRCT) has developed a distinct system of medico-legal documentation where a proactive effort of identifying victims is coupled with a follow-up of treatment and/or legal action enabling the NGO to work towards rehabilitation and prevention simultaneously. The BRCT has developed a comprehensive database system of news clippings and data about torture incidences and the rehabilitation process. The aim is to use the database for research on both the phenomenon of torture, preventive strategies and the rehabilitation process. The BRCT documentation system is rather new and the use of the data has not been developed fully.

The Archbishops Human Rights Office in Guatemala (ODHAG) has taken a different approach to medico-legal documentation launching a pilot study and attempting to be as true as possible to the Istanbul Protocol. The ODHAG study is thus quite similar to that of RCT in aiming to investigate how the Istanbul Protocol can be implemented by a rehabilitation centre but there are important variations due to the context: The ODHAG study involved prison visits and was potentially dangerous for both the investigator (the documentation was conducted by one person alone, a psychologist) and the inmates. As a safety precaution, the prison authorities were not informed about the true purpose of the visits. Six individuals and one group were documented, demonstrating that group documentation can also be a way of obtaining information though this type of information hardly meets the requirements for evidence presented in legal proceedings. The documentation process was not optimal since access to prisoners was restricted – the investigator, for instance, had to interview prisoners through bars and could not always inspect injuries thoroughly. An important achievement of the ODHAG study was the use of data obtained in the study in a case at the Inter-American Court for Human Rights (IACHR). ODHAG has furthermore used the data to substantiate a shadow report on Guatemala to the UN Committee Against Torture in May 2006.

Possible Use of Data

Traditionally medico-legal documentation was developed as a way of gathering evidence to persecute perpetrators, but the review of literature on the subject and current practices have revealed several other ways to use medico-legal documentation:

National legal proceedings: Medico-legal documentation is a way of gathering evidence of torture. The methods are applied in various forms in court cases across the world and many of RCT's partners pursue this strategy although it is often difficult due to malfunctioning legal systems and authorities that hamper their efforts, often violently. In Denmark, the main obstacle to assisting victims in persecuting their perpetrators is not a malfunctioning legal system but the fact that the crime most often was committed several years ago in a country far away. A case can only be pursued if both the victim and the alleged perpetrator are residents in Denmark, which rarely occurs. Furthermore, the far-away crime scene and the time passed makes it extremely difficult to investigate the allegation and often the authorities in the country are not helpful in investigating allegations against their own police/military. A specialized agency, the State Prosecutor

for Special International Crimes (SAIS) has been created to deal with these cases, and the implementation of medico-legal documentation at RCT could prove an important source of information and identification of victims/witnesses for the SAIS.

International legal proceedings: International Criminal Tribunals such as the International Criminal Court (ICC) and the Tribunals established in former-Yugoslavia (ICTY) and Rwanda (ICTR) as well as International Human Rights Courts such as the Inter-American Court for Human Rights (IACHR) and the European Court for Human Rights (ECHR) are likely outlets for medico-legal documentation²¹. As a rule of thumb, domestic channels for persecuting perpetrators should be exhausted as the international options are reserved for those cases that cannot or will not be pursued nationally. Also, it is generally more complicated taking a case through the international system. Neither RCT nor its partners have been involved in this type of activity, with the exception of ODHAG in Guatemala who has provided medico-legal documentation to one case at the IACHR. Medico-legal documentation has, however, been presented as evidence in several cases at the international level²².

Asylum cases: Medico-legal documentation can be instrumental in investigating asylum cases, where the asylum seeker alleges torture as a reason for being granted asylum. Previous subjection to torture does indicate that the person has been persecuted by the authorities and thus faces an increased risk of torture upon return if the regime has not changed. Asylum cases represent special problems for conducting medico-legal investigations, since there is often suspicion that the asylum seeker has exaggerated or invented the allegations of torture with the aim of obtaining asylum. RCT is not ordinarily involved in documenting asylum cases. This is generally undertaken by Amnesty Medical Group, Danish Section, or, if initiated by the Danish Immigration Services, the Forensic Departments at the Universities. RCT does, however, offer advice and expertise if requested to do so.

Research: The information collected for documentation can – especially if it is systematically and meticulously registered – be used for various research purposes. A database could, for instance, be used to identify individuals or groups for research projects, i.e. to identify clients who have been subjected to the same kind of torture or experience similar sequelae. But such a database could also be used for research on its own. One possibility is to conduct quantitative analysis on torture methods in various regions. It could also be used to study the effect of medico-legal documentation on the prevention of torture. BRCT in Bangladesh has compiled medico-legal documentation and information about the rehabilitation process for almost two years now and is considering how the data can be used for research. The CPTRT has studied police conduct and torture patterns through medico-legal documentation.

Lobbyism: Lobbying is another area where medico-legal documentation can be useful to substantiate communications with authorities and others who have the ability to change the situation. The process of persuading authorities to change behavior is facilitated if they can be presented with documentation that the problem is indeed real and severe. In a Danish context, medico-legal documentation could be presented at hearings in

²¹ Giffard & Rodley (2002): 19-45. A thorough discussion of the mandate, appropriateness and procedures of each type of international mechanism can be found in: Giffard, Camille (2000): *The Torture Reporting Handbook*, Essex University.

²² Giffard & Rodley (2002): 19-45.

Parliamentary Committees as a way of supporting the arguments presented. Internationally, ODHAG has, as previously mentioned, used medico-legal documentation in a shadow report to the UN Committee against Torture (CAT) as well as in their nationally oriented lobbying activities. Also the AHRC and CPTRT are skilled in using this type of information for international and national lobbying. The CPTRT even succeeded in establishing a dialogue with the authorities, which enabled them to gain access to prisons on an almost regular basis. Medico-legal documentation can also be applied in “urgent action” appeals such as those of the International Rehabilitation Council for Torture Victims (IRCT), where focus is on persuading authorities to intervene on behalf of an individual judged to be in imminent danger.

Advocacy: Advocacy efforts can also be strengthened by medico-legal documentation. In media strategies, focus is typically on individual case stories, but statistics on, for instance, the prevalence of different torture methods or on where the torture took place could be relevant for this kind of activity. Amnesty International typically publishes individual cases with focus on the narrative. This has both an advocacy aim and a legal aim. At the BRCT, the Asian Human Rights Commission (AHRC), and CPTRT the journalistic approach is part of the preventive and awareness-raising work in the society.

Implementing the Istanbul Protocol at RCT

As a central element in implementing the Istanbul Protocol, RCT conducted a pilot study involving medical documentation on five torture victims in the fall of 2005²³. The aim of the pilot study was to assess how the procedure for medico-legal documentation described in the Istanbul Protocol fits into the everyday life and needs of the RCT and its clients. Factors considered included an assessment of the required time and resources as well as of client and staff perceptions towards the idea. Moreover, the considerations about data registering and processing played an important role since the strategy adopted for this part of the implementation process affects the resources required as well as the later use of data.

The Development of an RCT Medical Documentation Procedure

The review of different organizational experiences and literature on the subject discussed in section 2 served as important input in tailoring the Istanbul Protocol to fit the needs and possibilities at RCT. The first draft contained all information listed in the Istanbul Protocol as well as an expansion on the legal aspects. The later versions, which were eventually tested on the five clients, were somewhat condensed and the categories without relevance for the RCT context were taken out. The format can be found in Annex I.

Medically

The medical and psychological part of the examination corresponds largely to that of the rehabilitation. Only differences were explored into detail since the RCT staff already

²³ Lise Worm has long time experience in working with torture victims from RCT and the Amnesty International Medical Group, Danish Section.

performs a thorough examination of each client. In depth descriptions on how to examine torture victims can be found in the Istanbul Protocol and in: "Medical Documentation of Torture" from 2002 edited by Peel and Iacopino.

One of the main differences between the medical documentation and the rehabilitative examination is the need to record injuries and traces of injuries even if they cannot be treated. Scars, for instance, can be highly indicative of torture and should always be recorded, preferably photographed, when performing medical documentation. Scars are, however, largely irrelevant for the rehabilitative process, since they are already healed and only rarely affect the present health status of the victim. Documenting thus requires the doctor to "read" the signs of torture and record them accordingly even if they are without significance to the current treatment.

Also specific of medical documentation is the requirement that the doctor must interpret how the physical and psychological findings correspond with the account of torture and abuse. This requirement places the doctor in a new role, where the patient-doctor relationship is no longer purely treatment-oriented, but one of judging the credibility of the victim. This role-change was however not considered difficult by the RCT physician performing the documentation, since there is hardly any doubt whether the accounts given by RCT's clients are true. The clients treated at RCT have already obtained asylum or a permanent residence permit and has no inclination to put forward false allegations in terms of obtaining asylum. Moreover, the rehabilitative process is so thorough and the RCT personnel so experienced in dealing with torture victims that false statements would most likely be discovered along the way. However, the situation might be different if RCT became involved in asylum cases or in prison visiting activities.

Legally

The RCT staff is not used to collecting information for legal purposes and it was thus particularly this aspect of documentation that required a review of the literature and existing practices²⁴. Looking into what type of information was required and how detailed it should be was needed. Was it, for example, enough that the name of the prison and the prison cell number was recorded or did the physician have to record the client's description of the cell, the size and the daily regimen? The literature generally recommends that as much detail as possible is recorded, but this is difficult due to time restraints.

Since the implementation of medico-legal documentation has generally been directed at finding ways of assisting the relevant authority in investigating crimes of torture, the Special International Crimes Office (SAIS) was asked to prepare a list of information that would be relevant in their investigations:

- A detailed description of both physical and psychological injuries
- Why was the victim arrested or detained?
- Was a crime or a political activity involved? Description of the crime/political activity/context.
- Was the victim member of any political organization and was the membership of the organization the reason for arrest/detainment?
- Who undertook the arrest? Police, para-military, military, others

²⁴ Inspiration was found in Giffard (2000).

- Date for the arrest/detainment.
- The place of detention: country, city, name of prison, placement within the prison
- Where did the abuse/torture take place?
- A detailed description of the abuse/torture
- Description of any tools used in the abuse/torture and how they were used
- The name of/description of the person(s) responsible for the abuse
- The number of people present during abuse/torture. Names/descriptions of both active and passive people present
- Names of witnesses (i.e. fellow inmates) who will be able to corroborate the statement
- An indication of whether or not any witnesses or the alleged perpetrator resides in Denmark. If the victim has met either: their names, and time/place for the meeting
- SAIS would also like RCT to inform the victim about SAIS and the possibility of persecuting perpetrators residing in Denmark
- An indication of whether or not the client would permit SAIS to read his/her journal/file.

The information sought by SAIS corresponds largely to the information listed in the Istanbul Protocol, except for the last three bullets that concern the specific Danish context.

The Results of the RCT Pilot Study

Four out of five clients were positive towards participating in the Pilot Study and expressed comfort in being able to participate in the fight against impunity. One client, however, was concerned about his anonymity but wanted to participate once this was guaranteed.

The documentation-component was added late in the rehabilitation process, i.e. after 7-9 months of rehabilitation. This approach was chosen since much of the information would already be recorded through the rehabilitation process and a trustful relationship between the doctor and the client would by then be established. From a legal point of view; however, it would be worth considering if some of the basic, but important, information such as name and address of prison could be obtained earlier and thus be accessible for SAIS to use at an earlier stage²⁵. This would also prevent the victim forgetting important information.

The modified RCT version of the Istanbul Protocol (Annex I) follows the format listed in the back of the Istanbul Protocol, but some categories are left out, while a few extra have been added. Throughout the testing of the guidelines, it became clear that a large part of the information has been obtained in the rehabilitative process and could be found by reading through the files. The information was, however, not registered systematically. This meant, for instance, that only some journals contained information

²⁵ Comment from Ole Espersen.

about where the torture took place. Moreover, each and every journal had to be meticulously analyzed in order to extract the sought after information.

The information in the RCT format can generally be categorized according to:

- Information already recorded in the text of the patient's journal
- Information already recorded systematically in the patient's journal, i.e. in predefined categories
- Information recorded through the existing monitoring and evaluation system
- New information

Despite variation in the type and detail of information gathered, most of the information in the RCT version of the Istanbul Protocol falls into the first three categories. However, it is not gathered and stored in a way that makes it accessible for medico-legal purposes. The information that tends to be missing from the files is:

- The physician's qualifications
- The date of the arrest
- The arresting authority
- Identification of the perpetrator(s)
- The place(s) where the torture took place
- Identification of any physician present during the torture incidence or consulted in connection with it
- Identification of any witnesses
- Photos
- Contact to authorities (i.e. complaints) before/during/after abuse
- Conclusions: Consistency between findings and torture story

The first bullet – the physician's qualifications – will not have to be included in the everyday work of the RCT physician, but it should be noted who performed the documentation. The remaining questions are all central but the level of detail can be varied. The question about identification of perpetrators, for example, can be limited to the unit of the police and their rank, but it can also include a detailed description of their looks, dialect, behavior etc. Interviewing the victim about the remaining information and filling out the format took about ½-1 hour extra per client.

The Pilot Study pointed out three important conclusions for the implementation of the Istanbul Protocol in an RCT-context:

- A large part of the information in the Istanbul Protocol is already recorded in the rehabilitation process
- The information is not easily accessible in the current system
- Obtaining the additional information will take ½-1 hours extra per client depending on the level of detail.

Thus, there are important *synergies* between collecting data for the rehabilitation process and for medico-legal documentation. A large part of the implementation of the Istanbul

Protocol thus consists of finding a way of systematizing the data already collected in connection with the rehabilitative process.

Data Collection and Storing

The pilot study demonstrated the need for a database system for registering medico-legal documentation. For the synergies in data collection between documentation and rehabilitation to be realized, it is however necessary to create a database where *all* data - monitoring and evaluation, client journals, and documentation – can be registered simultaneously, where information for one purpose can be used for other purposes, and where cross-referencing of data is possible. The ultimate vision is one central system with the ability to feed the various purposes of treatment and rehabilitation, national and international legal proceedings, research, lobbying, and advocacy activities.

The question thus arises: How can information gathering for the Istanbul Protocol be combined with information gathering for other purposes such as monitoring, evaluation efforts, and the client journal? One possibility is a central data registering system, where data is recorded by the rehabilitation team throughout the rehabilitative process, thus obtaining most of the information required for the Istanbul Protocol in connection with other purposes, leaving only ½-1 hour's interview with the doctor in the end in order to fill out the blanks. This does however present certain problems for the validity of the data, since it significantly diminishes if many people are involved in the data entry process. In order to deal with this problem, the information and documentation could be noted separately by the rehabilitation team, and then entered into the system by a specialized RCT employee. The exact set-up of the data registering system will have to be worked out under consideration of the amount of medico-legal documentation collected at RCT, the existing or anticipated systems of monitoring and evaluation, and the resources available for both constructing and maintaining the database. It is, however, extremely important that the implementation of the Istanbul Protocol is incorporated into the rehabilitation process and monitoring and evaluation system in order to realize the synergies.

Issues of Anonymity

A dilemma in implementing medico-legal documentation is safeguarding the anonymity of the patient. One of the most basic principles in the doctor-patient relationship is confidentiality, and the patients have the final say in how information about his/her case is used, or even if it should be used at all. The client concerned with maintaining his anonymity in the RCT pilot study is fully entitled to refuse documentation. The results of medico-legal documentation at RCT can thus not be shared with the SAIS or other institutions unless it is with the explicit permission of the client. This presents certain problems, since safeguarding anonymity requires more than just concealing the name of the client²⁶.

²⁶ The Rehabilitation Department of RCT has a reference system whereby clients are registered under numbers for the monitoring and evaluation systems.

When constructing a central database, it will be necessary to consider how the identity and privacy of the individual torture victim can be safeguarded while still allowing for the identification of clients. Moreover, it seems obvious that RCT will have to administer the database and conduct searches on behalf of external actors interested, then contact the victim or witness and obtain explicit permission to pass the information on to the prosecutor or whichever institution in question. Only then can the prosecutor begin to communicate with the client. Another possibility is to include a section at the end of the format, where the client can authorize other departments of RCT and/or external actors to access the information. Proceedings on behalf of the client or other use of the information would, however, still require explicit permission of the client.

Is it worthwhile?

The quality and thus the use of the medico-legal data depend heavily on the effort put into gathering it: important data may be overlooked and the quality of the data invariably diminishes if the process is rushed and not prioritized by staff. For legal purposes, a screening system may be enough to identify possible victims/witnesses but even then valuable information risks being overlooked or oversimplified by being rushed into pre-defined categories. For research purposes, the quality of the data and the data gathering process is even more defining for the result since both validity and reliability is at stake and since the amount of data collected and the level of detail more or less defines the research scope possible.

On the other hand, collecting detailed data of a high quality *is* a time-consuming and therefore costly task. In the field of torture rehabilitation and prevention where resources tend to be scarce, choosing to perform high quality medico-legal documentation thus implies spending less time and resources on other activities. The aim of documenting must therefore be carefully and continuously thought through in order to ensure that resources spent are worthwhile. Before commencing on gathering medico-legal documentation on a large scale, an important question must be answered:

Do the anticipated results and the probability of reaching them justify the resources spent?

The lack of research on the effect of medico-legal documentation in preventing torture makes it difficult to answer this question. Measuring the results from medico-legal documentation, however, is not an easy task. Performing medico-legal documentation is a relatively new task with ample space for continued research in both documentation methods and their reliability. The effect of using medico-legal documentation in the prevention of torture, however, is even more under-researched.

A connection between preventing torture and applying high-quality medico-legal documentation in legal proceedings, advocacy and lobbying activities and asylum cases is widely presumed by both practitioners and scholars in the field, but hardly evidence-based in any scientific way, with the exception of the notable research by Malcolm Evans and Rod Morgan²⁷. Thus, more research on the effect of applying medico-legal

²⁷ Morgan, Rod & Malcolm Evans (1998, 2001a, 2001b).

documentation for the various purposes listed in this report is urgently called for. Especially since medico-legal documentation is becoming more and more accepted as means by which the anti-torture movement can help prevent and alleviate torture worldwide.

Summing up

In the last decade, the fight against impunity for perpetrators of torture has been significantly strengthened, one very important achievement being the development of the Istanbul Protocol on medical documentation in 1999. An additional achievement has been the establishment of international and national institutions responsible for the legal persecution of perpetrators of crimes such as genocide, crimes against humanity, war crimes, and other serious crimes, including torture. On this background, and with a general desire of contributing to the fight against impunity for perpetrators of torture, the RCT began an inquiry into the possibilities of implementing the Istanbul Protocol at RCT in the fall of 2005.

A modified version of the Guidelines in the Istanbul Protocol was developed on the basis of the review of literature and current practices and in consideration of the RCT context. The modified Guidelines were tested on five RCT clients. The aim was twofold: 1) to assess the client's attitude towards the idea of adding a documentation component to the rehabilitation process, and: 2) to assess the practical circumstances of implementing the Istanbul Protocol in the rehabilitative process. Results so far have shown that all five clients were positive towards the project and found comfort in being able to contribute to the fight against impunity. One client was however somewhat reluctant due to concerns about anonymity. Another important result of the Pilot Study was the realization that a large part of the information required for the medico-legal documentation was already obtained through the rehabilitation process, but that it was not accessible due to lack of systematization and a data registering system. The study thus revealed that there are important *synergies* between the data collection for rehabilitation and documentation, and that a joint database system is necessary to realize these synergies.

Before beginning a large scale implementation process; however, it is necessary to consider the role change of the health care personnel – adding an investigative perspective to the treatment oriented focus. Also, it is important to consider how the anonymity of the client can be safeguarded and whether or not documentation is worthwhile. To answer the last question, more research is needed on the effect of medico-legal documentation on the prevention of torture. If the solutions to these dilemmas can be found, the synergies between rehabilitation and documentation can be realized, allowing the rehabilitation activities of the RCT to be used for various preventive purposes as well.

Literature

Aeschlimann, Alain (2005): "Protection of detainees: ICRC action behind bars". In: *International Review of the Red Cross*, Vol. 87, no. 857, pp. 83-122. Geneva, March 2005.

Allden, Katherine (2002): "The Psychological Consequences of Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 117-133. GMM, London & San Francisco.

APT (2002): *Joint NGO Commentary on the Proposed Optional Protocol to the UN Convention against Torture*.

[http://www.apr.ch/un/opcat/Joint%20NGO%20Commentary%20\(Eng\).pdf](http://www.apr.ch/un/opcat/Joint%20NGO%20Commentary%20(Eng).pdf)

Bernath, Barbara (1999): *The CPT: History, Mandate and Composition, Handbook on The Prevention of Torture in Europe*, Brochure no. 3. Association for the Prevention of Torture (APT), Geneva.

BRCT (2005): *Policy Paper 2005-2009*. Bangladeshi Rehabilitation Centre for Trauma Victims.

CAT (2002): *Conclusions and recommendations of the Committee against Torture: Denmark*. 28/05/2002, CAT/C/CR/28/1. (Concluding Observations/Comments).

[http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/CAT.C.CR.28.1.En?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CAT.C.CR.28.1.En?Opendocument)

Christen, Darcy (1993): Visits to detainees by the International Committee of the Red Cross (ICRC). *A possible deterrent to torture*. Presented at the Workshop on "The Crime of Torture; Causes, Consequences, Cures" at the 11th International Congress on Criminology, Budapest, 22-27 August 1993.

CPT (2002): *Report to the Government of Denmark on the visit to Denmark*, carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

http://www.cpt.coe.int/documents/dnk/2002-18-inf-eng.htm#_Toc18901590

CPT (2002): *The CPT Standards – "Substantive" sections of the CPT's General Reports*. European Committee for the prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) under the Council of Europe (CoE), CPT/Inf/E (2002).

CPTRT (2004): *Pesquisa*.

<http://www.cptrt.org/pdf/Pesquisa.pdf>

CVICT (2004): *Alternative Report to Second, Third and Fourth periodic (Combined) State Report from Nepal*. Submitted to the UN Committee Against Torture. December 2004.

- Danielsen, Lis & Ole Vedel Rasmussen (2005): *Dermatological Findings after Alleged Torture*. Istanbul Protocol Implementation Project, IRCT 2005.
- Danielsen, Lis (2002): "The Examination and Investigation of Electric Shock Injuries". In Peel & Iacopino: *The Medical Documentation of Torture*, pp. 191-207. GMM, London & San Francisco.
- Daudin, Pascal & Hernan Reyes (1996): "How visits by the ICRC can help prisoners cope with the effect of traumatic stress". In: *International Responses to Traumatic Stress*. Baywood Publishers.
www.icrc.org/web/eng/siteeng0.nsf/html/57MTS
- Draminsky Petersen, Hans & Finn Kjærulf (2005): Mission Report for the Mid-Term Review in Honduras (2005): *The Challenge of Developing Sustainable Organizational Strategies for anti-TOV Action*, p. 13. CPTRT-RCT-DANIDA project 2003-06.
- Espersen, Harhoff & Spiermann (2002): *Folkeret* [Public International Law], 1. udgave, 1. oplag, Christian Ejler's forlag, Copenhagen.
- Evans, Malcolm D. and Rod Morgan (1998): *Preventing torture : a study of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*. Clarendon Press, Oxford
- Forrest, Duncan (2002): "Examination Following Specific Forms of Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 159-171. GMM, London & San Francisco.
- Frey, Barbara (2002): "Documenting a Well-Founded Fear: How Medical Caregivers Can Assist Torture Survivors in the Asylum Process?" In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 45-63. GMM, London & San Francisco.
- Giffard, Camille & Sir Nigel Rodley (2002): "The Approach of International Tribunals to Medical Evidence in Cases Involving Allegation of Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 19-45. GMM, London & San Francisco.
- Giffard, Camille (2000): *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.
- Grünewald, Francois (1995): "From Prevention to rehabilitation: action before, during and after the crisis: the experience of the ICRC in retrospect". In: *International Review of the Red Cross* no. 306, p. 263-281, Geneva 30 June 1995.
- Hinshelwood, Gill (2002): "The Sexual Abuse of Females". In Peel & Iacopino: *The Medical Documentation of Torture*, pp. 171-179. GMM, London & San Francisco.
- Iacopino, Vincent (2002): "History Taking". In Peel & Iacopino: *The Medical Documentation of Torture*, pp. 101-177. GMM, London & San Francisco.

ICRC (2002a): *Deprived of Freedom*. International Committee of the Red Cross, Central Tracing Agency and Protection Division, Geneva 2002.

ICRC (2002b): *Face to face with torture*. International Committee of the Red Cross, Geneva 11-06-2002.

www.icrc.org/web/eng/siteeng0.nsf/html/5B7ECN

ICRC (2005): *Protection and central tracing agency: extract from ICRC Annual Report 2004*. International Committee of the Red Cross, Central Tracing Agency and Protection Division, Geneva 17-06-2005.

www.icrc.org/web/eng/siteeng0.nsf/htmlall/6D7KAW?OpenDocument&style

IRCT (2004a): *Mission Report: Training Seminar, Sri Lanka*. December 2-6 2004

IRCT (2004b): *Mission Report: Training Seminar, Morocco*. November 29 – December 2, 2004.

IRCT (2005): “Medical Physical Examination of Alleged Torture Victims”. *Istanbul Protocol Implementation Project*, IRCT 2005.

Kessing, Peter Vedel (2003): “Ny Tillægsprotokol the FN’s Torturkonvention – Dansk ratifikation og implementering” [“The New Optional Protocol to the UN Convention against Torture– Danish Ratification and Implementation”]. In: *EU-ret & Menneskeret*, 10. årgang 2003 [EU Law and Human Rights, volume 10 2003], pp. 153-174.

Kirschner, Robert & Michael Peel (2002): "Physical Examination for Late Signs of Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 149-159. GMM, London & San Francisco.

Morgan, Rod & Malcolm Evans (2001a): *CPT Standards regarding prisoners, Handbook on The Prevention of Torture in Europe*, Brochure no. 6. Association for the Prevention of Torture (APT), Geneva

Morgan, Rod and Malcolm Evans (2001b): *Combating torture in Europe: the work and standards of the European Committee for the Prevention of Torture (CPT)*. Council of Europe Publishing, Strasbourg

NMA (2004): *Doctors working in prisons: human rights and ethical dilemmas*. A web-based course for health care personnel working in prison. Norwegian Medical Association 2004, <http://lupin-nma.net/>

ODHAG (2005): *Consultoría para la ratificación del OPCAT en Guatemala*. Recopilación de Informes I Y II, ODHAG 2005.

Ozkalipci, Önder (2002): "Physical Examination Following Allegation of Recent Torture", In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 133-149. GMM, London & San Francisco.

Peel, Michael (2002): "Male Sexual Abuse in Detention", In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 179-191. GMM, London & San Francisco.

Physicians for Human Rights (2001): *Examining Asylum Seekers. A Health Professional's Guide to Medical and Psychological Evaluations of Torture*. Physicians for Human Rights, Boston, MA, USA, www.phrusa.org

RCT (2005): *OPCAT Conference Report: Preventing Torture in Places of Detention through Systems of Regular Visits to Places of Detention – Monitoring, Documentation and Research*. International Department, RCT

Reyes, Hernan (1995); "Torture and it's Consequences". In: *Torture*, vol. 5 no. 4, p. 72-76, Copenhagen 1995.

Reyes, Hernan (1997): "Visits to prisoners by the ICRC". In: *Torture*, Supplementum no. 1, p. 28-30, Copenhagen 1997.

Reyes, Hernan (2002): "Visits to Prisoners and Documentation of Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 77-101. GMM, London & San Francisco.

SAIS (2004): *Beretning fra Statsadvokaten for Særlige Internationale Straffesager 1. juni 2002 – 31. maj 2004* [Report from the Prosecutor for Special International Crimes, June 1, 2002 – May 31, 2004].

http://www.sico.ankl.dk/media/beretning_sais_010602-3105.pdf

SAIS(2005): *Årsberetning 2004* [Annual Report 2004]

http://www.sico.ankl.dk/media/2004_arsberetning.pdf

SAIS (2005b): *Det har vi gjort* [What We Have Done].

<http://www.sico.ankl.dk/page7.aspx>

Scanche Olsen, Jone (2004): *Travel Report on BRCT*. RCT 2004

Sharma, Bhogendra and Mark Van Ommeren (1998): "Preventing Torture and Rehabilitating Survivors in Nepal". In: *Transcultural Psychiatry*. March 1998.

Sidoti, Chris & Dr Fadia Daibes-Murad (2004): *Mapping of Palestinian, Israeli and international human rights, good governance and public participation sector non-government organizations relating to the occupied Palestinian Territories*. Danida.

Somerville, Ann, Hernan Reyes & Michael Peel (2002): "Doctors and Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp. 63-77. GMM, London & San Francisco.

Staiff, Marina (2000a): "Visits to detained torture victims by the ICRC (I): The psychological impact of visits and interviews with detained torture victims". In: *Torture*, vol. 10, no. 1, pp. 4-7, Copenhagen 2000.

Staiff, Marina (2000b): "Visits to detained torture victims by the ICRC (II): The psychological impact of visits and interviews with detained torture victims". In: *Torture*, vol. 10, no. 2, pp 41-44, Copenhagen 2000.

Vedel Rasmussen, Ole (1990): "Medical Aspects of Torture". In: *Danish Medical Bulletin*, vol. 37, suppl. No 1, January 1990.

Welsh, James (2002): "The Problem of Torture". In: Peel & Iacopino: *The Medical Documentation of Torture*, pp 1-19. GMM, London & San Francisco.

Wendt, Erik (2002): *Community Based Participation for prevention of torture and rehabilitation of victims of torture and organized violence in Bangladesh*. Interim Phase 1 May – 31 December, RCT, p. 13.

Worm, Lise (2004): "Dokumentation af tortur – metoder og begreber"
[Documentation of Torture – Methods and Concepts]. In: *Psyke & Logos* [Psyche & Logos], no. 1, 2005, issue 25.

Websites:

CPTRT: <http://www.cptrt.org/index.htm>
CPT: <http://www.cpt.coe.int/en/>
ICRC: <http://www.icrc.org/eng>
CAT: <http://www.ohchr.org/english/bodies/cat/>
ODHAG: <http://www.odhag.org.gt/>
AHRC: <http://www.ahrchk.net/index.php>
CVICT: <http://www.cvict.org.np/>
SAIS: <http://www.cvict.org.np/>

ANNEX I: The RCT Version of the Istanbul Protocol

1. General information

- a. Date and place of examination
- b. File number
- c. The name of the client
- d. Social security number
- e. Age
- f. Sex
- g. Country of birth
- h. Current address
- i. Name of the interviewer
- j. Name of the interpreter and the language of interpretation

2. The physician's qualifications

- a. Résumé, including specialties, clinical experience, scientific publications and special education.

3. Background information

- a. Marital status
 - i. Married
 - ii. Unmarried
 - iii. Divorced
 - iv. Widower
- b. Number of children
 - i. In Denmark
 - ii. In the country of origin
 - iii. Deceased
- c. Education
- d. Occupation before the torture incidence
- e. Present occupation
- f. Pre-torture medical history, including physical and psychological health status prior to the torture incident and any hospitalization
- g. Previous medical examinations/reports in relation to the torture incidence
- h. Social status before the torture incidence
- i. Political activity and/or affiliation

4. Description of torture and ill-treatment

- a. Arrest(s)
 - i. Date and time
 - ii. Arresting authority, including a description of the number of persons, names, titles, description of clothing/uniform, weapons, vehicles, license plates, and witnesses.

- a. Police
 - b. Military
 - c. Others
 - iii. Reason for arrest (s)
 - a. Political activities
 - b. Family relations
 - c. Accusations of crime
 - d. No particular reason
 - e. Other
 - b. Detention centre(s)
 - a. Name (s)
 - b. Address(es)
 - c. Time spent in the detention centre(s)
 - d. Circumstances
 - e. Names of witnesses (fellow prisoners, staff or others)
 - c. Prison(s)
 - a. Name(s)
 - b. Address(es)
 - c. Time spent in the prison(s)
 - d. Circumstances
 - e. Names of witnesses (fellow prisoners, staff or others)
 - d. The place where the torture took place
 - i. At the home of the client
 - ii. In connection with the arrest
 - iii. On the way to detention/prison
 - iv. In the detention centre/police station
 - v. In prison
 - vi. Other
 - e. Description of the place, where torture occurred
 - i. Cell/room number, address, description of vehicle, etc.
 - ii. Number of people present, active and passive
 - iii. Names, means of identification
 - iv. Name and identification of any doctors present and a description of his/her role
 - f. Methods of torture
 - i. Physical (check-list)
 - ii. Psychological (check-list)
 - iii. Sexual (check-list)
 - g. Any medical treatment before, during and after the torture incidence
 - h. Total time in detention
- 5. Patient's description of symptoms immediately after the torture incidence**
- a. Physical (check-list)
 - b. Psychological (check-list)
 - i. Diagnostic tests used

- 6. Patient's description of current symptoms**
 - a. Physical (check-list)
 - b. Psychological (check-list)
- 7. Physical examination**
 - a. Physical (check-list)
 - b. Psychological (check-list)
- 8. Psychological examination**
 - a. Physical (check-list)
 - b. Psychological (check-list)
- 9. Medication, including any substance abuse**
- 10. Photos**
- 11. Supplementary examination (x-ray, scanning, blood samples etc.)**
- 12. Contact to authorities/complaints**
 - a. Attempts of family/friends/neighbors to contact the authorities
 - b. Presentation before a judge/legal assistance
 - c. Legal proceedings
 - d. Official investigations of the incidence
- 13. Conclusions**
 - a. Consistency between the patient's description of torture, the patient's symptoms and the findings of the examination
 - i. High degree of consistency
 - ii. Consistency
 - iii. Partial consistency
 - iv. No consistency
 - b. Remarks
- 14. Recommendations**
- 15. The physician's signature**
- 16. If the information has been passed on to other institutions/people**
- 17. Annexes**
 - a. Anatomical drawings
 - b. Photos
 - c. Diagnostic test results
 - d. Etc.