The following text is an important part of the Istanbul protocol. It gives an outline and documentation form sample, serving as a general frame that might have to be adapted to the evaluation setting and forensic requirements in a specific country. The IP gives examples in some categories that can guide users in such regional or local adaptation. The form should be used together with the other appendices such as the anatomical chart to locate injuries.

You can further make use of the ARTIP tools such as rulers, time chart and photo documentation sheet. A case from the ARTIP case practice examples can be used to simulate an investigation, such as in preparation of a training, “mock” trial. The exercise can be collaborative between legal and medical professionals in interdisciplinary training settings.

ANNEX IV

Guidelines for the medical evaluation of torture and ill-treatment

The following guidelines are based on the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. These guidelines are not intended to be a fixed prescription, but should be applied taking into account the purpose of the evaluation and after an assessment of available resources. Evaluation of physical and psychological evidence of torture and ill-treatment may be conducted by one or more clinicians, depending on their qualifications.

I. Case information

Date of exam: . . . . . Exam requested by (name/position): . . . . . .

Case or report No.: . . . . . Duration of evaluation: . . . . . hours, ... minutes

Subject's given name: . . . . . Birth date: . . . . . Birth place: . . . . . .

Subject's family name: . . . . . Gender: male/female: . . . . . .

Reason for exam: . . . . . Subject's ID No.: . . . . . .

Clinician's name: . . . . . Interpreter (yes/no), name: . . . . . .

Informed consent: yes/no If no informed consent, why?: . . . . . .

Subject accompanied by (name/position): . . . . . .

Persons present during exam (name/position): . . . . . .

Subject restrained during exam: yes/no; If "yes", how/why? . . . . . .

Medical report transferred to (name/position/ID No.): . . . . . .

Transfer date: . . . . . Transfer time: . . . . . .

Medical evaluation/investigation conducted without restriction (for subjects in custody): yes/no

Provide details of any restrictions: . . . . . .

II. **Clinician's qualifications** (for judicial testimony)

Medical education and clinical training

Psychological/psychiatric training

Experience in documenting evidence of torture and ill-treatment

Regional human rights expertise relevant to the investigation

Relevant publications, presentations and training courses

Curriculum vitae.

III. Statement regarding veracity of testimony (for judicial testimony)

For example: "I personally know the facts stated below, except those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background information

General information (age, occupation, education, family

composition, etc.) Past medical history

Review of prior medical evaluations of torture and ill-treatment

Psychosocial history pre-arrest.

V. Allegations of torture and ill-treatment

1. Summary of detention and abuse
2. Circumstances of arrest and detention
3. Initial and subsequent places of detention (chronology, transportation and detention conditions)
4. Narrative account of ill-treatment or torture (in each place of detention)
5. Review of torture methods.

VI. Physical symptoms and disabilities

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute symptoms and disabilities
2. Chronic symptoms and disabilities.

VII. Physical examination

1. General appearance
2. Skin
3. Face and head
4. Eyes, ears, nose and throat
5. Oral cavity and teeth
6. Chest and abdomen (including vital signs)
7. Genito-urinary system
8. Musculoskeletal system
9. Central and peripheral nervous system.

VIII. Psychological history/examination

1. Methods of assessment
2. Current psychological complaints
3. Post-torture history
4. Pre-torture history
5. Past psychological/psychiatric history
6. Substance use and abuse history
7. Mental status examination
8. Assessment of social functioning
9. Psychological testing: (see chapter VI, sect. C.1, for indications and limitations)
10. Neuropsychological testing (see chapter VI, sect. C.4, for indications and limitations).

IX. Photographs

X. Diagnostic test results (see annex II for indications and limitations)

XI. Consultations

XII. Interpretation of findings

1. Physical evidence

   A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabil- ities with allegations of abuse.

   B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)

   C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.

2. Psychological evidence

   A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.

   B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.

   C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual?

   D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.

E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

XIII. Conclusions and recommendations

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.
2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and care for the individual.

XIV. Statement of truthfulness (for judicial testimony)

For example: "I declare under penalty of perjury, pursuant to the laws of ..... (country), that the foregoing is true and correct and that this affidavit was executed on ..... (date) at ..... (city), ... (State or province)."

XV. Statement of restrictions on the medical evaluation/investigation (for subjects in custody)

For example: "The undersigned clinicians personally certify that they were allowed to work freely and independ- ently and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities"; or "The undersigned clinician(s) had to carry out his/her/ their evaluation with the following restrictions: ....."

XVI. Clinician's signature, date, place

XVII. Relevant annexes

A copy of the clinician's curriculum vitae, anatomical drawings for identification of torture and ill-treatment, photographs, consultations and diagnostic test results, among others