

# Documentation of torture victims, assessment of the Start Procedure for Medico-Legal Documentation

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## Abstract

A Pilot Study was performed at the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen in order to explore the possibilities for adding a medico-legal documentation component to the rehabilitation of torture victims already taking place. It describes the process and results on implementing medico-legal documentation in a rehabilitative setting.

A modified version of the Guidelines in the Istanbul Protocol was developed on the basis of the review of literature and current practices described in "Documentation of torture victims. implementation of medico-legal protocols".<sup>1</sup> The modified guidelines were tested on five 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 everyday life of a rehabilitation centre. Results show that all five clients were positive towards the project and found comfort in being able to contribute to the fight against impunity. Also, the Pilot Study demonstrated that a large part of the medico-legal documentation was already obtained in the rehabilitation process. It was however not accessible due to lack of systematization and a data registering system. There are thus important *synergies* in collecting data for rehabilitation and documentation but a joint database system is necessary to realize these synergies.

*Key words:* torture, torture prevention, medico-legal documentation, impunity, legal, Istanbul Protocol

## Introduction

The first step of the Pilot Study was to develop a tailored version of the Istanbul Protocol, which was adapted to the needs and possibilities at the RCT. The first draft contained all the information listed in the Istanbul Protocol as well as an expansion of the legal aspects. The later versions, which were eventually tested on the five clients, were somewhat condensed and the categories without relevance for the specific context was taken out. The format can be found in Annex I.

### *Medically*

The medical and psychological part of the examination corresponds largely to the data collected in the ordinary rehabilitation process and only differences were explored in detail since the RCT staff already performs a thorough examination of each client. Detailed descriptions of the examination of torture victims can, for example, be found in the Istanbul Protocol.<sup>2</sup>

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 can, for instance,

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be highly indicative of torture and should always be recorded, preferably photographed, when performing medical documentation. Scars are however largely irrelevant for the rehabilitation process, since they are already healed and 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 to medical documentation is the necessity of rendering an interpretation about 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. 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 at RCT have already obtained asylum or a permanent residence permit and have no inclination to exaggerate claims of torture. 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.

#### *Legally*

The RCT staff is not used to collecting information for legal purposes and it was particularly this aspect of documentation which required a review of the literature and existing practices.<sup>3</sup> There was a need for finding out what type of information was required and how detailed it should be. 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 constraints.

Since the implementation of medico-legal documentation was directed at finding ways of assisting the relevant authority in investigating crimes of torture, a list of pertinent information was prepared by the Special International Crimes Office (SAIS), the relevant Danish authority:

The information sought by SAIS corresponds largely to the information listed in the Istanbul Protocol, with the exception of the three bullets specific to the Danish context.

- An indication of whether or not any witnesses or the alleged perpetrator resides in Denmark. If the victim has met either, then their names, and time/place for the meeting
- SAIS would also ask 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 results of the Pilot Study**

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

The documentation component was added late in the rehabilitation process, approximately after seven to nine months of rehabilitation. This approach was chosen because much of the information would already be recorded in the rehabilitation process and because after a trusting rela-

tionship between the doctor and the client would need to be established. From a legal point of view, it could be worth considering if some of the basic, but important, information such as name and address of the prison could be obtained earlier and thus be accessible for SAIS at an earlier stage.<sup>4</sup> This would also prevent the victim from forgetting information.

The modified RCT version of the Istanbul Protocol (Annex I) generally follows the format listed in the Istanbul Protocol. 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. For instance only some journals contained information about where the torture took place. Moreover, every journal had to be meticulously analyzed in order to extract the 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 pre-defined 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. It is, however, not gathered and stored in a way where it is 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 physician(s) present during the torture incident or consulted in connection with it
- Identification of witnesses
- Photographs
- Contact with authorities (i.e. complaints) before/during/after abuse
- Conclusions: Consistency between findings and torture story

The first bullet, the physician's qualifications, would not be included in the physician's everyday work, 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 can, for example, be limited to the unit of the police and their rank, but can also include a detailed description of their appearance, dialect, behaviour etc. Interviewing the victim about the remaining information and filling out the format took about a half hour to one hour extra per client.

All in all, the Pilot Study pointed to 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 a half hour to one hour extra per client depending on the level of detail

There are thus 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 rehabilitation 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 necessary to create database where *all* data – monitoring and evaluation, client journals and documentation – can be registered simultaneously, and 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 a half hour to one hour's interview with the doctor in the end in order to fill out the blanks. However, this does 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 em-

ployee. The exact set-up of the data-registering system will have to be determined under consideration of the amount of medico-legal documentation collected at RCT (or whoever does data collecting), the existing or anticipated systems of monitoring and evaluation, and the resources available for both constructing and maintaining the database. It is, however, important that the implementation 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. The client concerned with maintaining his anonymity in the 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 client.<sup>5</sup>

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, 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 relevant institution. Only then can the prosecutor begin to communicate with the client. Another possibility is to include a section at the end of the documentation 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 predefined 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 are at stake and since the amount of data collected and the level of detail more or less defines the research scope.

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. 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 is, however, not an easy task. Performing medico-legal documenta-

tion 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 is, however, 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 Morgan.<sup>6-8</sup> More research on the effect of applying medico-legal documentation to the various purposes listed in this report is thus urgently called for. Especially since medico-legal documentation is becoming more and more accepted as a means by which the anti-torture movement can help prevent and alleviate torture worldwide.

### Conclusion

Before implementing medico-legal documentation, it is necessary to consider the role change of the health care personnel – adding an investigative perspective to the treatment oriented focus. It is also 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 regarding the effect of medico-legal documentation on the prevention of torture. If 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.

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## 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. Resumé, 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 incident
- 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 incident
- h. Social status before the torture incident
- 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 incident
- h. Total time in detention

#### **5. Patient's description of symptoms immediately after the torture incident**

- 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. Photographs**

#### **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 incident

#### **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. Photographs
- c. Diagnostic test results
- d. Etc.