Istanbul Protocol 2022 Edition Factsheet

In 1999, The Istanbul Protocol (IP) and its Principles established guidance for States to fulfil their obligation of effective investigation of torture and ill-treatment and to empower civil society to hold States accountable. Since that time, it has been widely recognized by UN & regional human rights bodies and courts and has been increasingly used by State and non-State actors to guide their investigations into torture and ill-treatment.

The 2022 edition of the IP includes updates and clarifications of the content of the original 6 chapters as well as additional guidance in 2 new chapters – Chapters VII and VIII. There were no changes to the IP Principles in Annex I. Annex II, previously on “Diagnostic Tests”, was replaced with “Guidelines for Documenting Torture and Ill-Treatment of Children,” which summarizes children-related information in all chapters. The new edition was developed in coordination with the UN Office of the High Commissioner for Human Rights and included more than 180 contributors from 51 countries.

This Factsheet summarizes significant changes in the 2022 edition of the IP and includes relevant paragraph citations. Since the Factsheet is not comprehensive, IP users should read the 2022 edition thoroughly and be familiar with all updates, clarifications and new IP guidance.

**Chapter I - Relevant International Legal Norms and Standards**

**Updates on Legal Norms and Standards**

The IP 2022 includes additional information on the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, or OPCAT (para. 17-20), relevant provisions in the revised UN Standard Minimum Rules for the Treatment of Prisoners – now known as the “Nelson Mandela Rules”, the revised Minnesota Protocol, and the Bangkok Rules. It also includes additional information on human rights bodies, mechanisms, & Special Procedures and describes relevant mandates and work related to torture & ill-treatment (para. 24-56).

**Additional Recognition of the IP as a legal standard for the effective investigation of torture and ill treatment**

The IP 2022 includes additional statements by the UN Committee against Torture (CAT), the UN Special Rapporteurs on Torture, and the Inter-American Court on Human Rights that recognize and affirm the critical importance of clinical evaluations of torture and ill-treatment in accordance with the IP and its Principles. For example:

* CAT has stated that, “investigations into torture should include a medical examination that complies with the Istanbul Protocol” (para. 15);
* The UN Special Rapporteur on torture Juan Méndez stated that, “The Istanbul Protocol serves as a standard for evaluation of medical evidence, as a reference tool for experts delivering expert opinions, as a benchmark for assessing the effectiveness of the domestic fact-finding and as a means of redress for victims” and that, “[q]uality forensic reports are revolutionizing investigations of torture” (IP Background section);
* Special Rapporteur Nowak has stated that “[a]n independent forensic expert should be part of any credible fact-finding or prevention mechanism” (para. 40);
* The Inter-American Court on Human Rights has recognized the IP as a component of a legal framework to facilitate the effective investigation of torture (para. 67).

**Additional Information and Clarifications on Torture & Ill-Treatment**

Chapter I includes additional information on the prohibition on torture and ill-treatment, namely the jus cogens status and non-derogable nature of the prohibition of & universal jurisdiction for the crime (para. 1) and clarifies that States:

* Are responsible for acts of torture and ill-treatment committed by non-State actors and when officials fail to prevent, investigate & prosecute & punish torture & ill-treatment (para. 4-5).
* And cannot authorize corporal and capital punishments that are prohibited by international law (para. 5).

Furthermore, the Inter-American Court of Human Rights:

* Explicitly rejects limitations on State liability for torture and ill-treatment including statutes of limitations and amnesty (para. 66);
* Prohibits classification or withholding of information about human rights violations (para. 70);
* Presumes State responsibility for the burden of proof of torture and ill-treatment (para. 71);
* Presumes State responsibility for sexual violence as a form of torture committed by non-State actors when the authorities failed to prevent and investigate the crime (para. 76).

Chapter I includes additional jurisprudence on distinguishing torture and ill-treatment on the basis of purpose, intention and severity in international and regional contexts and the importance of recognizing the ongoing evolution of such distinctions (para. 6-8, 63, 82-84, 86).

**Clarification of Definition and Scope of Torture & Ill-Treatment**

During the past 20 years, the definition and scope of torture and ill-treatment has expanded in international and regional human rights jurisprudence to include:

* Extra-custodial use of force (para. 41);
* Gender-based violence such as rape (para. 25, 42, 76, 78, 85, 125, 128-129), female genital mutilation (para. 25, 30), interference with reproductive rights (para.88), virginity testing, forced sterilisation, widow-burning, & human trafficking (para. 41, 152);
* Violence based on sexual orientation & gender identity (para. 50, 152) including forced anal examinations of men (para. 46);
* abusive healthcare practices (para. 41, 152 in Chapter II).

Regional human rights courts have also clarified the definition and scope of torture and ill-treatment to include threats (para. 84), deplorable detention conditions (para. 90) and solitary confinement (para. 100) and noted that incommunicado detention (para. 105) and the failure to conduct effective investigations may lead to torture & ill-treatment (para. 87). It has also made clear that evidence of physical or mental injury is not necessary for a conclusion of torture or ill-treatment (para. 82, 86).

**Additional Jurisprudence on Prevention, Redress, and the Exclusionary Rule**

Chapter I includes additional jurisprudence on:

* Preventive measures and mechanisms such as monitoring visits by the UN Subcommittee on Prevention of Torture (SPT) & National Preventive Mechanisms (NPM)s and many relevant statements by the UN Special Rapporteur on Torture (para. 17, 41);
* Redress for victims including restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition (para. 9k);
* The exclusionary rule, whereby statements extracted under torture & ill-treatment are prohibited as evidence in any proceedings (para. 16, 41, 88).

**Relevant Refugee Law**

Chapter I includes additional information on non-refoulment in refugee law, namely that asylum applicants should not be returned to the country from which they fled, as stated in the Refugee Convention or any country where there is a risk of persecution or torture, as stated by CAT (para. 115).

UNHCR has stated that States have a duty to make impartial and independent case-by-case assessments including the risk of torture. (116). And according to the UN Committee on the Rights of the Child, children should not be returned to a country with there is a risk of irreparable harm including female genital mutilation (para. 30).

Chapter I also cites example of refoulment in regional human rights courts (para. 113).

**International Criminal Justice**

Chapter I includes additional information on decisions by international criminal courts and tribunals that affirm:

* The unequivocal prohibition of torture and ill treatment in all armed conflicts (para. 117-118);
* The principle of universal jurisdiction (para. 124);
* That torture and ill-treatment may constitute war crimes (para. 119);
* Acts of torture do not require a purpose or evidence of State acquiescence (para. 125-126);
* Individuals may be held criminally responsible for torture under international humanitarian law (para. 127);
* That rape can be prosecuted as torture and as an act of genocide (para. 128-130).

**Chapter II - Relevant Ethical Codes**

**Relevant Ethics of Legal Professionals**

Updates on relevant ethics of legal professionals include the duty of all legal professionals to conduct themselves independently & professionally, treat people equally without discrimination and respect & promote human rights (para. 133-134).

Judges have a duty to prevent torture and may be responsible for human rights human rights violations if exercising their authority to conceal abuses. As a precaution against possible torture, judges should bring suspects before them as early as possible to check that they are being treated properly (para. 135-137).

Prosecutors have a duty to investigate & prosecute torture and ill treatment and refuse illegal evidence such as that obtained by torture (para. 138-141).

All lawyers must treat their clients’ interests as paramount and maintain confidentiality (para. 142-144).

**Ethical Obligations of Health Professionals**

Chapter II describes ethical obligations articulated in the Nelson Mandela Rules (para. 148), which include:

* Maintaining the same ethical standards in places of detention as those in the community – beneficence, autonomy & confidentiality – and an absolute prohibition on active or passive complicity in acts of torture and ill-treatment (Mandela Rule 32(1));
* Prohibiting any role in disciplinary sanctions or other restrictive measures such as solitary confinement (Mandela Rule 46(1));
* A duty to document and report cases of torture and ill-treatment (Mandela Rule 34).

Similarly, the Bangkok Rules for the treatment of women prisoners (para. 149) establish duties of:

* Providing equal treatment and care for gender-specific physical and mental healthcare needs (Rule 10);
* Documenting signs of torture & ill-treatment (Rule 60);
* Maintaining medical confidentiality (Rules 8 and 11).

Chapter II clarifies that the duty to document torture & ill-treatment extends to a wide range of acts as recognized by the UN Committee against Torture, and the UN Special Rapporteur on Torture including:

* + Abusive practices related to gender discrimination such as virginity testing, anal examinations to “detect homosexuality,” rape, forced marriage, child marriage, honour killing, widow-burning, human trafficking, female genital mutilation, “conversion therapies” to change sexual orientation, non-consensual gender reassignment surgeries, forced or coerced pregnancy testing, forced or coercive sterilization, medical determinations of gender without consent, and unnecessary surgery and treatment on intersex children without their consent (152);
	+ Abuses in healthcare settings such as force-feeding hunger strikers, the denial of pain relief, compulsory detention for medical reasons such as compulsory drug detention and “rehabilitation,” non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement for both long- and short-term application (152).
	+ The WMA (World Medical Association) has also recognized the following acts to constitute torture or ill-treatment: prolonged solitary confinement, forced body searches, force feeding competent individuals such as hunger strikers, forced anal examination to substantiate same sex activity, and female genital mutilation surgery (156).

Since 2006, the WMA has recognized the duty of physicians to document and denounce acts of torture and ill-treatment and provides that a failure to do so constitutes complicity in such abuse. The WMA also recommends support for doctors and national medical associations in reporting torture and ill-treatment and reporting mechanisms and referrals to the UN Special Rapporteur on Torture (para. 155).

**Application of Ethical Principles in Clinical Evaluations of Torture and Ill-Treatment**

Chapter II refers to 4 basic ethical principles (para. 159):

Beneficence – that is, acting in the best interests of one’s patient;

Non-maleficence – or “do no harm”;

Respecting the autonomous decisions of one’s patient, such as informed consent;

Maintaining the confidentiality of information.

It clarifies that:

* Beneficence in children includes ensuring that children are protected from harm, are not exposed to risk of harm, and that any such risk is reported and addressed immediately (para. 164);
* That informed consent is an imperative and requires comprehensible disclosure of all material information including the purpose of the evaluation, potential risks and benefits, the nature of the evaluation, including the possibility of taking photographs, limits on confidentiality including any mandatory reporting requirements of the clinician (para. 167-168);
* That health professionals have an obligation to recognize and respect the legal capacity of all adults, including persons with disabilities and persons with impaired mental capacity, to make decisions about their care. Clinicians should not substitute their own opinions for those of their patients (para. 169);
* Children should be informed about the clinical evaluation in accessible terms and given the opportunity consent. Informed consent should be obtained from parents, but informed consent does not absolve the duty to safeguard children and their best interest (para. 170) ;
* That the autonomy of individuals who refuse to provide consent for an evaluation should be respected and, under no circumstances, forced to comply with an evaluation – for example forced virginity and anal examinations (para. 171).

**Health Professionals with Conflicting Obligations**

Chapter II clarifies that the primary ethical obligation of health professionals is to act in the best interest of their patients (para. 145, 173). In fact, the IP 2021 has replaced the term “dual obligations” with “conflicting obligations” to ensure that health professionals understand that there is no duty equivalent or greater than that to one’s patient (para. 173).

It clarifies that clinicians who evaluate alleged victims who fear reprisals and refuse to consent to a clinical evaluation should not breach the primary ethical duties of "do no harm" and respect for autonomy over the obligation to document and report (para. 176-177, 179).

However, additional guidance is provided on conditions in which breaching confidentiality may be considered based on statements of international bodies including (para. 178):

* Failure to document & report torture or ill-treatment will result in imminent severe or life-threatening harm to others;
* Disclosure of information will prevent imminent serious or life-threatening harm;
* The alleged victim & clinician deem the risk of reprisals to be low;
* There is significant clinical evidence to warrant a suspicion of torture or ill-treatment;
* Information can be provided to an independent body that will conduct a prompt, impartial and effective investigation.

Chapter II also clarifies that health professionals in State institutions have the same ethical obligations as other health professionals and should facilitate trust by identifying oneself, informing the alleged victim of the purpose & content of the evaluation, disclosing any mandatory reporting requirements, and ultimately respecting the individual’s autonomy (para. 181).

**Chapter III - Legal Investigation of Torture and Ill-Treatment**

**General Considerations & Principles of Investigations**

Chapter III clarifies that:

* Investigations of torture and ill-treatment may involve different investigative bodies, including commissions of inquiry, in a wide range of criminal, civil and administrative legal proceedings (para. 185) and that all investigations of torture and ill-treatment and legal proceedings should be conducted in accordance with IP standards (para. 185).
* State obligations relevant to effective legal investigations include recognition of the role of non-State actors such as national, regional and international human rights bodies and human rights defenders who document torture (para. 188).
* Facts must be determined in an investigation depending on the elements in the jurisdiction (para. 192)
* The State has the duty to establish mechanisms with full investigatory powers including principles for carrying out investigations (para. 193);
* Individuals have a right to an effective remedy and reparation and to complain about such treatment and to have such complaint promptly and impartially examined (para. 196).

**Procedures of an Investigation**

Chapter III provides some important clarifications including:

* States must ensure that any investigation of torture is carried out by an independent and impartial body, which has no institutional links to the alleged perpetrator(s) (para. 201);
* States must provide training, and adequate guidance and instructions, on IP standards (para. 203);
* Investigators need to be mindful of multiple (national and international) investigations and coordinate efforts to avoid retraumatisation (para. 205);
* Investigative bodies should plan the investigation (para. 204) and obtain: testimonial evidence from the alleged victims, witnesses, and alleged perpetrators; physical evidence, including forensic evidence; digital evidence; and documentary evidence, in relation to specific allegations of torture or ill-treatment and broader patterns of torture and ill-treatment (para. 206);
* Seeking informed consent from children involves their parents or legal guardians, but also consideration of possible independent consent from the child (para. 209);
* Children should not be isolated from positive and supportive adult contact and investigators should have skills and expertise in interviewing child victims of torture or ill-treatment (para. 210);
* Children should not be expected to interpret for parents who allege torture or ill-treatment (para. 210);
* Interpreters who participate in interviews with children must have special training and prior experience of working with children (para. 219);
* Investigators with appropriate legal authority should obtain all physical evidence relevant to allegations of torture and perpetrators including material, biological, electronic, and trace evidence (para. 223);
* Crime scenes should be evaluated for evidence collected and analyzed by forensic experts who maintain appropriate chain of custody (para. 226).

**Procedures of an Investigation**

Chapter III includes important clarifications on medico-legal evidence including:

* Medico-legal documentation includes notes, medical charts (including body charts, such as those included in Annex III, to show location of injuries), official medical certificates, computer files, digital mobile files, recordings, photographs, reports, or a combination thereof (para. 228);
* Medico-legal evidence includes clinical evaluations forensic specimens from the body (para. 228);
* Medico-legal evidence should only be collected & analyzed by trained health and forensic professionals. Investigators requesting medical records or patient information shall only do so where duly mandated, having the requisite legal powers, and by fully considering confidentiality, data protection and informed consent (para. 228);
* Medico-legal evaluations require informed consent of the alleged victim and examination by a clinician of the gender of the alleged victim’s choice, in a setting that is private and secure (para. 229);
* When alleged torture and ill treatment results in death, investigations should arrange for an autopsy conducted in accordance with the Revised Minnesota Protocol (para. 229);
* Clinicians are required to provide an “interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment” and a clinical opinion on the overall possibility of torture and ill-treatment based on all relevant clinical evidence including, “physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.” (para. 230);
* The investigator shall respect the right of an alleged victim and family members who allege that acts of torture or ill-treatment to request an independent clinical evaluation and report at any time (para. 231).

Chapter III also includes additional guidance on digital, photographic and documentary evidence, for example:

* Investigators must seek to secure any probative information or data that is stored on, received or transmitted by electronic devices (para. 232);
* Digital evidence includes electronic health records; videos recorded by CCTV cameras; pictures and videos of alleged crime scenes & physical injuries, pictures, videos posted on social media; information stored on computer hard drives memory cards, USB drives, CD-ROM; emails, texts and instant messages; aerial photos and satellite imagery; location information stored on cell phone or social media; and metadata (e.g. time and location when a digital photograph was taken) (para. 232);
* Experts on digital evidence should analyze relevant data and prepare a report or affidavit that can be used in court (para. 232);
* Investigators should obtain digital open-source information in accordance with the Berkeley Protocol (para. 233).
* Photographs should be taken using a digital camera that records the date and time. If a film camera is used, it should have a date & time function and the chain of custody of the film, negatives and prints must be fully documented (para. 234);
* Official and non-official documents should be collected in particular from detention sites, official buildings, military bases, court records, hospital archives, historical archives or open sources (para. 235-237).

**Clarifications on Commissions of Inquiry**

Chapter III includes the following clarifications on commissions of inquiry:

* That commissions of inquiry, alone, do not fully satisfy a State’s obligation to investigate torture and ill-treatment under international law (para. 238);
* That they should be vested with adequate resources and have adequate representation and relevant experience among its members (para. 239, 241);
* That their reports should be public, and that States should expeditiously and effectively implement its recommendations (para. 250).

**Role of Prosecutors, Judges, National Human Rights Institutions, and Other Actors**

Chapter III includes a new section on The Role of Prosecutors, Judges, National Human Rights Institutions, and Other Actors. It states that prosecutors:

* Have a duty to investigate and prosecute crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law (para. 253);
* Have a duty to refuse and make inadmissible evidence obtained through torture and ill-treatment and use such evidence in the prosecution of alleged perpetrators (para. 254);
* Must be professionally qualified, and provided with regular training, adequate resources, independence, and protection to enable them to adequately discharge their duties in accordance with the IP & its Principles (para. 255).
* And in response to torture or ill-treatment allegations or suspicions: immediately take measures to ensure prompt, impartial, effective, gender- and child-sensitive investigation is carried out in accordance with IP; ensure adequate protection of alleged victims & witnesses, bring appropriate charges and recommend punishment commensurate with the gravity of the crime(s) committed (para. 256).

And that Judges:

* Must be provided with the requisite independence, training, resources, and protection that enable them to adequately discharge their duties in accordance with the IP & its Principles (para. 257);
* Have the judicial authority to order and ensure that suspects and detainees are not arbitrarily detained or detained/transferred to places where they could be tortured (para. 258);
* Should initiate investigations or inform prosecutors when torture/ill-treatment are alleged or suspected (para. 259) and be held responsible for failing to investigate, prosecute and punish torture (para. 258);
* Must not admit any evidence alleged to have been obtained as a result of torture or ill-treatment in any proceeding (para. 259);
* Should ensure that the outcome of legal procedures should not be dependent on a prior full investigation of allegations of torture or ill-treatment) (261);
* Should ensure that legal proceedings are conducted in accordance with the IP and its Principles (261).

National Human Rights Institutions & National Preventive Mechanism (para. 262):

* Should be established in accordance with the Paris Principles and mandated to investigate all complaints of torture or ill-treatment;
* Receive training on the IP and its Principles;
* And receive and respond to allegations of torture or ill-treatment.

Non-State actors, such as civil society organizations, play an important role in (para. 263):

* Documentation of torture & ill-treatment;
* Representing victims;
* Prompting investigations;
* Providing evidence and/or expertise to investigative bodies;
* And scrutinizing proceedings, and providing legal analysis of the adequacy of investigation.

And non-State actors should seek timely documentation from reliable and identifiable sources and States should respect the role of non-State actors and ensure effective protections (para. 263).

**The Use of Evidence of Torture or Ill-Treatment in Other Legal Procedures**

Chapter III also includes new guidance on the use of Evidence of Torture or Ill-Treatment in Other Legal Procedures, namely that:

* The exclusionary rule applies in civil & administrative legal procedures (para. 264);
* Decision-makers in asylum & refoulment cases should apply the “more likely than not” standard of proof and consider clinical evidence even when there are negative credibility findings (para. 265);
* And understand that the lack of clinical evidence does not establish that a person has not been tortured, or that the claim of a person alleging torture lacks credibility (para. 265).

**Chapter IV - General Considerations for Interviews**

**Preliminary Considerations**

Chapter IV includes updates and clarification in the section entitled Preliminary Considerations, for example that clinicians should:

* Be aware of essential conditions and interview skills and apply them in their documentation practices including: objectivity, impartiality, accuracy, essential knowledge, safety, privacy, timing, building trust & rapport, empathy, honesty, and explaining the purpose & content of the evaluation including any mandatory reporting requirements (para. 269);
* Anticipate and mitigate retraumatisation in seeking disclosure ill-treatment, especially of sexual torture (para. 274);
* Understand torture and ill-treatment based on gender, sexual orientation and gender identity and how the gender of the clinician may also influence the evaluation process (para. 283).
* In interviewing children, clinicians should (para. 284-293):
* Obtain specialized training;
* Take time to build rapport using clear & age-appropriate language, give breaks and opportunities for questions;
* Respect the right to informed consent of both parent/guardian and the child;
* Understand that trauma & parental separation may adversely affect memory formation;
* Understand age-related effects of trauma & potential beneficial and adverse role of parents/guardians in the interview;
* Recognize how the presence of parents can affect a child’s comfort in sharing information;
* Use age-appropriate questioning techniques;
* Use effective techniques for eliciting reactions such as drawing a timeline, using well know chronological anchors, using movement to relax, and drawing pictures and explaining it. Although toys can be helpful for calming children, they should not be used to elicit history as it can blur the line between reality and fantasy.
* And clinicians should have cultural humility and a transcultural perspective (para. 294);
* Be mindful that anger and rage towards torturers and perpetrators during the interview may be perceived by the survivor as disgust or anger directed at him/her. Clinicians must regulate their emotions instead (para. 299);
* Use caution in relying on interpreters to provide cultural context as their knowledge may be out of date if the interpreters left the country years before (para. 296).

**Conducting Interviews**

Chapter IV provides additional information on Clinical qualifications, for example:

* Conducting IP evaluations does not require certification as a forensic expert, despite normative State practices (para. 303);
* Examples of clinical qualifications are listed in para. 307;
* Clinicians should have knowledge of regional prison conditions and torture methods (para. 307);
* The most important clinical qualification is knowledge of how to apply the IP and its Principles (para. 307);
* All clinicians may acquire knowledge and skills to necessary to conduct a psychological evidence of torture and ill-treatment (para. 308);
* Judges and legal experts should qualify forensic and other clinical expert witnesses in legal proceedings on the basis of their expertise, knowledge, experience and training, rather than on the basis of a particular professional license or certificate (para. 305).

Regarding the integration of the physical & psychological evaluations:

* In legal cases, it is important to integrate the findings of multiple evaluations into one comprehensive evaluation (para. 309);
* If there are separate clinical evaluations, the totality of evidence should be considered (para. 309);
* The conclusion on all of the clinical evidence should be the highest level of consistency reported in either of the separate clinical evaluations or, if confirming the same conclusion, it could be higher (para. 383).

Clinicians should also prepare for the interview by:

* Familiarizing themselves with the case and potential topic areas to focus on (para. 323);
* Building in flexibility for discussing other topic areas as they arise in the interview (para. 323);
* Reviewing appropriate documents/affidavits prepared by the individual’s legal counsel (para. 323);
* Information in legal documents/affidavits should be independently verified (para. 323);
* All information relevant to a clinical evaluation should be gathered by the clinician (para. 323).

Regarding communication barriers:

* The clinician should anticipate and seek to address possible environmental, physical, psychological, sociocultural, & interviewer-specific barriers to effective communication (para. 325);
* Be aware that questions about psychological distress can sometimes be considered taboo in traditional societies and may come across as insulting (para. 278).

In conducting interviews, clinicians should understand that building rapport takes time and showing respect to the interviewee through attentiveness, effective communication, & empathy (para. 326).

Regarding the Level of detail in the history:

* Clinicians should obtain as much relevant detail as possible (para. 329) and alleged victims should be advised to qualify any uncertainty in their account of events (para. 330);
* A lack of detail should not be considered as an indication of being untruthful as many factors may the ability to provide detailed information such as level of trust and rapport, gender alignment in the interview, age, social class, literacy and level of education, cultural factors, and clinical conditions affecting cognitive processes (para. 331-332).

Variability and inconsistencies in the history should be expected in clinical evaluations of torture and ill-treatment. Clinicians should understand that:

* Variability and inconsistencies in the history does not necessarily indicate that the narrator is providing false or unreliable information, since memory may be affected by the physical and psychological effects of torture and ill-treatment, for example head trauma, disorientation to time and place, PTSD symptoms such as avoidance of painful thoughts (para. 343-345);
* Clinicians should use judgment about how much specific detail is needed to document the alleged abuse (para. 346);
* Clinicians have a duty to pursue possible explanations of inconsistencies by asking for further clarification and seeking other evidence that supports or refutes the account of events (para. 347);
* Clinicians should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess (para. 348).

**Addressing Variability and Inconsistencies**

Chapter IV provides guidance on Addressing variability and inconsistencies, first by noting that the reliability of clinical evidence depends on internal & external consistency. Internal consistency is the corroboration between elements of an individual case (para. 349), for example:

* Consistency between the description of physical injuries and reports of subsequent acute symptoms, the healing process and chronic symptoms and disabilities (para. 350);
* Congruency between an alleged victim’s observed affect (emotional state) during the interview and the content of the evaluation (para. 350);
* The level of consistency between specific allegations of abuse and documentation of physical and psychological findings (para. 350);
* The temporal relationship between the alleged abuse and onset of psychological symptoms (para. 352).
* Fluctuations in psychological symptoms in relation to internal and external psychological stressors and mitigating factors (para. 352);
* Congruency between an individual’s emotions (both reported to and observed by the clinician) and the individual’s coping mechanisms (para. 352);
* The individual meaning assigned to the alleged abuse in light of an individual’s psychosocial history (para. 352).
* PTSD symptoms that corroborate specific allegations of torture and ill-treatment such as the content of nightmares, triggers for intrusive recollections & reliving experiences, as well as avoidance thoughts and behaviours (para. 352).

External consistency is the corroboration between individual case findings and regional torture and ill-treatment practices and other information, for example:

* Specific torture and ill-treatment methods or specific devices, body positions & methods of restraint used; perpetrator & detention facility information (para. 353);
* And witness testimony, medical reports, treatment records, and photographs (para. 353).

**Content of Interviews**

The section entitled Content of Interviews includes several important updates and clarification including:

* IP Principles apply to all clinical evaluations except the formulation of an opinion on torture or ill-treatment in non-legal contexts (para. 354-355);
* If time is limited, clinicians should elicit the most critical information in accordance with IP Principles and report the time limitation (para. 356);
* Clinicians must introduce themselves and provide detailed information on the purpose, conditions and content of the evaluations before obtaining informed consent (para. 358-359);
* Chapter IV clarifies and lists the components of evaluations of physical and psychological evidence of torture and ill-treatment (para. 373);
* At the closing of the interview, clinicians should assess and mitigate signs of stress, including self-harm and suicide, and make appropriate referrals (para. 375);
* The decision to report clinical evidence of torture and ill-treatment depends on informed consent not statutory or mandatory reporting requirements (para. 376).

**Post-interview Considerations**

Chapter IV provides important clarification and additional guidance on the Interpretation of Findings and Conclusions and Recommendations, which is reflected in Chapters V, VI and VII.

Regarding Interpretation of Findings, Chapter IV clarifies that:

* Clinicians are required to provide an “interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment (para. 379);
* Levels of consistency, used for interpretations and opinions, include: Not consistent with/Consistent with/Highly consistent with/Typical of/Diagnostic of; however, psychological evaluations rarely use “Typical of” and “Diagnostic of” (para. 380);
* The highest level of consistency of an individual finding often determines the level of consistency for all of the clinical evidence (para. 381) and, in some cases, the overall evaluation will report a higher level of consistency than each individual finding, especially when taking together (para. 381).

Clarification on Conclusions and Recommendations include the following:

* The Istanbul Principles require clinicians to provide a clinical opinion on the overall possibility of torture and ill-treatment considering all relevant clinical evidence including, “physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.” as stated in Annex IV (para. 382);
* A conclusion on all clinical evidence should be based on the highest level of consistency reported in one or more evaluations of physical and psychological evidence (para. 383);
* Medico-legal evaluations that fail to assess and provide an opinion on the possibility of torture and ill-treatment are deficient (para. 384);
* Clinical opinions on the possibility of torture are based on the probability that the totality of clinical evidence was caused by the alleged torture or ill-treatment as defined by the UN Convention against Torture or other applicable legal definitions (para. 384);
* Causation is expressed in terms of consistency rather than judicial standards of proof to avoid the conflation of clinical opinions with judicial determinations (para. 384);
* Conclusions on torture in children should take into relevant legal thresholds, which may be lower for children, particularly when deprived of their liberty (para. 382).

Chapter IV also provides additional information on Self-infliction and Simulation, for example:

* If the clinician suspects fabrication, another clinician should conduct additional interviews. Documentation of the possibility of self-infliction or simulation should be noted with the agreement of both clinicians in the interpretation of findings and conclusion. Clinicians do not have a duty, however, to consider these possibilities in the absence of an evidentiary foundation (para. 386);
* Also, it is important to note that without medical knowledge of human anatomy and pathophysiology, most individuals would not be able to fabricate accurate historical information regarding the physical sequalae of specific forms of torture and ill-treatment (para. 351).

Regarding the Reliability of Clinical Evidence and Credibility:

* Clinicians are advised not to comment on the credibility of an alleged victim or suspect. If the clinician is asked by a legal expert to provide an assessment of credibility, the clinician should provide their assessment of the reliability of clinical evidence as it relates to credibility and be sure to distinguish their assessment and opinion from a judicial determination of credibility (para. 388-389);
* The reliability of clinical evidence is often based on elements of internal and external consistency (para. 349-353).

Chapter IV also recognizes important clarifications on the Limitations and Misuse of the IP, namely that:

* The IP may aid in the discovery of clinical evidence of alleged torture and/or ill-treatment, but the absence of does not mean that it did not take place (para. 390);
* Many factors may account for the absence of clinical evidence and documenting these factors may aid corroborating specific claims of torture and ill-treatment (para. 390);
* The inherent value of the IP is its capacity to discover clinical evidence that may support specific claims of abuse. It is not a tool to prove that a hypothetical act did not take place (para. 392).

**Chapter V - Physical Evidence of Torture & Ill-Treatment**

**Medical History**

Chapter V clarifies that:

* A full review of symptoms should be obtained including those related to possible sexual torture (para. 394);
* In those seeking asylum, medical records and reports from the country of origin may help corroborate allegations of torture or ill-treatment, but also may deliberately omit mention of torture or ill-treatment (para. 395).

**The Physical Examination**

Chapter V clarifies that clinicians should:

* Conduct a complete examination of the whole body in sections, keeping as much of the body covered as possible (para. 400);
* Understand that the absence of physical finding does not necessarily mean that torture did not occur (para. 401).
* Follow local procedures for ensuring chain of evidence (para. 402);
* The clinician should obtain the best photographs possible rules and colour scales and supplement with detailed descriptions and body diagrams, then follow up with professional photographs as soon as possible (para. 402);
* If a lesion cannot be seen on a photograph, this does not mean it was not there, especially if the clinician is not a trained forensic photographer with quality equipment (para. 403);
* Consider bone scintigraphy to detect non-fracture bone lesions following beatings, particularly when torture has been prolonged (para. 403);
* Note additional information on physical findings from strangulation by ligature or hands (para. 410-411).

**Interpretation of Physical Findings**

Chapter V includes important clarifications on the interpretation of physical findings, first, that clinicians should correlate the level of consistency between:

* The history of acute and chronic physical symptoms and disabilities consistent **and** the allegations of torture and/or ill-treatment (para. 417a);
* The physical examination findings **and** the allegations of torture and ill-treatment (para. 417b);
* The findings of the examination **and** knowledge of regional torture methods and their common after-effects (para. 417c);

The clinician should indicate the level of consistency for each individual examination finding and consider possible causes of the physical findings as suggested by the evidence, for example, torture or other deliberate harm, medical conditions or procedures, accidental injury, ritual practices, and self-harm (para. 420).

Injuries that are not specifically attributed to torture, but were gained while trying to evade perpetrators, falls in the definition of “torture injuries” if the person was within the control of the perpetrator at the time (para. 421).

Clinicians should understand that accidental injuries are more commonly located on the extremities and individuals may not recall the cause, while that multiple scars in the same location suggests intentional injury (para. 422). Also, self-injury (para. 423):

* Is usually caused by a singly modality, most commonly cutting within reach of the dominant arm;
* Individuals may disclose these injuries readily or conceal them due to shame and stigma;
* Consideration of self-injury and fabrication should be viewed in light of the sum total of clinical findings.

**Conclusions and Recommendations**

Chapter V makes clear that:

* Clinicians should formulate a clinical opinion on the possibility of torture and ill-treatment based on all relevant clinical evidence, state current symptoms and disabilities and likely effects on social functioning and provide any recommendations for further evaluations and care for the individual (para. 424-425).

**Examination & Evaluation Following Specific Forms of Torture**

Chapter V includes additional information on examination & evaluation following specific forms of torture, for example:

* Skin Damage:
* The colour of bruises does not indicate the age of injury (para. 428). However, it may be possible to state that a wound is very recent if it is red and crusting (para. 434);
* Blunt force injury may result in a laceration rather than a bruise depending on the force applied, the object used, and protective barriers (para. 429);
* The evolution of a scar depends on many factors - usually, it is not possible to give an exact opinion on the date of a lesion, it may be possible to state that the appearance is inconsistent with the timeline stated (para. 434);
* Scars caused at the same time and by the same mode of injury may heal at different rates (para. 434).
* Head trauma:
* Minor traumatic brain injury even without loss of consciousness may affect memory and concentration and brain injury from asphyxia torture may also lead to cognitive deficits (par 437);
* Late effects of brain injury can be detected with specialized radiological techniques (para. 437).
* Suspension:
* The reported time of suspension is often inaccurate as victims are disoriented or lose consciousness (para. 445);
* Brachial plexus injuries may manifest in complex and subtle findings that often warrant referral to a specialist (para. 446).

**Sexual Torture Including Rape**

Chapter V also includes additional information on sexual torture including rape summarized as follows:

* There is considerable variability in recall of events by victims and disclosure of sexual torture may be difficult and delayed (para. 455);
* The absence of physical injuries should not be considered evidence of consent (para. 457);
* A full review of symptoms may aid in disclosure of sexual violence (para. 457);
* Violent and repeated rape or sexual assault by anal penetration with an object can cause significant physical damage with long lasting effects (para. 458);
* Examination of ano-rectal injuries may need to be performed under sedation (para. 461);
* Examination should proceed at a pace dictated by the alleged victim and stopped if too stressful (para. 462);
* Most injuries heal within a few days and are not present at the time of examination (para. 478);
* Sexually transmitted infection may be detected but does not necessarily confirm torture as the cause (para. 469);
* Sexual dysfunction may occur in those who have not suffered sexual torture, or it may be that they have not yet disclosed sexual torture (para. 470);
* Men who experience sexual arousal during anal rape should be reassured that this is a physiological reaction that does not reflect their sexual orientation (para. 470b);
* Symptoms of sexual dysfunction include profound effects on the psyche (para. 470c);
* Small lacerations or tears of the vulva normally heal completely but can scar (para. 471a);
* Genital examination findings may include scarring from cigarette burn or cutting injuries (para. 471d).

**Specialised Diagnostic Tests**

Chapter V clarifies that:

* Specialized diagnostic tests are not essential for clinical evaluation of torture or ill-treatment (para. 480);
* That such tests have limitations in specificity and reliability that clinicians should be aware of (para. 480);
* And may not be useful following the healing of acute injuries (para. 482);
* MRI detects bone contusion and stress or occult fractures before it can be imaged by x-rays, CT or scintigraphy (para. 483);
* Open scanners and sedation may be helpful in alleviating anxiety and claustrophobia (para. 484);
* Blood tests and urinalysis can be effective screens for injuries to the chest and abdomen (para. 413).

**Assessment of Functional Disability**

Chapter V also recommends using World Health Organization Disability Assessment Score version 2.0 as a tool used to assess functional disability for compensation claims and rehabilitation planning in six domains of function: cognition, mobility, self-care, getting along, life activities and participation (para. 485-487).

**Children**

Chapter V also includes additional guidance on clinical evaluations of children including:

* Medical examination should be carried out in a child friendly setting by trained clinicians with experience in assessing and documenting physical injury in children including sexual assault (para. 488);
* Consent should be obtained from the child’s guardian and where appropriate from the child (para. 488);
* Clinicians may need to seek additional information from other children, young people and their caretakers (para. 488);
* Children victims must have access to trained, competent paediatric examiners, wherever possible, who can provide medical assessment and recommendation for care (para. 489);
* The evaluation must include safeguarding for the prevention of further torture and ill-treatment, recommendation for recovery and reintegration, and reduction of exposure to experiencing or witnessing violence (para. 489);
* Examination of the genital and anal areas should be conducted only when necessary, and by experienced clinicians & under general anaesthesia (para. 490);
* Clinicians should be aware that scar formation in children may be different from that in adults as wounds might heal faster. Bony injuries, depending on their position related to the growth plate, may not be apparent on initial x-rays or months after a fracture has healed.  Radiological techniques should be used scrupulously in children given the anxiety they may cause and potential after-effects of childhood radiation  (para. 490).

**Chapter VI - Psychological Evidence of Torture & Ill-Treatment**

**General Considerations**

In the General Considerations section, Chapter VI:

* Clarifies the central role of the psychological evaluation in evidencing torture, holding perpetrators responsible and achieving redress (para. 491);
* Clarifies that the variability of prevalence of PTSD and depression is likely due to differences in population samples, assessment methods, co-existing stressors, and other factors (para. 493);
* Notes the importance of considering culture-specific ways of experiencing, expressing and describing psychological distress (para. 494);
* Also notes the importance of documenting post-traumatic conditions that may affect or alter the victims’ recall of experiences, which in turn may affect their ability to participate and testify in legal proceedings (para. 495).

**Psychological Consequences of Torture and Ill-treatment**

The section on Psychological Consequences of Torture and Ill-treatment clarifies that (para. 498):

* Intensity of trauma-related psychological symptoms changes over time depending on personal trauma processing, effectiveness of available coping strategies, and external factors;
* The absence of a formal diagnosis does not exclude severe mental suffering and disability and is not inconsistent with torture or ill-treatment;
* The psychological assessment should document multiple short- and long-term psychological, psychosomatic and psychosocial reactions beyond and not limited to a possible psychiatric classification. “An absence or subthreshold level of symptoms at the time of assessment can be due to the episodic nature or delayed onset of specific symptoms or to denial of symptoms because of shame.”

IP users should also be aware of updates on common psychological responses (para. 500-511) as well as updates on DSM V and ICD 11 diagnostic classifications for depressive disorders, acute stress disorder, substance use disorder, and others (para. 512-523).

**The Psychological/Psychiatric Evaluation**

The section on The Psychological/Psychiatric Evaluation includes a number of important clarifications including that:

* Observations of verbal and non-verbal communication, emotional reactions, affective resonance and behaviour are important components of a psychological evaluation (para. 524);
* The pursuit of detailed information should not result in retraumatisation the alleged victim (para. 526).
* Assessment of social functioning should include multiple dimensions: behavior, social skills, feelings and overall wellbeing (para. 538);
* Psychological testing is optional, at the Clinician’s discretion, and personality tests are not appropriate (para. 539);
* Assessment instruments should have established validity and reliability for the population being assessed (para. 580.). A lack of cross-cultural validity and linguistic differences can severely limit the meaningfulness and reliability of results (para. 539);
* The levels of consistency for psychological evidence are the same as those for physical evidence, noting that “typical of” and “diagnostic” are rarely used for psychological evidence (para. 540-545);
* The presence or absence of a "typical psychological reaction" should not be considered any more or less meaningful or corroborative than the “highly consistent” level of consistency (para. 545);
* The clinician has an obligation to formulate a clinical opinion on the possibility of torture and ill-treatment based on all relevant clinical evidence and should reiterate current symptoms and disabilities and likely effects on social functioning and provide any recommendations for further evaluations and care for the individual (para. 546-547).

**Children**

Chapter VI provides additional information on children & torture including new sections on conducting the evaluation, diagnostic classification, and the family context. In conducting evaluations of children, clinicians should:

* Wherever possible, collect relevant information from parents, teachers, and caretakers and others (para. 556);
* Establish a trustful and welcoming setting, especially for unaccompanied children (para. 556);
* Provide comprehensible & age-appropriate information and explanations about the evaluation (para. 557);
* Schedule adequate interview time to ensure rapport building and time for breaks (para. 557);
* Include the parent or guardian in the assessment process when in the best interest of the child (para. 557);
* Understand that trust may be undermined by age and power imbalances (para. 558);
* Introduce interpreters, explained their role, and the meaning of confidentiality (para. 558);
* Limit access to any recordings of the interview to the assessment team only (para. 559);
* Begin the assessment with neutral subjects on matters related to the child’s everyday life to reduce psychological distance and formality (para. 559);
* Assessment instruments should have established validity and reliability for the population being assessed (para. 560).

Chapter VI also provides information on developmental considerations for children and adolescents, as well as strategies to employ during the evaluation.

* Preschool children generally have high levels of suggestibility and social compliance with adults’ requests and their cognition is characterized by prelogical, magical and egocentric thinking that might be confused with factual events. They respond best to short, concrete, probing questions designed to expand on and clarify their ideas (para. 571);
* Children between the ages of 6-12 can understand cause and effect relationships and perform different mental tasks, but have a limited capacity to discuss abstract issues and reflect on possible outcomes (para. 572);
* Because they place a high value on peer influence, the clinician should let the adolescent know that their opinions and inputs and valued and explain how their privacy will be secured (para. 573).

Chapter VI clarifies that a psychological assessment of children should include information on (para. 581):

* The child’s age, developmental status, as well as current and past psychological and medical functioning (including cognitive, communication and language abilities, special needs, social and school functioning, behavioral adjustment and emotional disorders);
* Chronological personal and family history of life events, residences, etc.;
* Description of the alleged torture or ill-treatment, its frequency and duration;
* Information regarding whether the child witnessed the death and/or torture of others;
* The alleged torturer’s identity and what it represents for the child;
* Protective factors and indicators of resilience;
* The availability of family and other caregivers to provide psychosocial supports;
* The legal status of the child;
* The provisions in place for treatment and support.

It also notes that clinicians must rely more heavily on observations of the child’s behavior than on verbal expression (para. 582).

It also provides additional information on diagnostic classification of common psychological disorders among children who have experienced torture or ill-treatment including:

* Post-traumatic stress disorder (para. 586-587);
* Separation anxiety disorder (para. 588);
* Specific phobia (para. 589-590);
* Disorders of social functioning with onset specific to childhood and adolescence (para. 591);
* Conduct disorder (para. 592);
* Oppositional conduct disorder (para. 593);
* Disruptive mood dysregulation disorder (para. 594).

And recognizes the potential effects of parental torture on children, for example:

* Parents who are torture survivors may fear overwhelming their children with their emotions and have associated feeling of guilt and shame (para. 596);
* The effect of torture on parents may raise concerns over parental functioning, including child neglect and physical, sexual and emotional abuse and addressed within appropriate legal and social frameworks (para. 597);
* Alternatively, the child can be parentified and expected to care for parents which can hamper development and result in a depressive symptomatology or in aggressive behaviour (para. 598);
* And parents may show outbursts of anger and violence against a child as well as other forms of domestic violence, which the child might experience in a traumatic way (para. 598).

**LGBT and Intersex Persons and Torture and Ill-Treatment**

In a new section, Chapter VI recognizes that:

* LGBTI persons are frequently stigmatized, dehumanized and subjected to persecution, criminalization, imprisonment, torture and ill-treatment. Providing a sense of safety and respect will help the person reveal torture and ill-treatment (para. 599).

It also provides new guidance to Clinicians in providing a sense of safety and respect to LGBTI individuals by (para. 600):

* Recognizing that diversity is normal and not a mental illness;
* Understanding physical & psychological effects of LGBTI persecution experiences;
* Understanding how social, cultural and political factors affect the physical & mental health of LGBTI individuals;
* Enquiring about abuse related to sexual orientation and gender identity;
* Creating a supportive environment to allow for disclosure of relevant information;
* Understanding that information may represent the first disclosure of sexual orientation, gender identity, and sex characteristics;
* Using proper names and pronouns chosen by the individual;
* Understanding how one’s own biases may affect the clinical evaluation;
* Understanding that LGBTI people may experience additional stigma on the basis of being HIV+, refugee status, being a sex worker, physical disabilities, etc.;
* Not attempting to change the individual’s sexual orientation or sexual identity;
* Not seeking to “explain” sexual orientation or sexual identity;
* And not assuming a person’s sexual orientation or sexual identity on the basis of appearance.

**Chapter VII - The Role of Health Professionals in Documenting Torture and Ill-Treatment in Different Contexts**

Chapter VII is a new chapter that aims to clarify the role of health professionals in different contexts, particularly non-legal settings. IP guidance in Chapter VII should be considered as supplemental to that in Chapters II, IV, V and VI and Annexes I-IV.

Documentation contexts may include (para. 607):

* Police and military custody or prison;
* Immigration contexts;
* Healthcare, psychiatric and social institutions;
* Ad-hoc national and international settings;
* Healthcare facilities, emergency rooms and urgent care centers;
* NGO investigations and individual evaluations of alleged victims;
* Rehabilitation and treatment centers for torture victims.

**Documentation Challenges and Mitigation Strategies**

Clinicians may experience significant challenges in these documentation contexts including:

* Fear of reprisals (para. 612-613);
* Lack of training (para. 614-615);
* Lack of time, heavy workload burden and inadequate number of health professionals (para. 616-617);
* Lack of adequate professional space or conditions (para. 618-619);
* Non-disclosure (para. 620);
* Vicarious trauma and burnout (para. 621);

And Chapter VII provides mitigation strategies to address these challenges (Para. 612-621).

**Implementing Ethical Obligations**

As mentioned in Chapter II, the ethical duty to document torture and mandatory State reporting requirements may conflict with the ethical duties of non-maleficence (“do no harm”), autonomy (“informed consent”), and confidentiality (para. 622-623, also see 159-172).

Chapter VII guidance clarifies that clinicians should not breach the primary ethical duties of "do no harm" and respect for autonomy over the obligation to document and report and provides guidance for clinical encounters with possible torture and ill-treatment victims including (para. 622-624):

* Obtain informed consent;
* Disclose any mandatory reporting obligation;
* Document and report torture and ill-treatment in accordance with the IP;
* And, in the absence of informed consent, consider all ethical obligations & only consider breaches in confidentiality in limited circumstances, e.g. anonymous reporting as discussed in paragraphs 177 & 178;
* Document patterns of abuse anonymously and report such patterns of abuse to international and national human rights institutions;
* Consider the need for referrals, either for treatment purposes or for further documentation by other clinicians.

Real or perceived obligations to third parties must not compromise professional ethical obligations or independence (para. 624).

Clinicians need to recognize and mitigate explicit and implicit biases in working with patients, clients, and alleged victims (para. 625).

And clinicians should do their best to evaluate torture and ill-treatment where access to clinical experts is limited (para. 626).

**Summary of Guidance and Procedures for Clinical Evaluations in Legal Contexts**

IP guidance in legal contexts is articulated extensively in Chapters IV, V, VI and Annexes I-IV. In summary:

* The State’s duty to investigate includes clinical assessments in accordance with the IP including formulating an opinion on the possibility of torture or ill-treatment (para. 629);
* States should establish policies and procedures for State-employed health professionals to perform evaluations in accordance with the IP and its Principles (para. 630);
* The duty of health professionals to examine potential victims and document torture and ill-treatment supersedes any limitations that may be imposed by statutory considerations, the scope of a legal inquiry, and/or specific questions that prosecutors and judges may ask of clinical and forensic expert witnesses (para. 631);
* Clinicians who conduct any health assessments of persons deprived of their liberty should be trained and have the capacity to conduct clinical evaluations in accordance with the IP and its Principles (para. 631);
* When non-governmental experts provide a medico-legal opinion on torture and ill-treatment in legal cases, their evaluations should conform to the minimum standards contained in the Istanbul Principles (para. 632).

**Clinical Evaluations in Non-Legal Contexts**

Chapter VII provides additional guidance for clinical evaluations in non-legal contexts (para. 633-637). For alleged or suspected torture or ill-treatment, the clinician should:

* Obtain informed consent (para. 634a);
* Exclude any third parties from the evaluation room (para. 634b);
* Inquire about the cause of any injuries or psychological distress (para. 634c);
* Document physical and/or psychological symptoms or disabilities related to the alleged abuse (par 634);
* Conduct a directed physical examination including a brief mental status examination and a risk assessment for harm to self and to and from others (para. 634d-e);
* Document all injuries with body diagrams (see Annex III), and photographs if possible (para. 634f);
* If ill-treatment is alleged or suspected, make appropriate referrals and notify appropriate authorities and inform the individual of his or her right to clinical evaluations by independent, non-governmental clinical experts (para. 634g);
* Clinical interpretation of findings & conclusions on the possibility of torture may be considered by clinicians who have knowledge and experience applying the IP and its Principles, but is not required (para. 634h);
* Provide a copy of the documentation/evaluation to appropriate legal authorities and the patient, if requested, and/or the patient’s legal representative but not to law enforcement officials. Health Professionals should keep one copy of the evaluation and documentation for themselves in secure medical files (para. 634i);
* If the clinician is unable to conduct an evaluation, document the reasons (para. 634j);
* Take measures to prevent return of alleged victims to the place of alleged abuse (para. 634k).

Clinical evaluations in non-legal contexts should follow the Istanbul Principles and note any departures from the required elements of these Principles where applicable (para. 635, 636, 638).

Clinicians should also be aware that it can be difficult for individuals to disclosure and recall traumatic experiences (para. Para. 636).

Clinical evaluations in non-legal settings should strive to provide all of the information inherent in a full medico-legal evaluation as described elsewhere in the Protocol (para. 638).

**Reporting and Monitoring**

Chapter VII provides clear guidance on reporting evidence of torture and ill-treatment, noting that despite the ethical obligation to report torture & ill-treatment & mandatory reporting requirements, clinicians have a core ethical obligation to obtain informed consent and respect autonomy even if this is in conflict with the law (para. 638).

It notes the important role that national health professional associations and national human rights institutions can play in ensuring ethical reporting practices (para. 640).

…and calls upon States to monitor and ensure the quality of all official evaluations where torture and ill-treatment is alleged or suspected and take remedial action for non-compliance and ensure compliance with IP and its Principles (para. 641).

**Chapter VIII – Istanbul Protocol Implementation**

Chapter VIII is a new chapter that provides guidance to States and civil society about the necessary steps for effectively implementing the IP & its Principles.

The Chapter begins with identification of the necessary conditions for effective IP implementation including:

* Official recognition of IP standards (para. 646);
* Political will as reflected in statements, planning and remedial action (para. 647);
* An effective criminal justice system (para. 648-649);
* Adequate financial and human resources (para. 650);
* Good governance (para. 651);
* Cooperation (para. 652);
* And active civil society participation (para. 653).

**Implementation Phases**

Systematic & comprehensive implementation of IP standards typically involves three complementary activities: assessment, capacity building, and policy reform - that are applied in interdependent phases - First by developing a common understanding among stakeholders (para. 655), followed by activities to transfer knowledge and skills to relevant target groups and implementing policy reforms (para. 656), and lastly efforts focused on transferring implementation activities to local civil society and state actors, institutionalizing IP standards & practices, and monitoring the outcome of implementation efforts (para. 657). Such implementation requires sustained efforts over significant periods of time that results in meaningful progress.

**Legal, Administrative and Judicial Reforms**

States need to establish a normative framework and institutional safeguards to prevent torture & ill-treatment, which includes (para. 658-659):

* Defining and criminalizing acts of torture;
* Ratifying and ensuring effective implementation of the OPCAT including NPMs;
* Ensuring that lesser statutes such as “abuse of power” do not preclude prosecution of torture;
* Ensuring appropriate rules on admissibility of evidence (the “exclusionary rule”);
* Ensuring safeguards and effective complaint mechanisms for persons deprived of liberty.

The State’s obligation of effective investigation of torture & ill-treatment includes (para. 660):

* Implementing a system of mandatory health evaluations of detained persons;
* Ensuring access of alleged victims to health professionals of the detainee’s choice at any time;
* Ensuring admissibility of clinical evaluations by non-governmental clinicians in court;
* And ensuring clinicians have prompt access (less than 24 hours) to alleged victims.

States should also:

* Develop a strong legal framework to provide reparation for torture and ill-treatment (para. 661);
* Ensure that all relevant personnel receive training on the effective legal and clinical investigation and documentation of torture and ill-treatment in accordance with the IP (para. 662);
* Ensure that law enforcement personnel receive specific training on internationally accepted interrogation methods and effective measures to prevent torture and ill-treatment (para. 662);
* And ensure respect for legal and medical ethical duties as described in Chapter II (para. 663).

**State Forensic and Health Professional Reform**

States Should:

* Ensure policies, practices, and capacities for the effective investigation and documentation of torture and ill-treatment by State-employed forensic experts and clinicians (para. 664-665);
* Ensure the right of alleged victims to access to independent health professionals and clinical experts (para. 666, 673);
* Provide state forensic institutions with adequate financial & human resources (para. 667);
* Ensure prompt evaluations ((immediately and not later than 48 hours from the time that torture or ill-treatment is alleged or documented in an initial clinical evaluation) by qualified, independent clinicians in accordance with the IP in all cases (para. 668).

And State forensic institutions and health agencies should:

* Ensure that IP standards are integrated into policies and practices (para. 665);
* Ensure respect for relevant ethical principles & clinical independence (para. 645, 666);
* Codify procedural safeguards for clinical evaluations of torture & ill-treatment in domestic law and regulations (para. 669);
* Respect and facilitate an individual’s right to be evaluated by one or more non-governmental health professional(s) of his or her choosing anytime and inform an alleged victim of this right (para. 670);
* And ensure that all relevant personnel receive training on the IP and its Principles (para. 671-672).

**IP Implementation Monitoring and Accountability**

* Monitoring IP implementation efforts and measuring meaningful outcomes is essential in holding States accountable (para. 674);
* States should mandate and support an independent monitoring body to monitor the implementation of IP standards and conditions necessary for effective investigation and documentation of torture and ill-treatment (para. 674);
* Ensuring the independence of monitoring bodies may be informed by guidelines for NPMs and the Paris Principles (para. 675);
* Monitoring functions should include all relevant norms, procedures and practices and report findings should be public (para. 674-675, 677);
* States should also support the monitoring activities of UN and other international and domestic human rights bodies and organizations (para. 678) and ensure “whistleblower” protections for medico-legal and health personnel (para. 679).

**Cooperation and Civil Society**

* Effective IP implementation by States often depends on international cooperation coordination and technical assistance and actions by civil society. To this end, Chapter VIII advises States to coordinate IP implementation activities in cooperation with multilateral institutions and provide foreign assistance for IP implementation, particularly in emerging democracies where torture and ill-treatment are widespread (para. 680-681);
* Chapter VIII also recognizes the critical role that civil society can play in IP implementation and advises States to collaborate with civil society in their remedial anti-torture actions (para. 682). It also urges civil society not to rely on State initiatives, but to independent remedial action to organize and work with international and regional human rights bodies and organizations to develop the necessary capacities within civil society to implement IP standards and other anti-torture activities (para. 682-683).