Handbook on Medico Legal Management of Torture Survivors and Detainees Based on the Istanbul Protocol, for Sri Lankan Medico-Legal Practitioners

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PREFACE

The Family Rehabilitation Centre (FRC) is pleased to present this publication that aims to increase the professional understanding and knowledge of the principles and methodologies for prevention of torture through effective investigation and documentation as set out in the Istanbul Protocol.

The Istanbul Protocol, formerly known as *The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*, is the first set of international guidelines ever published for the documentation of torture and its consequences. The Istanbul Protocol provides internationally accredited procedures for the assessment of persons who allege to have been tortured or subjected to ill treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary or any other investigative body. The Istanbul Protocol forms the basis for Judicial Medical Officers in Sri Lanka to investigate an allegation of torture. This publication will serve as a guideline for medical officers serving in provincial hospitals to document alleged torture in the absence of the consultant Judicial Medical Officers (specialists in forensic medicine). It will also be used as key source material in the training programmes to be conducted for legal and medical officers.

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Lahiru Perera
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August 2015

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Foreword

"Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted upon a person for such purposes as obtaining from him or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected to have committed or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind; when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."[1] It is thus evident that pain or suffering arising from lawful sanctions is not considered as torture.

Torture has become a major concern in the world community. It not only adversely affects the physical and emotional wellbeing of those who undergo it, but also destroys the dignity and the will of entire communities at times. Torture of any form under any circumstances is prohibited by international human rights and humanitarian law. Yet, torture and other forms of inhuman, cruel or degrading treatments or punishments are practiced in varying degrees in more than half of the world's countries.[2] This demonstrates the timely need for states to identify and implement effective measures to protect citizens against torture. This manual is compiled by the College of Forensic Pathologists of Sri Lanka with this aim in mind and is based on the Istanbul Protocol – 'Manual on the Effective

Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment'.[3]

As some victims of torture may present themselves to the doctor some time after the torture incident, minimal findings may be present in some of them. Thus a detailed examination and recording of all positive findings as well as the significant negatives is a must. Failure to record such detail may erroneously be interpreted as concealing the crime of torture. Thus attention to detail and adherence to a standard format will benefit the criminal justice process.

This manual specifically designed for the Sri Lankan setup, covers a wide array of topics pertaining to torture. It is specifically designed for medical officers who during their medico legal duties happen to examine likely victims of torture. This manual is easy to read and essential practical aspects are summarized in a concise form as guidance for the practicing medical officers. This will help in improving the standards of care by an ordinary medical officer towards victims of torture and indirectly enable Courts of Law to arrive at appropriate decisions, thus positively contributing to the criminal justice process.

Chapter 1

Introduction

The College of Forensic Pathologists of Sri Lanka was founded in the year 2000. Since then the College has undertaken many important tasks on various medico-legal issues. The most recent task the College has taken up is the preparation of this handbook on medico legal management of detainees and torture survivors produced by law enforcing authorities in the Sri Lankan context, based on the Istanbul Protocol. The main objective of the booklet is to provide medical professionals with brief but detailed enough information necessary to perform a proper medico-legal management of alleged and suspected cases of torture.

Torture is a profound concern of the world community. In Sri Lanka too issues related to torture do exist. The objective of torture is mainly to extract confidential information from a person but almost inevitably during this exercise it also destroys the physical and emotional well-being of the individual concerned.

Although international human rights and humanitarian law consistently prohibit torture under any circumstance, torture and ill-treatment of detainees are practiced in more than half of the world's countries. Perusal of electronic and print media

will provide substantial evidence of this. This signifies the importance of this issue in the local setup. The striking disparity between the absolute prohibition of torture and its prevalence in the world today demonstrates the need for states to identify and implement effective measures to protect individuals from torture and ill-treatment.

The Istanbul Protocol is intended to serve as a set of international guidelines for the assessment of persons who allege torture and ill treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary and any other investigative body. This is intended to be used worldwide in dealing with cases of torture. This was initiated and put in to place to enable standardized investigation and management of suspected cases of torture.

Medico legal professionals in our country are also faced with issues pertaining to torture. Therefore it is very important to have an idea about international standards in dealing with such cases. As professionals we have to maintain our moral standards and ethical code at all times. Ethical standards are established primarily in two ways: by international instruments drawn up by bodies like the United Nations and by codes of principles drafted by the professions themselves, through their representative associations, nationally or internationally. We have our obligations for the individual victims, to the society and also to our colleagues in order to maintain the honour of the profession in the eyes of the judiciary.

The College of Forensic Pathologists of Sri Lanka decided to prepare this handbook as an easy and a quick reference guide for the doctors engaged in medico-legal work in Sri Lanka. This handbook will provide brief but adequate information which will be useful in dealing with suspected cases and alleged cases of torture and is expected to standardize the investigation and management of such cases. The College also hopes that this information guide would help to provide a quality medico-legal management of suspected and alleged torture victims and maintain international standards in dealing with such victims in Sri Lanka.

Chapter 2

Sri Lankan Legal Framework for Torture

Torture is a human rights violation. It was identified in the United Nation's Declaration of Human Rights in 1948. According to article 05 of the Declaration, no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. Article 11 of the declaration says that every person charged with a penal offence has the right to be presumed innocent until proved guilty. Article 7 of the International Covenant on Civil and Political Rights (1966), provides that no one shall be subjected to torture or subjected to medical or scientific experimentation without his free consent.

Sri Lanka became a signatory to this covenant in 1982. This was incorporated in to the laws of Sri Lanka as the International Covenant on Civil and Political Rights (ICCPR) Act, No. 56 of 2007.

As a matter of policy and practice the Government of Sri Lanka maintains a zero-tolerance policy on torture. Article 11 of the 1978 Constitution of the Democratic Socialist Republic of Sri Lanka expressly prohibits torture. It states, "No person shall be subjected to torture, or to cruel, inhuman or degrading treatment or punishment."

The enactment of the Torture Act, No. 22 of 1994 and the Corporal Punishment (Repeal) Act, No. 23 of 2005 as well as several provisions contained in the Code of Criminal Procedure Act, No. 15 of 1979 as amended from time to time is a clear manifestation of positive legal measures taken by the Government of Sri Lanka in its fight against torture.

In 2004, the Istanbul Protocol was introduced to the medico legal fraternity of Sri Lanka. Training of doctors and lawyers on the Istanbul Protocol has been carried out in many provinces with the help of the International Rehabilitation Council for Torture Victims (IRCT).

In the World Medical Association (WMA) Declaration of Tokyo (1975), the participation or presence in torture, and the provision of a place or knowledge of torture are prohibited for physicians. They also have absolute independence in the management of torture victims. Forceful feeding of hunger strikers is also prohibited.

Legal procedure and redress for victims of alleged torture

1. Complain to the local police (OIC, HQI, ASP or SP of the area).
2. If these officers refuse to receive the complaint or they fail to take any action, then a complaint can be made at the Police Head Quarters in Colombo.

3. After recording a complaint a Medico Legal Examination Form (MLEF) is issued to the complainant and referred to the Judicial Medical Officer (JMO) for medico legal examination.

4. Upon the report of the JMO on his MLEF, the police can file a case against the torturers in the Magistrate Court.

5. The court will summon the JMO to send the Medico Legal Report (MLR) on the victim.

6. The victim or a lawyer representing the victim may also request a MLR to file a private court case [Fundamental Rights (FR) case or complaint to the Human Rights Commission (HRC)].

7. Depending on the gravity of the torture, the Attorney General can file indictment against the perpetrator in the High Court. Those found guilty on criminal charges are either imprisoned or jailed.

8. If the Police authorities or the Attorney General do not take action against the torturers, then the victim can file a Fundamental Rights application in the Supreme Court for cruel, inhuman and degrading treatment by the torturers based on the MLEF and MLR. If found guilty of torture, the Supreme Court will award damages and compensation to the victims.

9. The survivor of torture can also petition the Human Rights Commission (HRC) for violation of

his human rights. The HRC will hold an inquiry and order compensation for damages can also recommend the Public Service Commission to take appropriate disciplinary action against the perpetrator.

10. In all of these stages of redress the MLR is a vital document. Therefore it is mandatory the medical officer submit an accurate report in the MLEF and MLR.

Chapter 3

Torture Methods and Clinical Features

Torture methods change with time. Perpetrators want to inflict maximum pain or fear with minimum physical injuries. Repetitive infliction, infliction at different times, infliction over the unexposed body parts like back and buttocks, injury resisting body parts like soles and providing first aid or medical treatment during or after torture sessions are significant features of torture events.

Knowledge of different torture methods and the spectrum of resulting injuries are of paramount importance for the diagnosis and management of victims. The same method of torture can produce different clinical findings in different victims due to variation of force, nature of the contact, surface of the weapon, health condition of the victim, resistance of the skin, presence of clothes, healing or complications due to delayed presentation etc.

Redness of the skin due to assault and rough handling disappears within a few hours. Abrasions heal within 7-10 days. Contusions usually disappear within two weeks. In dark skinned people like Sri Lankans some deep contusions may leave dark pigmented marks for several years. Lacerations, cuts and second or third degree burns will leave a permanent scar. Superficial cuts healing with primary intention may not leave a visible scar.

For academic convenience, torture methods are divided into physical, psychological and sexual methods. But they frequently overlap. The psychological damage caused as a result of physical and sexual torture may be more severe than the physical effects i.e. bodily injuries.

Following are the different torture methods with important clinical features:

1. **Binding of body parts** wrists, ankles, thumbs, male genitalia may be bound with various ligatures. There may be imprint abrasions related to the pattern of ligature, contusions and in severe cases lacerations around the body part along the course of the ligature. Lawful application of handcuffs may produce linear abrasions around wrists.
2. **Contusions** are common in torture victims because of the frequent use of smooth surfaced weapons (batons, rubber hosepipes). The head is hit on walls frequently. Most bruises initially appear red, blue or dark blue, purple or crimson. As the hemoglobin in the bruise breaks down, the colour gradually changes to violet, green, dark yellow or pale yellow and then disappears. It is very difficult, however, to date (age of the contusion) accurately the occurrence of contusions. In some skin types, this can lead to hyper pigmentation, which can last several years. Contusions that develop in deeper subcutaneous tissues

may not appear until several days after injury, when the extravagated blood has reached the surface. In cases of an allegation but an absence of a contusion, the victim should be re-examined after several days.

a. **Beating** with a long smooth surfaced rod like weapons such as poles, batons, rubber hosepipes will produce tram-line contusions (two parallel contused lines with middle normal color skin) which are commonly seen on buttocks, upper/lower limbs and back. Contusions are more evident in people vulnerable for easy bruising such as thin people, people with more fat tissues, vitamin deficiencies, cirrhotic people and people with bleeding disorders. The shape of the contusion may show the shape of the contact surface of the weapon. The pattern of the contact surface can produce a pattern abrasion. Indirect contusions can be seen in lower body areas due to the gravitation of blood from the direct injury site.

b. **Beatings to the feet (Falanga)** Falanga is the most common term for repeated application of blunt trauma to the feet (or more rarely to the hands or hips), usually applied with a batten, a length of a pipe or similar weapon. The most severe complication of falanga is closed compartment syndrome, which can cause muscle necrosis, vascular obstruction or

gangrene of the distal portion of the foot or toes. In acute cases the victim has difficulty in walking due to pain, swelling and redness of soles. Permanent deformities of the feet are uncommon but do occur, as do fractures of the carpal, metacarpal and phalanges. Because the injuries are usually confined to soft tissue, Falanga may produce chronic disability. Walking may be painful and difficult. The tarsal bones may be fixed (spastic) or have increased motion. Numerous complications and syndromes can occur.

3. **Lacerations** are seen on the scalp and bony points such as hands, feet, elbows, knees or shin. Assault with rough surfaced weapons, assault with more force or fall while running are the common possibilities.

4. **Cuts are uncommon** Self-inflicted cuts and falls on to a broken glass are important possibilities to be excluded as torture.

5. **Burning** is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, these changes may be of diagnostic value. Cigarette burns often leave 5-10 mm in diameter, circular or ovoid, macular scars with a hyper or a hypo pigmented center and a hyper pigmented relatively indistinct periphery. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis.

Burning with hot objects produces markedly atrophic scars which reflect the shape of the instrument and which are sharply demarcated with narrow hypertrophic or hyper pigmented marginal zones corresponding to an initial zone of inflammation. This may for instance, be seen after burning with an electrically heated metal rod or a gas lighter.

Few cases of burning with melted polythene bags (grocery bags) have been reported. In such cases superficial burns with irregular shapes can be seen. It is difficult to make a differential diagnosis if many scars are present. Spontaneously occurring inflammatory processes lack the characteristic marginal zone and only rarely show a pronounced loss of tissue. Burning may result in hypertrophic or keloid scars as is the case following a burn produced by burning rubber.

6. **Nails** may be pulled off. Pins may be inserted in to nail beds. Nails may be deformed due to trauma.

7. **Fractures** If fracture is suspected with severe pain, localized tenderness, inability of movements, localized swelling or deformity, the examinee should be admitted to hospital, radiologically investigated and a surgical referral should be done. Fracture of nasal bones due to punches on face, rib fractures, lower limb and skull are seen more often than other fractures. Some torture victims show old healed fractures to mislead the medical

officer. Re-fracturing of old fractures may occur with minimal force trauma. Radiologically aging of fracture can be performed.

8. **Head trauma** is one of the least common forms of torture. Contusions may be difficult to see in dark-skinned individuals, but will be tender upon palpation. Scalp contusions are better felt than seen. Having been exposed to blows to the head, a torture survivor may complain of continuous headaches. These are often somatic or may be referred from the neck. The victim may claim to suffer pain when touched in that region, and diffuse or local fullness or increased firmness may be observed by means of palpation of the scalp. Scars can be observed in cases where there have been lacerations of the scalp. Hitting on the head after placing a book or some object on the head without causing any obvious injury but persistent headache has been reported in Sri Lanka in recent times.

   Injuries of the head, loss of consciousness, bleeding from ear, nose and throat, vomiting, and cerebrospinal fluid (CSF) leak from nose are important clinical features of severe head injury.

   Headaches may be the initial symptom of an expanding subdural haematoma. They may be associated with the acute onset of mental status changes which requires urgent inward management.

Violent shaking as a form of torture may produce cerebral injury without leaving any external marks, although bruises may be present on the upper chest or shoulders where the victim or his clothing has been grabbed. At its most extreme, shaking can produce injuries identical to those seen in the shaken baby syndrome: cerebral oedema, subdural haematoma and retinal haemorrhages.

More commonly, victims complain of recurrent headaches, disorientation or mental status changes. Shaking episodes are usually brief, only a few minutes or less, but may be repeated many times over a period of days or weeks.

9. **Suspension** is a common form of torture that can produce extreme pain, but which leaves little, if any, visible injury. Peripheral neurological deficits and brachial plexopathy are the dangerous results. Suspension can be applied in various forms:

   a. Cross suspension. Applied by spreading the arms and tying them to a horizontal bar;

   b. Butchery suspension. Applied by fixation of hands upwards, either together or one by one;

   c. Reverse butchery suspension. Applied by fixation of feet upward and the head downward;

   d. "Palestinian" suspension. Applied by suspending the victim with the forearms bound together behind the back, the elbows flexed 90 degrees and the forearms tied to a

horizontal bar. Alternatively, the prisoner is suspended from a ligature tied around the elbows or wrists with the arms behind the back. Paralysis of both upper limbs due to brachial plexus damage is seen frequently.

e. "Darmachakraya" (Parrot perch) suspension. The victim's wrists are tied together and kept over the flexed knees in a sitting position. A bar is passed behind the knees and in front of the elbows. Then the victim is suspended by the ends of the bar and may be rotated and beaten in this suspended position. Abrasions and contusions on the back of the knees and the front of the elbows are seen sometimes. It may produce tears in the cruciate ligaments of the knees. Victims will often be beaten while suspended or otherwise abused.

In nerve damage due to suspension, it is usual for pain and tenderness around the shoulder joints to persist, as the lifting of weight and rotation, especially internal, will cause severe pain many years later.

Complications in the acute period following suspension include weakness of the arms or hands, pain and paresthesia, numbness, insensitivity to touch, superficial pain and loss of tendon reflexes. Intense deep pain may mask muscle weakness.

In the chronic phase, weakness may continue and progress to muscle wasting. Numbness and more frequently, paresthesia

are present. Raising the arms or lifting weight may cause pain, numbness or weakness.

In addition to neurologic injury, there may be tears of the ligaments of the shoulder joints, dislocation of the scapula and muscle injury in the shoulder region. On visual inspection of the back a "winged scapula" (prominent vertebral border of the scapula) may be observed with injury to the long thoracic nerve or dislocation of the scapula.

Neurologic injury is usually asymmetrical in the arms. Brachial plexus injury manifests itself in motor, sensory and reflex dysfunction.

10. **There are many forms of positional torture** all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions, which cause severe pain and may produce injuries to ligaments, tendons, nerves and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiological findings, despite subsequent frequently severe chronic disability. When the victim is kept in a head down position for some time features of positional asphyxia will be seen such as congested eyes with petechial hemorrhages.

11. **Electric shock torture** An electric current is transmitted through electrodes placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips and genital area. Trace electrical

burns are usually a reddish brown circular lesion from 1 to 3 millimeters in diameter, usually without inflammation, which may result in a hyper pigmented scar. Skin surfaces must be carefully examined because the lesions are not often easily visible. A biopsy may show histological features of burning.

12. **Dental torture** may be in the form of breaking or extracting teeth or through the application of electrical current to the teeth. It may result in a loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement and, in some cases, subluxation of this joint due to muscle spasms occurring as a result of blows to the face. Referring the case to an oral and maxillofacial (OMF) surgeon or forensic deontologist is essential.

13. **Asphyxia** Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no mark, and recovery is rapid. Normal respiration might be prevented through such methods as covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, hot peppers, chili powder, etc. This is also known as “dry submarino”. Various complications might develop, such as petechiae of the skin, nose bleeds,

bleeding from the ears, congestion of the face, infections in the mouth and acute or chronic respiratory problems.

Forcible immersion of the head in water, often contaminated with urine, faeces, vomit or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is called “wet submarino”.

In hanging or in other ligature asphyxiation for a short period, patterned abrasions or contusions can often be found on the neck. In severe forms petechial hemorrhages of eye lids are seen. The hyoid bone and laryngeal cartilage may be fractured by partial strangulation or from blows to the neck.

Plastic bag suffocation - Putting a grocery bag over the head and face will produce difficulty in breathing and sometimes even death. Petrol or noxious substances are put in the bag to cause irritation of the respiratory tract.

Different exertions to cause fatigueness of the victim - forcing the victim to stand up, walk, carry weight, jump or to be in one position over a long period like putting the person into a bag and kneeling down.

14. **Trauma to the ear** Slapping both ears simultaneously (telephono) may rupture the ear drums or lacerate the external ear canal. Haemotoma of external ear or canal floor may also be seen.

15. **Trauma to the eyes** black eyes, conjunctival or sub-conjunctival hemorrhage, lens dislocation, retinal hemorrhages.

16. **Sexual Torture:**

    a. Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. An individual is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always a background of potential abuse, rape or sodomy.

    b. Verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects, all part and parcel of the procedure.

    c. Groping of women (searching blindly with hands) is traumatic in all cases and is considered to be torture.

    d. Vaginal torture - Insertion of objects or local irritants (chili powder) has being reported. Patients may have vaginal discharge, vaginitis, and an itchy feeling in the vulva. There may be injuries to the vaginal wall.

    e. In men, electricity and blows generally target the genitals.

    f. Prisoners may be placed naked in cells with family members, friends or total strangers, breaking cultural taboos.

g. Anal torture - anal intercourse or insertion of objects into the anus of either gender can produce pain and bleeding for days or weeks. This often leads to constipation, which can be exacerbated by the poor diet in many places of detention. Gastro- intestinal and urinary symptoms may also occur. In the acute phase, any examination beyond visual inspection may require local or general anaesthesia and should be performed by a specialist. In the chronic phase, several symptoms may persist, and they should be investigated. There may be anal scars of unusual size or position, and these should be documented. Anal fissures may persist for many years, but it is normally impossible to differentiate between those caused by torture and those caused by other mechanisms.

17. Psychological torture

Detainees may be psychologically tortured in the following manner:

a. Making the victim observe or hear other people being tortured.

b. Threatening to kill, rape, or torture family members.

c. Mock execution taking the victim to be killed but bringing him back, asking him to dig his own burial pit, firing a gun without bullets.

d. Preventing sleeping with repeated assaults, interrogation, splashing water.

e. Not providing basic facilities like water, sanitary facilities, sleeping facilities.

f. Keeping the victim in isolation, or in a dark room.

g. Pouring petrol on to the body as if to set fire to it, but doing nothing. Petrol causes irritation of the skin.

h. All the above physical torture methods will also produce psychological effects.

The psychological effects of torture can often be worse than the physical effects, because a person can never recover from torture and might be in such pain and despair, which might even lead them to take their own lives. Individuals who have suffered through an act or acts of torture are permanently scarred from such events and can exhibit some or all of the symptoms below.

a. Re-experiencing the trauma – Acting or feeling like the torture is happening all over again or feeling very upset when something reminds the victim of the torture.

b. Avoidance and emotional numbing – Avoidance of conversations or thoughts that remind the victim of the event, personal detachment, and social withdrawal.

c. Hyper arousal – Difficulty in sleeping, inability to relax or feel comfortable, being afraid that something bad will happen, irritability with outbursts of anger, difficulty concentrating, hyper-vigilance, anxiety, and

shortness of breath, dry mouth and gastrointestinal distress.

d. Symptoms of anxiety and depression:

- depressed mood
- appetite disturbance and weight loss
- insomnia or hypersomnia
- fatigue and loss of energy
- feelings of worthlessness and excessive guilt
- difficulty recalling memory
- thoughts of death or dying or suicidal ideas
- attempted suicide
- feeling like you do not care about life or what happens to you
- feeling sad or angry often
- feeling like you are not interested in things.

e. Dissociation/detachment and depersonalization

f. Psychosis – Delusions, hallucinations, bizarre behavior, and paranoia.

g. Substance abuse – Alcohol and drug abuse can occur as it help victims forget about traumatic events and to manage anxiety.

The symptoms described above are sometimes referred to as acute stress disorder or Post Traumatic Stress Disorder (PTSD) and are very often seen in victims of torture, war veterans and others who have witnessed or experienced traumatic events. PTSD sufferers may also experience serious neurobiological changes including:

a. Changes in the body's ability to respond to stress through alterations in stress hormones.

b. Changes in attention and arousal through changes in the neurotransmitter system.

c. Development of an imbalance in the noradrenergic system.

d. Heightened psychophysiological arousal and reactivity.

f. Possible changes in the hippocampus, an area of the brain related to contextual memory.

Rape and sexual assault during torture deserves particular mention as it is highly correlated with the subsequent development of psychological problems and high rates of PTSD. Most of the literature on rape as a form of torture pertains to women and there is little documented research on men. High levels of PTSD, depression and suicidal tendencies, feelings of powerlessness, loss of control and vulnerability are common as a result.

Chapter 4

Presentation of Torture Survivors for Medico Legal Examination in Sri Lanka

In Sri Lanka detainees and survivors of alleged torture can be presented to the Medico Legal Examiner in the following ways:

1. Produced by the same police station that issued the MLEF as a legitimate detainee before producing before the Magistrate.
2. Presented on his/her own with the MLEF issued by another police station on the order issued by a high ranking police officer.
3. Admitted to the hospital and then referred with the MLEF.
4. Admitted to hospital and referred by another consultant without the MLEF.
5. Admitted to private hospital and referred by the same hospital with or without the MLEF.
6. Referred by court on an order of a Magistrate or High Court Judge.
7. Referred by the Supreme Court in Fundamental Rights Application.
8. Referred by the Human Rights Commission.

9. Referred by the Prison Medical Officer with or without the MLEF.

In the case of 4 and 5, it is advisable to inform the Police and get the MLEF issued. However non-availability of an MLEF should not be taken as a reason for delaying medico legal examination.

General Consideration

1. Obtain informed written consent from the examinee.
2. Obtain thumb imprint of the examinee especially if examinee was produced by the police.
3. No enforcement officers should be present inside the room at the time of examination.
4. No handcuffs or blindfolds should be allowed during the examination.
5. No examination should be carried out inside vehicles.
6. If the examination is done at night at the place of on call other than the hospital there should be an appropriate place with good lighting and seating facilities for the examinee and the doctor. At present in some hospitals medico legal practitioners stay at their official quarters and residencies during night on call.
7. Do not examine injuries at night but admit the examinees to the closest hospital after examining them for consumption of alcohol. If advice was given to admit the examinee then get the signature of the police officer who

produced the examinee to prove that he was informed about the necessity of admission of examinee.

8. If the examination was done without the MLEF, advice the examinee the best method to get it issued in his/her name. When the MLEF is issued the doctor has to attend to it subsequently.

9. When a referral has been made and the examinee is to be taken by the police officer to a particular consultant, take the signature of the police officer to prove that he duly received the advice on referral and also to bring back the report from the specialist to whom the examinee was referred to.

10. If the doctor thinks that the presence of injuries on the examinee and the information gathered from the detainee should not be divulged to the producing police officer as it may cause more torture, a copy of the MLEF should not be given to the officer concerned but it can be handed over to the police station later in routine manner.

11. If the examinee denies any torture it should be noted and it is advisable to examines the person for injuries even in a case of denial.

12. Cases that should preferably be seen by a specialist in forensic medicine are:

a. Considerable time has lapsed after the alleged incident.

b. The alleged torture occurred in the same police area

where the doctor is working.

c. If the doctor has any conflict of interest in relation to victim or perpetrator.

d. Sensitive cases of national or local interest.

e. At the request of the examinee.

Chapter 5

Protocol for the Examination of Detainees and Torture Victims

1. Date, time and place of examination should be noted.

2. From the Officer producing the detainee to be examined:

a. Identity of the officer producing the detainee/torture victim for examination.

b. A brief history from the officer as to why the detainee is produced and the purpose of examination.

c. An explanation for the presence of injuries and the clinical state of the detainee.

3. From the detainee:

a. Identification of the examinee (detainee):

- Name, Age, Sex, Occupation and Address of the examinee.
- The NIC number or number of any other identification document. (Passport, Driver's license)
- Ideally obtain the left thumb impression to prevent the allegation or possibility of impersonation by the law enforcing authorities.

c. Consent: Obtain the written informed consent on the reverse side of the Medical Officer's copy of the MLEF after explaining to the detainee the nature of the examination and submission of the report to relevant

authorities where the same findings may be used as evidence supportive or against the examinee.

4. Reference details (check whether all details are in order).

a. MLEF number, date of issue, police station of issue, signature of the officer who issued the MLEF.

b. Number of the case, name of the organization and date of trial if referred by the courts or HRC.

5. History from the examinee (detainee or torture survivor):

a. No police officer, prison official or any other official producing the victim must be present during the history taking or examination.

b. A translator is allowed if the victim does not understand the examiner's language. The translator should be preferably from the hospital staff and the identity of the translator must be noted.

c. Details of the arrest, where and by whom?

d. Means and ways of transportation.

e. Place/places of detention.

f. If assaulted/tortured: details of each method of torture and each torture session.

- When
- By whom

- Weapons used
- Method of torture
- Where
- Signs and problems felt during the torture

g. Treatment given for injuries sustained during the torture/assault.

h. Presenting complaints.

i. Present and past illnesses of victim including psychiatric diseases.

j. Social history including alcoholism and substance use.

6. Examination

Avoid examination at night. However, such examination may be carried out in an emergency situation to reveal the consumption of alcohol. The review and the examination of injuries should be carried out the following morning:

General examination

- Height, weight, build, complexion.
- Whether the victim walks on his own, or is aided by officers into the examination room.
- Demeanor of the victim.
- No examination should be carried out if the victim is handcuffed or blindfolded.
- Even if the victim denies any assault or torture, he/she should be examined for injuries and scars of

injuries.

Skin

- Includes the entire body surface.
- Generalized skin diseases, chicken pox scars, lesions inflicted by torture such as abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal, etc.
- Torture lesions should be described by their site, size, shape, symmetry, colour and surface (e.g. scaly, crusty, and ulcerating), features of healing/ complications, as well as their demarcation and level in relation to the surrounding skin.

Head and face

- Scalp and facial tissue should be palpated for evidence of tenderness, swelling, crepitation, fracture, etc.

Eyes

- There are many forms of trauma to the eyes, including conjunctival hemorrhage, lens dislocation, subhyeloid hemorrhage, retro bulbar hemorrhage, retinal hemorrhage and visual field loss, etc.
- Refer cases of eye trauma to an Eye Specialist.

Ears

- Trauma to the ears, especially rupture of the tympanic membrane, is a frequent consequence of

harsh beatings/slapping.

- The ear canals and tympanic membranes should be examined with an auroscope and injuries, bleeding, etc. should be described.
- Since chronic otitis media with discharge is common in people, it is important to diagnose acute perforation. Presence of a blood clot will be very helpful for diagnosis. Percentage of perforation is helpful for categorization of hurt.

Nose

- The nose should be evaluated for alignment, swelling, tenderness, crepitation, deviation of the nasal septum, bleeding inside, etc.
- Refer such cases to an ENT surgeon.

Jaw, oropharynx and neck

- Mandibular fractures or dislocations may result from beatings.
- Temporo-mandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw.
- The patient should be examined for evidence of crepitation over the hyoid bone or laryngeal cartilage resulting from blows to the neck.
- Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electrical shock or other trauma.
- Gingival hemorrhage and the condition of the gums

should also be noted.

Oral cavity and teeth

- Dental care may be purposefully withheld to allow caries, gingivitis or tooth abscesses to worsen.
- Tooth avulsions, fractures of the teeth, dislocated fillings and broken prostheses subluxation may result from direct trauma or electric shock torture.
- Oral hygiene should be noted.
- Dental caries and gingivitis should be noted.
- Poor quality dentition may be due to conditions in detention or may have preceded the detention.
- The oral cavity must be carefully examined including palate, bucal mucosa and inner aspects of lips.
- During application of an electric current, the tongue, gums or lips may be bitten.
- Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current.
- Refer such cases to OMF surgeons.

Chest and abdomen

- Examination of the trunk, in addition to noting lesions of the skin, should be directed towards detecting regions of tenderness or discomfort that would reflect underlying injuries of the musculature, ribs or abdominal organs.
- The examiner must consider the possibility of

intramuscular, retroperitoneal and intra-abdominal haematoma, as well as laceration or rupture of an internal organ.

- Routine examination of the cardiovascular system, lungs and abdomen should be performed in the usual manner.
- X-rays of the chest, spine and abdomen may have to be done.

Musculo-skeletal system

- Physical examination of the skeleton should include testing for mobility of joints, the spine and the extremities.
- Pain with motion, contracture, strength, evidence of compartment syndrome, fractures with or without deformity and dislocations should all be noted.
- X-rays of suspected fractures, dislocations and deformities has to done.

Genito-urinary system

- Genital examination should be performed only with the consent of the patient. A chaperone of the examinee's gender must be present.

Injuries following sexual abuse

a. In females

- Injuries to para-sexual areas - breasts, lips, thighs
- Genital injuries - Perineum, posterior fourchette,

labia majora, labia minora, hymen, vagina.

- Injuries to genital tract and anus following insertion of foreign objects.
- Presence of foreign bodies.
- Refer such cases to VOG.

b. In males

- Injuries including swelling and tenderness should be examined in the scrotum, testes, epididymis, cords, and penile shaft, prepuce, glance penis, frenulum and also in the anus.

On examination of the anus, the following findings should be looked for and documented:

- Fissures tend to be non-specific findings as they can occur in a number of "normal" situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are a more specific finding and can be considered as evidence of penetration;
- Rectal tears with or without bleeding may be noted;
- Disruption of the rugae pattern may manifest as smooth fan-shaped scarring.
- Skin tags, which can be the result of healing trauma;
- Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a

discharge is noted. Insertion of a barbed wire through a plastic pipe to the anus and subsequent removal of the plastic pipe has been reported. The barbed wire is pulled while in interrogation. This leads to multiple anal and rectal tears or cuts.

- Application of irritants to the anus and glance penis (chilies, kochchi or pepper) may cause burning pain. Refer such cases to a Genito-Urinary Surgeon.

Central and peripheral nervous systems

- The neurological examination should evaluate the cranial nerves, sensory organs and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin deficiencies, disease, etc.
- In patients who report being suspended, special emphasis on examination for brachial plexopathy (asymmetrical hand strength, wrist drop, arm weakness with variable sensory and tendon reflexes) is necessary.
- Radiculopathies, hyperalgesia, paresthesia, hyperaesthesia, change in position, temperature sensation, motor function, gait and coordination may all result from trauma associated with torture. In patients with a history of dizziness and vomiting, a vestibular examination should be conducted, and evidence of nystagmus noted.

7. Photo-documentation:

- Photo-documentation is advisable whenever possible.
- A measuring scale should be kept at the level of the injury. The photo should include the serial number or the encrypted date and time and preferably a colour code. The lens of the camera should be kept parallel to the injury to minimize disproportionation unless it is indicated.
- A close up to get more details of the injury and a moderately distant one to locate the injury are advised/beneficial.
- Photo-documentation of patterned injuries are very useful as it documents most of the features which may be difficult to explain.
- It is useful in obtaining 2nd specialized opinion if necessary.

8. Investigations and referrals

Investigations and referrals are performed as indicated and some are mentioned below:

a. X-rays, tests for pregnancy, scans (US, CT, MRI, etc.), audiograms, etc.

b. Consultant psychiatrist, consultant radiologist, consultant obstetrician, venerologist, consultant OMF surgeon. Forensic odontologist, dental surgeon, eye surgeon, ENT surgeon, orthopedic surgeon, general surgeon, etc.

c. It is important to evaluate the psychological status by referring to a consultant psychiatrist, if any symptoms of psychological disturbances are present.

d. Obtaining an opinion from a Consultant Judicial Medical Officer of the district is advisable and reference may be necessary in complex situations.

e. In a case of referral or investigations make sure that the producing officer is aware of such referral and investigation by getting his signature in the doctor's copy of the MLEF or in the copy of the referral letter.

9. Review

a. Re-examination of the examinee may be necessary especially to assess the delayed effects of some injuries, scarring etc.

b. Consider the reports of the specialists to whom the victims were referred.

c. At times detainees and torture survivors are subjected to repeated assault after the initial examination by a doctor resulting in "fresh injuries".

10. The Duly completed Police copy of the **Medico-Legal Examination Form** (MLEF) should be handed over after the examination to the police unless review, referrals or investigations are planned. The medical officer's copy of the MLEF should be filed and kept with the doctor for future reference and to prepare a MLR later. Please note that the examining doctor is responsible for this copy.

11. Fitness of detainee

Persons with the following conditions should be referred to the closest hospital for indoor or OPD management. Necessity of admission or referral to hospital for treatment should be clearly mentioned in the remarks column of the MLEF and the signature of the producing officer should be obtained to prove that the officer is aware of such recommendation.

a. Presence of injuries or acute illness requiring treatment. (specially refer to head injuries)

b. Presence of natural diseases such as Ischaemic Heart Diseases, Hypertension, Bronchial Asthma.

c. Any other grievous symptoms of natural diseases like fever, severe cough, diarrhea, confusion, vomiting etc.

12. Medical recommendations on detention conditions

If any special attention is necessary while in detention, it should be noted in the remarks column. Ex: special diet in diabetes mellitus. Regular drugs in IHD, HT, DM and etc.

13. Medico Legal Report (MLR)

The MLR is sent when the doctor receives summons from the court of law or the Human Rights Commission to do so. The victim is entitled to have a medico legal

report on his injuries at any time after the examination at his request. The victim or representing lawyer can have a copy of the MLR which has already been sent to courts on request. The doctor can charge a professional fee stipulated by the government for issuing such a report. However, the accused party should not be furnished a copy of the report as they can obtain it from the court of law.