

**Guidelines for Medico-Legal Examination in
Police Custody and Documenting
Custodial Torture**



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Aaram Society Road,

Vakola, Santacruz (E),

Mumbai 400055

Tel.: (91) (22) 26673154, 26673571

Fax: (91) 26673154

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List of Contributors

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|---------------------------|--|
| 1. Aarthi Chandrasekhar | Researcher, CEHAT |
| 2. Anand Grover | Lawyers Collective |
| 3. Baljeet Kaur | Researcher, Quill Foundation |
| 4. Devika Prasad | Commonwealth Human Rights Initiative (CHRI) |
| 5. Dolphy D'Souza | Commonwealth Human Rights Initiative (CHRI) |
| 6. Indrajit Khandekar | Prof. Forensic Medicine MGIMS, Sevagram |
| 7. Jagadeesh N. Reddy | Prof & HOD Forensic Medicine, Bangalore |
| 8. Jayshree Bajoria | Human Rights Watch (HRW) |
| 9. Karunakaran Mathiharan | Prof. Forensic Medicine |
| 10. Kurity Roy | Masum, West Bengal |
| 11. M. Rakesh | Director, Human Rights Law Network (HRLN), Manipur |
| 12. Manisha Tulpule | Advocate |
| 13. Meena Savjani | M.O. Rajawadi Hospital, Mumbai |
| 14. Padma Deosthali | Senior Advisor, CEHAT |
| 15. R. Karunanidhi | Advocate, Peoples Watch Madurai, Tamilnadu |
| 16. Sangeeta Rege | Coordinator, CEHAT |
| 17. Sharib Ali | Program Head, Quill Foundation |

List of External Reviewers

- | | |
|-----------------------|---|
| 1. Anup Surendranath | National Law University Delhi (NLUD) |
| 2. James Lin | International Rehabilitation Council for Torture Victims (IRCT) |
| 3. Mrinal Satish | National Law University Delhi (NLUD) |
| 4. Neetika Vishwanath | National Law University Delhi (NLUD) |

List of Abbreviations

BP	Blood Pressure
CrPC	Criminal Procedure Code
CT	Computerised Tomography
DNA	Deoxyribonucleic Acid
ECG	Electrocardiography
FSL	Forensic Science Laboratory
HCP	Healthcare Provider
HIV	Human Immunodeficiency Virus
HBsAg	Hepatitis B surface Antigen
IEA	Indian Evidence Act
IPD	Indoor Patient Department
MoHFW	Ministry of Health and Family Welfare
MLC	Medico Legal Case
MTP	Medical Termination of Pregnancy
OPD	Outpatient Department
PC	Police Constable
PoC	Products of Conception
PEP	Post Exposure Prophylaxis
RMP	Registered Medical Practitioner
STI	Sexually Transmitted Infections
UNCAT	United Nations Convention Against Torture
UPT	Urine Pregnancy Test
VDRL	Venereal Disease Research Laboratory

Introduction

Deaths of criminal suspects in custody occurs too often in India. In response to this longstanding problem, Indian authorities including the courts and the National Human Rights Commission have set out detailed procedures to prevent and punish police use of torture and ill-treatment. However, Indian police still often torture suspects to punish them, gather information, or coerce confessions.¹

The World Medical Association of Tokyo, 1975, defines torture as “deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.”²

The United Nations Convention against Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 defines it as:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on 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 of having 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. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.³

Torture causes pain and suffering, and is intentionally inflicted with a purpose by a person in official capacity. It may be verbal, psychological, physical or sexual in nature and may be inflicted concurrently. Torture may also be used as a tool for discrimination against vulnerable and marginalized populations such as Dalits, Adivasis, women, and children.

The prohibition against torture is well-grounded in Indian law. India’s constitution guarantees fundamental human rights to all, including right to life and liberty. The Supreme Court has over the years sought to ensure adherence to these fundamental rights by requiring that all state action be just, fair, and reasonable.⁴ In a 1981 decision, the court stated:

No law which authorises and no procedure which leads to such torture or cruelty, inhuman or degrading treatment can ever stand the test of reasonableness and non-arbitrariness: it would plainly be unconstitutional and void as being violative of Article 14 and 21.⁵

¹ Bajoria, J. (2016, December 19). “Bound by Brotherhood”: India’s failure to end killings in police custody, Human Rights Watch. Retrieved from <https://www.hrw.org/report/2016/12/19/bound-brotherhood/indias-failure-end-killings-police-custody>.

² World Medical Association. (2016). *WMA declaration of Tokyo: Guidelines for physicians concerning torture and other cruel inhuman or degrading treatment or punishment in relation to detention and imprisonment*. France: World Medical Association Retrieved from <https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/>

³ United Nations Human Rights. (1987). *Convention against torture and other cruel, inhuman or degrading treatment or punishment: Adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, in accordance with article 27 (1)*. Geneva: United Nations Human Rights, Office of the High Commissioner. Retrieved from <https://www.ohchr.org/en/professionalinterest/pages/cat.aspx>

⁴ Ramakrishnan, N. (2013). *In custody: Law, impunity and prisoner abuse in South Asia*. New Delhi: Sage Publications India Pvt. Ltd.

⁵ Supreme Court of India (1981, January 13) *Francis Coralie Mullin v. Union Territory of Delhi*. New Delhi: Supreme Court of India. Retrieved from <http://indiankanoon.org/doc/7853>

In its various judgments, the Supreme Court has laid down directives for law enforcement that deal with various aspects of police work, including registering cases, treatment of arrested persons, and conducting interrogations. One such landmark judgment is the 1997 *D.K. Basu v. State of West Bengal* decision, in which the Supreme Court recognized the prevalence of custodial torture: "Experience show that worst violations of human rights take place during the course of investigation, when the police with a view to secure evidence or confession often resorts to third-degree methods including torture."⁶ In this ruling, the Court gave several directions for those arrested or detained, including regarding medical examinations to prevent and detect torture:

- The arrestee should, where he so requests, be also examined at the time of his arrest and major and minor injuries, if present on his/her body, must be recorded at that time. The 'Inspection Memo' must be signed both by the arrestee and the police officer effecting the arrest and its copy provided to the arrestee.
- The arrestee should be subjected to medical examination by a trained doctor every 48 hours during his detention in custody by a doctor on the panel of approved doctors appointed by the Director, Health Services of the concerned State or Union Territory.

The Code of Criminal Procedure, through various amendments, incorporated most of the Supreme Court guidelines, including the right of the detained/ arrested to be medically examined under section 54.⁷

The courts have also provided directives for police on issues such as protection of the rights of women, the poor, and the disadvantaged.⁸

India has ratified the International Covenant on Civil and Political Rights which prohibits torture.⁹ India has also signed but is yet to ratify the International Convention against Enforced Disappearance, which seeks to deter torture and other grave abuses.¹⁰

India is a signatory to the United Nations Convention against Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) since 1997, but has not ratified it despite recommendations from the Law Commission and National Human Rights Commission to do so.*

⁶ Supreme Court of India (1996, December 18). *D.K. Basu, Ashok K. Johari v. State of West Bengal, State of U.P.* New Delhi: Supreme Court of India. Retrieved from <https://indiankanoon.org/doc/501198/>

⁷ Supreme Court of India (2009, January 7). The Code of Criminal Procedure (Amendment) Act, 2009, Act No. 5 of 2009, s.54 on examination of arrested person by medical officer. New Delhi: Supreme court of India. Retrieved from <https://www.casemine.com/act/in/5a979da24a93263ca60b7195>

⁸ Tiwana, M. & Daruwala, M. (Ed.). (2005). *Human rights and policing: Landmark Supreme court directives and National Human Rights Commission guidelines*. New Delhi: Commonwealth Human Rights Initiative. Retrieved from http://www.humanrightsinitiative.org/publications/hrc/humanrights_policing.pdf

⁹ United Nations. (1976). *International covenant on civil and political rights (ICCPR)*, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force Mar. 23, 1976. New York: United Nations. Retrieved from <https://www.globalhealthrights.org/instrument/international-covenant-on-civil-and-political-rights-iccpr/>

¹⁰ United Nations Human Rights. (n.d.). *International convention for the protection of all persons from enforced disappearance*. New York/Geneva: United Nations Human Rights: Office of the High Commissioner. Retrieved from <https://www.ohchr.org/en/hrbodies/ced/pages/conventionced.aspx>

* Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, art. 1. As a signatory that has not ratified the Convention against Torture, India is not legally bound to implement the provisions of the treaty but cannot act to defeat its object and purpose. Vienna Convention on the Law of Treaties, concluded May 23, 1969, 1155 U.N.T.S. 331, entered into force January 27, 1980, art. 18. National Human Rights Commission, Annual report 2015-2016 http://nhrc.nic.in/Documents/AR/NHRC_AR_EN_2015-2016.pdf

At successive Universal Periodic Reviews at the United Nations Human Rights Council in 2008, 2012, and 2017, several countries recommended that India ratify UNCAT. Successive Indian governments have accepted the recommendations but failed to take action.

India has no specific law to address torture, nor is there a law for witness and victim protection. Victims are under great pressure not to report the torture. However, according to the Supreme Court of India, "international law has to be construed as a part of domestic law in the absence of legislation to the contrary and, perhaps more significantly, the meaning of constitutional guarantees must be illuminated by the content of international conventions to which India is a party."¹¹

In 2017, the Law Commission of India drafted the "Prevention of Torture Bill" and submitted a report recommending that the government ratify UNCAT. It also recommended that the government enact a law on torture to strengthen the mechanism of prevention, protection and redressal of torture according to provisions of Indian Constitution and international conventions. The Law Commission defined torture as including intentional or voluntarily inflicting grievous hurt, danger to life, limb or health, severe pain or suffering including physical and mental suffering caused through cruel, degrading treatment and death. However, this recognition of mental pain or suffering is contradicted in explanation III of section 3 that states that "mere mental agony or tension arising due to coercion shall not constitute the offence of torture."¹²

The bill calls for proper medical examination of every person remanded to judicial custody and the report be sent to the concerned trial court. Any law dealing with torture should also lay out the therapeutic role of health professionals, with emphasis on treatment and care for the person being examined.

Guidelines for mandatory medical examinations of those in police custody can help detect torture and act as a deterrent to police abuse. Evidence collected as part of these examinations can help toward accountability for violations by police. Early detection also means that the survivors can get therapeutic care, including psychological support, and steps can be taken to remove them from custody of perpetrators to prevent further torture. Healthcare providers are in a critical position to identify signs of torture based on health complaints presented to them.

Medico-legal documentation of clinical findings with a reasoned medical opinion has evidentiary value. Currently, India does not have guidelines for a standardized medical examination for those detained in police custody or in prison. There is no standardized proforma for such a medical examination either. This document aims to provide uniform, gender-sensitive guidelines for the medico-legal examination of those in police custody and documentation of custodial torture.

This document has been prepared based on international standards set by the Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1999)¹³ and Guidelines and Protocols for medico-legal care for

¹¹ Supreme Court of India (2017, August 24). *Justice K.S. Puttaswamy (Retd.) & Anr. v. Union of India & Ors.* New Delhi: Supreme Court of India. Retrieved from <https://indiankanoon.org/doc/91938676/>

¹² Law Commission of India. (2017). *Implementation of 'United Nations Convention against torture and other cruel, inhuman and degrading treatment or punishment' through legislation: Report no. 273.* New Delhi: Government of India. Retrieved from <http://lawcommissionofindia.nic.in/reports/Report273.pdf>

¹³ United Nations Human Rights. (2004). *Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment: Professional training series No. 8/ Rev.1.* New York/Geneva: United Nations Human Rights: Office of the High Commissioner. Retrieved from <https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

survivors/ victims of Sexual Violence laid down by the Ministry of Health and Family Welfare, Government of India (2014).¹⁴

Role of Healthcare Providers

Torture has both short and long-term consequences on the physical, mental and social health of the survivor. Healthcare providers have a dual role when it comes to responding to torture. Apart from collecting forensic evidence for use during any criminal investigation and prosecution, they are required to provide therapeutic care to patients. Their role is to arrive at the scientific truth as an independent professional.

Therapeutic care includes provision of both mental and physical health services in a non-discriminatory manner, ensuring accessibility, and high quality of care. Treatment should be provided, including first-line psychological support while ensuring privacy, dignity, and autonomy of the individual. This must be provided irrespective of whether the individual is an accused or convicted of a crime.

Medical examination reports including treatment prescriptions have evidentiary value in cases of torture and ill-treatment. Mere provision of treatment without documenting torture and reporting the act implies indirect involvement in torture on part of medical professionals.

Table Indicative of Findings Based on Forms of Torture¹⁵

The table below is indicative of the health consequences and medical examination that would be required, guided by history of torture. This is not an exhaustive list of the forms of torture that may be used. The healthcare provider must corroborate findings with history given by the patient indicating degree of consistency with the trauma described and whether it is typical of or diagnostic of the trauma. However, emphasis must be on overall evaluation rather than specific correlation of each finding with a particular form of torture.

Technique of torture	Findings	Health consequence
Prolonged application of tight ligatures	Linear zone (abrasion or contusion) extending circularly around the arm or leg, usually at the wrist or ankle.	Cicatricial alopecia
Superficial scraping	Abrasions	Scratches, brush-burn type lesions or larger scraped lesions
Tight tying together of hands	Single or multiple number of deep abrasions	Areas of hypo or hyperpigmentation especially on the inside of wrists (may last for a long period of time)
Blunt force – patterned contusions reflect contours of the instrument used.	Contusions (may be patterned) and bruises	Nutritional deficiencies associated with easy bruising or purpura

¹⁴ Ministry of Health and Family Welfare. (2014). *Guidelines & protocols: for medico-legal care for survivors/ victims of sexual violence*. New Delhi: Ministry of Health and Family Welfare, Government of India. Retrieved from <https://main.mohfw.gov.in/sites/default/files/953522324.pdf>

¹⁵ *Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment*, pp. 37-44

Use of pressure or blunt force – compressing the skin between the blunt object and bone surface	Lacerations, tearing or crushing of the skin on protruding parts of the body	
Deliberate use of force	Asymmetrical scars, scars in unusual locations, diffuse spread of scarring	
Whipping	Scars/healed lacerations	Depigmented scars, often hypertrophic, surrounded by narrow, hyperpigmented stripes
Beatings to the chest	Lacerations of the lung	Possible pneumothorax
Blunt trauma to the feet – use of baton (<i>lathi</i>)/ pipe	Pain while walking or on touching the feet, fracture of the carpal/ metacarpal/ phalanges, gangrene of the distal portion of foot or toes	Muscle necrosis, vascular obstruction Complications such as closed compartment syndrome, crushed heel and anterior footpads, rupture of connective tissue bands and rupture of plantar aponeurosis and tendons of the foot, plantar fasciitis
Cigarette burns	5-10 mm long, circular or ovoid, macular scars with hypo or hyperpigmented center and hyperpigmented relatively indistinct periphery	Permanent changes on the skin which may be of diagnostic value
Burning of tattoos with cigarettes	Correlating characteristic shape of the resulting scar and tattoo remnants	
Burning with hot objects such as electrically heated metal rod or a gas lighter	Atrophic scars which reflect the shape of the instrument and which are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation	Hypertrophic or keloid scars (similar to a burn produced by burning rubber)
Burning of nail matrix	Subsequent growth of striped, thin, deformed nails which may be broken up in longitudinal segments	Deformed nails
Pulling off of nails	Overgrowth of nail tissue from proximal nail fold	Pterygium formation (changes in the nail caused by Lichen planus will usually be accompanied by widespread skin injury and fungal infections are characterized by thickened, yellowish,

		crumbling nails which are different in nature)
Sharp trauma by knife, bayonet, broken glass; application of noxious substances to open wounds (such as salt, chili powder)	Stab wounds, incised or cut wounds, puncture wounds	Possible hypertrophic scars (caused by noxious substances on open wounds)
Use of blunt mechanical force on vector planes	Fractures	Distinguished radiological appearance of inflicted fracture
Beatings to the chest	Rib fractures	
Direct and indirect trauma to the head – blows to the head	Headaches and pains	Cortical Atrophy, diffuse axonal damage – contrecoup lesions of the brain in case of falls and contusions of the brain directly under the region in which trauma is inflicted in case of direct trauma Chronic headaches and localized pain which may be associated with expanding subdural haematoma (may be associated with acute onset of mental status changes)
Violent shaking	Possible presence of bruises on the upper chest or shoulders where the victim or his/her clothing was grabbed Complaints of recurrent headaches, disorientation or mental status changes	Cerebral injury with no external marks Extreme shaking can cause injuries identical to shaken baby syndrome – cerebral edema, subdural hematoma, retinal haemorrhages
Holding of abdomen while shaking	Acute abdominal trauma	Abdominal organ injury and urinary tract injury (findings may be negative)
Suspension Cross suspension - tying of arms to a horizontal bar Butchery suspension - upward fixation of hands Reverse butchery suspension - suspension with feet upward and head downward Palestinian suspension - suspension after tying forearms behind the back Parrot perch - suspension from a	Acute phase: Extreme pain/ chronic pain and tenderness around shoulder joints, weakness of the arms or hands, pain and paresthesia's, numbness, insensitivity to touch, tendon reflex loss Chronic phase: muscle atrophy, paresthesia, neurologic injury, ligament tears and dislocation. Winged scapula upon visual inspection – prominent vertebral	Permanent brachial plexus injury manifested in motor, sensory (tested through perception of heat and cold) reflex dysfunction Tears in cruciate ligaments of the knees

bar passed below the popliteal region after tying wrists to the ankles	border of the scapula with injury to the long thoracic nerve or dislocation of the scapula	
Use of electric shock	Trace electrical burns – reddish brown circular lesion 1-3mm in diameter usually without inflammation resulting in hyperpigmented scar	Pain in the muscle along the route of the electric current
Breaking or extracting teeth, application of electric current to teeth	Swelling of gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures, loss of fillings from teeth, loss of teeth, broken teeth	Temporomandibular joint syndrome
Near asphyxiation caused by covering mouth and nose, pressure or ligature around the neck, forced inhalation of dust, cement, chili powder, covering the head with plastic bag Forcible immersion of head in water contaminated with urine, feces, vomit, other impurities, aspiration of water into the lungs		Petechiae of skin, nosebleeds, bleeding from ears, congestion of face, infections in the mouth, Acute or chronic respiratory problems. Aspiration of water into the lungs may cause pneumonia
Hanging or ligature asphyxiation	Patterned abrasions or contusions on the neck	Fracture of the hyoid bone and laryngeal cartilages
Sexual torture – forced nudity, verbal sexual threats, abuse and mocking of a sexual nature, groping of women, crushing, wringing or pulling of the scrotum among men, forced anal penetration	STI, pregnancy among women Testicular torsion among men – late sequelae of lesion may be found (infarction of the testis)	Pain/sensitivity in genital and anal region, constipation, sexual Dysfunction, testicular torsion resulting from trauma to the scrotum, atrophy of the testes

The healthcare provider must infer the probable shape of the object from the shape of the bruise and document the description.

Physical examination of blunt trauma to the feet during the acute phase must be diagnostic. Continuous headaches may be the initial symptom of an expanding subdural haematoma, possibly associated with the acute onset of mental status changes; this may require psychological or neuropsychological assessment.

Ethical Principles

Healthcare professionals (HCP) must adhere to highest standards of ethics in carrying out their role, guided by four main principles of health care ethics.¹⁶

¹⁶ Beauchamp, T. L. & Childress, J. F. (2013). *Principles of Biomedical Ethics* (7th ed.). Oxford: Oxford University Press

- **Autonomy:** The patient has the right to make an informed decision, after being explained the consequences and benefits of the procedure. The patient must be allowed control over his/ her own body. The HCP must maintain confidentiality of information and also seek informed consent at every step of medical care.
- **Beneficence:** The HCP must do everything possible for the well-being of the patient in every situation, with a complete understanding of the unique situation that the patient is in.
- **Non-maleficence:** The HCP must be guided by the Hippocratic oath of “do no harm,” irrespective of the background of the patient and also considering the medical condition of the patient.
- **Justice:** The HCP must ensure fairness in his/her practice with regard to patient’s access to healthcare and distribution of resources to the patient.

Failure to document torture implies complicity in dealing with torture cases, albeit in an indirect manner and amounts to breach of medical ethics by the doctor.

Application of knowledge and skills to assist in interrogation, causing adverse effects on the mental and physical health of prisoners or detainees is in contravention to medical ethics.¹⁷

The World Medical Association’s International code of medical ethics in the Declaration of Hamburg specifically spells out the responsibility of the medical profession in resisting pressure to act contrary to the ethical principles and to support those who resist such pressure.¹⁸

Access to Healthcare

A person detained in police or judicial custody has access to a health facility in the following ways:

- Brought by police: The patient may be brought to the hospital either for mandatory physical examination soon after being taken into custody or for routine medical check-up while in custody.
- Through a court directive for medical examination.
- Those in judicial custody may approach the prison doctor.
- The patient may approach the hospital of their own accord upon release on bail or acquittal for treatment of health consequences of torture experienced during detention. The patient may or may not disclose torture to the HCP, but the HCP must be alert to the possibility of torture based on complaints presented.

In each of the above, the HCP must rule out torture while in detention or custody; and if presence of torture is noted, the HCP must document and treat the same. Those in solitary confinement must receive daily visits from the medical officer during the period of confinement.¹⁹ The HCP should seek earlier medical records of previous medical examination and treatment so as to ensure comprehensive care.

¹⁷ United Nations Human Rights. (1982, December 18). *Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment: adopted by General Assembly resolution 37/194 of 18 December 1982*. New York/Geneva: United Nations Human Rights: Office of the High Commissioner. Retrieved from <https://www.ohchr.org/en/ProfessionalInterest/Pages/medicalethics.aspx> (accessed August 8, 2018).

¹⁸ World Medical Association. (1997). *WMA International code of medical ethics*. France: World Medical Association. Retrieved from <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/>

¹⁹ Supreme Court of India (1978, August 30). *Sunil Batra etc v. Delhi Administration and Ors. etc* New Delhi: Supreme Court of India. Retrieved from <https://indiankanoon.org/doc/162242/>

Responding to Vulnerable Groups

Torture is not limited to men in custody. Women and transgender persons are also vulnerable to torture. Due to the marginalization and discrimination they face, lesbian, gay, bisexual, transgender, queer, and intersex persons are especially vulnerable to torture of a sexual nature. The health care provider must be sensitised and aware of the variations in gender identity and biology so as not to pathologize them. Pathologizing will result in perpetuating myths and preconceived notions about such persons and impede access to comprehensive healthcare.

Men, women and transgender persons may be involved in sex work, although sex work is associated mostly with women. Any individual involved in sex work has the right to decide with whom they will have sex. Abuse of such persons by police is a common occurrence. Police often conduct raids on brothels and detain sex workers at the police station. During this period of detention, sex workers are highly vulnerable to sexual torture. Healthcare providers must be sensitive to the problems of sex workers and must document any form of torture that may have taken place as well as offer treatment. Informed consent must be sought before the examination; any non-consensual examination/ forced examination would imply torture. Specific consent must be sought for genital examination. Individuals belonging to socially or economically marginalized communities such as religious minorities, Dalits or tribal communities are also vulnerable to torture during detention and custody. If they disclose any information on the role that their religious or caste identity may have played in them being subjected to torture, the HCP must document such information in the medico-legal report.

Who Can Carry Out the Medico-Legal Examination

Examination can be conducted by any Registered Medical Practitioner (RMP) registered with the state.²⁰ Given the sensitivity of the matter, private doctors should also carry out the examination.²¹ In cases where a complaint of torture is made, the magistrate may give directions for medico-legal examination by an independent healthcare provider including someone in private practice. Where possible, provision must be made for male or female medical practitioner depending on the preference of the patient. A transgender or intersex person must be given a choice of being examined either by a male or female doctor.

In the event of non-availability of such preferred doctor, the examination in such cases may be carried out by any RMP in the presence of a male/female attendant so as to prevent delay or denial of treatment and examination. The attendant should be of the choice of the person being examined. If no one available, then staff of the hospital can be present. It should be noted that under no circumstances can it be a police officer.

Providing care and treatment is the responsibility of the healthcare provider in addition to the forensic role. Further referral for physical (including physiotherapy) and psychological care as deemed necessary must also be carried out by the HCP. While HCPs have an obligation to assess and treat, the medical report may be produced in court. They must advise the patient it would be better to go to a government hospital for examination and medico-legal documentation.

²⁰ Bombay High Court. (2020, January 23). *Nayana D/o Mohanlal Chikwa & Godadevi wife of Mohanlal Chikwa vs The State of Maharashtra, Through Police Station*. Mumbai: Bombay High Court. Retrieved from <https://indiankanoon.org/doc/174533706/>

²¹ Allow private doctors, hospitals to do autopsies, suggest HC. (2014, November 2). *The Times of India*. Retrieved from <https://timesofindia.indiatimes.com/India/Allow-private-doctors-hospitals-to-do-autopsies-suggests-HC/articleshow/45008964.cms>
Private college hospitals can do autopsies, says court. (2014, November 2). *Deccan Chronicle*. Retrieved from <https://www.deccanchronicle.com/141102/nation-current-affairs/article/private-college-hospitals-can-do-autopsies-says-court>

Police and other investigative agencies must not be allowed during examination. Sufficient security must be ensured so that this can be implemented, for instance, stationing the police outside the examination area out of earshot (to ensure privacy). In the event that the patient may pose serious risk to the safety of the HCP, the security personnel of the health facility may be stationed outside the examination room for additional support, however out of earshot to ensure adequate privacy as well.

Ideally, the security personnel should be stationed at such distance that it does not impede disclosure of information on part of the patient due to intimidation.

Place of Examination

The HCP must ensure that the patient is made comfortable at the place of examination. The examination must always be carried out at a health facility. Examination must be carried out in a separate room with adequate space, lighting, a comfortable examination table and equipment as is necessary for examination, treatment and evidence collection, depending on the nature of torture which may be physical, sexual or psychological in nature.

The patient must have access to toilet facilities while ensuring adequate measures for security where relevant.

Documentation by prison doctors may not be accurate and reliable when torture is committed by a prison authority. Prison doctors may not be free of bias or may act under pressure, so if the prisoner asks for it, they should be allowed to be examined by an HCP outside the prison.

Procedure of Examination and Care

These steps should be followed when a patient is brought to the medical facility:

- First aid
- Informed consent
- Detailed history taking
- Medical examination
- Evidence collection
- Documentation
- Packing, sealing and handing over collected evidence to the police
- Treatment of injuries and health complaints
- Psychological support
- Record the name of the hospital where the examination is being carried out.
- If brought by police, note the name, designation and Police Constable number (PC No.) of the police personnel who brought him/ her. If the police have brought a written requisition, note the requisition number and date of the requisition.
- The HCP should not only be led by the police requisition for examination or be biased by the facts presented by the police in instances where the patient is brought by the police; HCP must independently and objectively explore and report findings. Findings consistent with torture and ill-treatment must be documented. The HCP must under no circumstances succumb to police pressure regarding what content should be included in or deleted from the medical report and must take the support of senior hospital authorities if the need arises.
- Record the name, age, sex, and address of the patient.

- Date and time of receiving the patient at the hospital as well as time of commencement of examination.
- Name, designation, and signature of the person who brought the patient.
- Document the Medico-legal case number (MLC No.), Outpatient Department number (OPD no.) and Indoor Patient Department number (IPD no.) as applicable.
- Note whether the person was conscious, and oriented in time, place and person; signs of intoxication or ingestion of drugs/alcohol must be ascertained – this information is critical to ascertain treatment as well as for evidentiary value.
- Record any physical or intellectual or psychosocial disability. Where necessary, interpreters or special educators must be made available so as to assist with the process of communication in the language understood by the patient. The signature of the interpreter or special educator must also be taken.

Informed Consent

Seeking informed consent from the patient is mandatory. Health professionals should recognise the legal capacity of all persons including persons with disabilities on an equal basis with others and the right to exercise it, including for informed consent.²²

Guidelines for examination of persons with disabilities:²³

- Be aware of the nature and extent of disability that the person has and make necessary accommodations in the space where the examination is carried out.
- Do not make assumptions about the person's disability and ask about it before providing any assistance.
- Do not assume that a person with disability cannot give history himself/ herself. History must be sought independently, directly from the person.
- Make arrangements for interpreters or special educators in case the person has a speech/ hearing or cognitive disability. Maintain a resource list with names, addresses and other contact details of interpreters, translators and special educators in and around your hospital, who could be contacted for assistance.
- Even while using the services of an interpreter, communicate with the person directly as much as possible, and be present while the interpreter or special educator is with the person.
- Understand that an examination in the case of a disabled person may take longer. Do not rush through things as it may distress the person. Take time to make the person comfortable and establish trust, in order to conduct a thorough examination.
- If an internal examination is required, recognize that the person may not have been through an internal examination before. The procedure should be explained in a language they can understand. They may have limited knowledge of reproductive health issues and not be able to describe what happened to them.
- Consent: All persons are ordinarily able to give or refuse to give informed consent, including persons with mental illness and intellectual disabilities, and their informed consent should be sought and obtained before any medical examination. Some specific steps may be required when taking informed consent from persons with mental illness or those with intellectual disabilities. If it is

²² United Nations. (2006, December 13). *Convention on the Rights of Persons with Disabilities [A/RES/61/106]*. New York: United Nations. Retrieved from <https://www.un.org/development/desa/disabilities/resources/general-assembly/convention-on-the-rights-of-persons-with-disabilities-ares61106.html>

²³ *Guidelines and Protocols for medico-legal care for survivors/ victims of Sexual Violence*, Page 15

deemed necessary, such persons should

- a) be provided the necessary information (what the procedure involves, the reason for doing the procedure, the potential risks and discomforts) in a simple language and in a form that makes it easy for them to understand the information;
- b) be given adequate time to arrive at a decision;
- c) be provided the assistance of a friend/ colleague/ care-giver in making the informed consent decision and in conveying their decision to medical personnel. The decision of the person to either give consent or refuse consent with the above support, to the medical examination, should be respected.

Informed consent must be sought from the patient for treatment, medico-legal examination, sample collection for clinical and forensic examination, and for police intimidation.

If the person is a convict and has been brought by the police or prison officials, HCP must inform the patient that a copy of the document will be shared with the police. However, the healthcare provider must also allay the patient's fear of disclosing information. HCP must explain the importance of treatment and convey that it will not be compromised.

There should be four copies of the medical report; the original to be preserved by the hospital, one copy to be given to the police, another copy to be forwarded to the magistrate or child welfare committee as applicable and a fourth copy to be given to the patient. This process will ensure transparency and prevent tampering of documented evidence.

The doctor must make efforts to demystify medical procedures. S/he must inform the person being examined about the nature, purpose and stages of examination, including the body parts that may be examined, depending on the circumstances and nature of evidence that may be collected. If the person is an accused in a crime, the doctor must convey to the patient that the findings of the examination can be used as evidence against him/ her.

The consent form must be signed by the patient and by a parent/ guardian if s/he is less than 12 years old. Where there is a conflict of interest between the parent and child, the consent of the child must prevail. The Child Welfare Committee or Juvenile Justice Board must be brought in to act in the best interest of the child.** Under no circumstances must consent be sought from the police.

The HCP must inform the patient of the possibility of having the presence of a witness during medical examination to ensure that the person is comfortable. The police cannot be a witness nor can anyone who is brought by the police act as witness. Signature of the witness must be obtained on the consent form along with the signature of the examining doctor. The witness must be informed that s/he may be called to court to testify.

Document two marks of identification such as moles or birthmarks preferably from exposed parts of the body. Describe these identification marks emphasizing size, site, surface, shape, color, fixity to underlying structures. Take the patient's left thumb impression below the patient's signature.

** In the case of those below the age of 12 years, consent must be sought from the parent if available or when not available consent may be obtained from the hospital authority (as is followed in the case of unaccompanied MLC).

Relevant Medical and Surgical History

- Record any surgeries, diagnostic procedures, medical treatment, consumption of medicines/ substances that may affect current findings.
- In the case of women, document menstrual history – cycle, length, duration, date of last menstrual period. Note whether the person is menstruating at the time of examination as this would affect evidence collection in the case of sexual torture. Document whether the person was menstruating at the time of torture, as this would also affect the evidence collection in the case of sexual torture.
- Seek information on vaccination status for Tetanus, Hepatitis B and document it as this will decide line of treatment.

History-Seeking in Relation to Experience of Torture

History seeking involves communication skills on part of the healthcare provider. It is an important aspect of the process as it guides treatment, examination and evidence collection. The HCP must ensure privacy and confidentiality while seeking history, explaining the boundaries of confidentiality. The HCP must communicate to the patient the importance of revealing entire history without holding back information and without fear so that best possible care and treatment can be provided. As far as possible, HCP must ask open-ended and non-leading questions, allowing the patient to narrate history. Questions may be asked to seek clarity or specificity.

While recording history, the healthcare provider must avoid the use of jargon and must explain medical terms that are being used. There must be distinction between history that the patient is 'not sure' of and that which is 'negative'. There may be some information that the patient does not know, which must be documented as 'do not know' after offering sufficient clarity on the kind of information being sought.

HCP must understand that trauma/ effect of drugs may have affected memory of circumstances and extent of torture. Inconsistencies in history must not be interpreted as falsification of information. Discrepancies could be due to several factors, including but not limited to time lapse since the incident, blocking out memory owing to trauma or effect of drug, fear of disclosure, shame associated with the incident. The HCP must show sensitivity in eliciting information from the patient.

Circumstances just before the time of examination, such as nature of restraints used at the time of arrival (e.g., handcuffs), any verbal or physical force used by the police with the patient before commencing the examination must be recorded. It is possible that the patient may have been accompanied by the perpetrator.

Seek information regarding date of incident being reported, time, and location.

Along with name of the specific location, the descriptions of the location must also be explored (e.g. specific smells, light conditions, sounds heard). This information is especially useful in situations where the person may have been blindfolded or was in the dark.

Note the estimated duration of each episode and number of episodes. The duration of each episode may be difficult to ascertain and can also be described based on activities such as immediately after lunch time until change of guard or from daylight right until dark.

Number of assailants – those actively inflicting torture as well as those present at the location, approximate age of the assailants, sex of the assailants, designation where applicable, names, role in the infliction of torture. Signature of the patient must be taken against sensitive information (after reading out or explaining what is documented in medical records) such as where identity of assailant(s) has been revealed.

Descriptive history must be recorded in the patient's own words as far as possible as it has evidentiary value in court. The term "alleged" should not be used as it casts aspersions on the history narrated by the patient.

The following information must be sought to document descriptive history of torture:

- Circumstances leading up to the torture.
- Details of past incidents of torture and duration of each incident.
- The doctor should make sure to document how much time passed between when the incident took place and the patient was able to access medical care. This is because often prisoners do not have immediate or easy access to medical care and attention. The doctor should also inquire about solitary confinement and document the overall impact of detention on the health of the prisoner.
- Details of recent episode.
- Detailed description of method of torture used:
 - Use of physical violence and its location on the body (e.g., pulling of nails, beating of legs, smashing of fingers, etc.)
 - Use of weapon with detailed description – wooden baton (approximate dimensions), rope, belt, cigarettes, electric shock (description of device used), use of weight on thighs – e.g. standing on the thighs and grinding with shoes.
 - Use of substances - chili powder/salt on wounds or orifices, forced ingestion of alcohol/drugs, use of any other noxious substance – to be specified, use of toxic doses of sedatives, neuroleptics, paralytics.
 - Use of restraints (handcuffs/ blindfolds/ insertion of objects into the mouth to stifle screams).
 - Description of verbal threats – threats to harm a loved one, threats to escalate form of torture, threats of attack by animals/ rodents/ arachnids, threats and humiliation based on caste or religion.
 - Use of photographs to blackmail and humiliate.
 - Sexual violence – penetrative and non-penetrative.
 - Access to medical care after the incident of torture.
 - State of clothing at the time of torture – whether disrobed, partially clothed, wrapped by clothes at the site of being hit.
 - Discussion among perpetrators during abuse (which may have instilled fear or humiliation).
 - Asphyxiation (strangulation, forced inhalation of dry substances, drowning especially the face/ forcing water through the nose, type of fluid used for drowning – filthy/ sewage water).
 - Being forced to witness the torture of others.
 - Being forced to torture others including sexual abuse of others.
 - Positional torture (being forced into a particular position for a certain duration of time).
 - Making conditions torturous - restricted access to/contamination of food and water, restricting access to toilet facilities, overcrowded cells (to be distinguished from regular

poor conditions in jail), sleep deprivation, withholding of medical treatment including dental treatment, solitary confinement.

The above list is not an exhaustive one; newer methods of torture may emerge. For each form of abuse, body position, restraint, nature of contact, duration, frequency, anatomical location and the area of the body affected must be documented.

Health consequences after each episode of violence: bleeding, head injury/ trauma, loss of consciousness, aches, pain, swelling, mention specific location on the body, difficulty in movement (whether there was requirement for help or being carried).

Whether unconscious at the time of incident. Reason for loss of consciousness where applicable – could be due to head trauma, drug, asphyxiation, pain.

If the patient had become unconscious during the episode of torture, s/he is not likely to be able to offer further details of that episode. Circumstances and changes after gaining consciousness must be documented such as location of regaining consciousness, state of clothing (e.g., found himself/ herself naked).

Specific information regarding current health complaints and those that the patient associates with the torture must be sought.

The HCP must also seek information on steps taken by the perpetrators to limit evidence of torture – for e.g., being wrapped by a blanket to diffuse the pain and reduce likelihood of injuries, use of water/ wet cloth/ gels during electric shock to prevent burns, immediate medication or access to medical attention to prevent health consequences (including presence of medical personnel when torture was being inflicted). This information is imperative to document as it explains reasons for lack of visible signs of torture.

History of Sexual Violence

The survivor is likely to be stigmatised if torture was of a sexual nature. The healthcare provider must convey trust and belief in the patient disclosing sexual torture and must express sensitivity while enquiring about sexual violence.

Psychosocial support must be provided to the survivor, especially when sexual torture has taken place. The HCP must convey important messages such as delinking the act from loss of honor, conveying that it is a violation of his/ her rights, that it is a misuse of power.

The HCP must understand the impact of sexual torture on men, women and transgender persons and be able to distinguish physiological reaction from pleasure, such as ejaculation by the victim during sexual torture as physiological coping. The same should be explained to the victim to avoid self-blaming.

Sexual violence is often inflicted concurrently with physical torture. It may also be verbal in nature, such as passing lewd comments.

Sexual torture may begin with nudity, which makes the person vulnerable and creates a real threat of further sexual abuse.

Men may be subjected to electric shock on their genitals, crushing, pulling or wringing of the scrotum, or anal torture. Sexual violence may result in feelings of loss of masculinity among men.

Groping is a common form of sexual abuse and humiliation among women. They may be subjected to forceful penetration and threat of pregnancy. However, the perpetrators may have also used a condom or given emergency contraceptive; such circumstances must be documented.

Prisoners may be forced to abuse each other sexually which has emotional consequences. They may also be forced to be naked in front of others, resulting in humiliation.

The HCP must not hesitate in seeking details of history pertaining to sexual torture. This information will be critical for examination and treatment. Body charts may be used to assist in eliciting specific information if required.

Past episodes of sexual torture must also be recorded as there may be resulting health consequences that require treatment.

The frequency and duration of sexual torture must be documented along with the nature of torture inflicted.

General Physical Examination

The examining doctor must ask the patient about the last examination conducted and seek medical papers where available. Orientation in space and time, ability to respond to all the questions asked by the doctor must be ascertained. Any signs of intoxication by ingestion or injection of drug/ alcohol must be noted. Pulse, blood pressure, respiration, temperature and state of pupils must be recorded. The state of clothing should be noted whether it was the same as that worn at the time of torture, any fresh tears/ stains with description of site, size and color of stains. Any specific smell from the clothing must also be recorded.

Examination for Injuries

Pattern of injuries may range from complete absence of injuries to grievous injuries. The healthcare provider must inspect the entire body surface for bruises, boils (blisters), burns (including electrical and chemical burns), abrasions, cuts, lacerations, fracture, tenderness, numbness, discharge.

Examine for signs of generalized skin disease, including any nutritional deficiency affecting the skin, skin diseases/ infections.

Note the injury type, site, size, shape, color, swelling, signs of healing, simple/ grievous, dimensions. Categorize the injury as 'grievous' in keeping with the interpretation provided under section 320 of the Indian Penal Code.[†]

[†] Section 320 of the Indian Penal Code designates the following as 'grievous hurt': Emasculation, permanent privation of the sight of either eye, permanent privation of the hearing of either ear, privation of any member or joint, destruction or permanent impairing of the powers of any member or joint, permanent disfiguration of the head or face, fracture or dislocation of a bone or tooth, any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits.

The possible weapon of infliction must be noted as hard, blunt, rough, sharp and/or high velocity or low velocity (like guns). The pattern of bruises may reveal the kind of weapon or instrument used.

Wherever injuries are present, the healthcare provider must note time lapsed since injury.²⁴

Injuries are best represented diagrammatically on body charts – number the injuries on the chart and provide detailed description of each. Photographic or video documentation should be carried out wherever appropriate technology is available. Informed consent of the patient/ injured must be sought. Absence of bruises does not rule out blunt trauma; HCP must also check for and document swelling or tenderness. Deep bruises may not be visible on immediate examination. Deep bruises are often visible on re-examination after lapse of a few days. Contusions (bruises) may be visible depending on how much time has passed since infliction of physical abuse. Where recent history is indicated, follow-up after a few days must be emphasized as some signs and symptoms may emerge with passage of time (deep bruises). However, the HCP on examination after a few days must also note that some injuries may have faded with time.

The HCP must bear in mind that injuries may vary according to age, sex, tissue characteristics, health condition of the patient and severity of trauma. Tendons, muscles and joints must be examined when there is history of positional torture. HCP must examine the body based on complaint of pain in the body region associated with these positions.

Describe type of stains seen on the body (blood, semen, lubricant, any other substance) by mentioning actual site, size, odor and color.

Absence of injuries could be due to the nature of torture, time lapse and delay in reporting for examination, and activities undertaken post incident.

Information on chronic symptoms and health complaints that the individual associates with the abuse must be sought; severity, frequency and duration of the condition must be noted – for instance, somatic complaints such as persistent headaches, gastrointestinal complaints, genito-urinary complaints, body aches and pains.

Psychological symptoms such as anxiety, depressive effect, sleep disturbances, nightmares and flashbacks, memory difficulties, emotional numbing, exaggerated startled response, suicidal ideation, must be documented.

Impact of torture may be seen even after a long period of time in the form of deformities or incorrect healing or psychological disturbances. This must be observed and documented by the healthcare provider.

Examination by Body Part²⁵

Body part	What to look for
Scalp	Areas of tenderness (due to pulling of hair/ dragging by hair)

²⁴ *Guidelines and Protocols for medico-legal care for survivors/ victims of Sexual Violence*, annexure 2, Page 55

²⁵ *Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment*, Page 35

Face	Facial bone injury, orbital blackening, tenderness, evidence of fracture, crepitation, swelling, motor and sensory loss of activities
Eyes	Petechial haemorrhage, lens dislocation, visual field loss
Ears (ear canals, tympanic membrane)	Rupture of tympanic membrane (common consequence of slapping), secretion/discharge, hearing loss Note: ruptures to the tympanic membrane less than 2mm in diameter may heal within 10 days
Nose	Alignment, crepitation, deviation of the nasal septum
Oral cavity	Worsening of pre-existing poor dentition, bruises, tenderness caused by biting of tongue or lips (caused during infliction of pain), lesions caused by forcing objects into the mouth, bleeding, edema, tear, discharge Note: Seek past dental records where available
Jaw and Oropharynx	Mandibular fractures, dislocations, temporomandibular joint syndrome, gingival haemorrhage, lesions consistent with burns or other trauma
Neck, shoulders, chest/breast	Crepitation of the hyoid bone or laryngeal cartilage, bruises, bite marks, tenderness
Limbs and joints	Pain, fracture, dislocation of joints, spine and extremities, ligament tears, osteomyelitis Note: Muscles and bone injuries may heal completely without scarring

Genital Examination^{††}

- The patient should be alerted and made comfortable before commencing with the genital examination.
- In case of past sexual violence, seek information on current ongoing symptoms such as urinary frequency and incontinence, irregular menstruation, history of pregnancy or abortion associated with the sexual abuse, problems with sexual activity including pain in the vaginal/anal region, constipation and incontinence. The HCP must ask the female patient if she had been given any pills (EC – emergency contraception) after the assault.
- Sexual torture has several physical and psychological health consequences; sexual dysfunction may be a possible consequence of the torture especially because of taunts by the abuser. Men may present with erectile dysfunction and issues pertaining to sexuality. Patients may present with aversion to members of the opposite sex and decreased interest in sexual activity, fear of sexual activity, painful sexual intercourse.
- Observe external genital area and perineum for evidence of injury, stains, lesions.
- Among males, examine the inner thigh, mons pubis, glans penis, scrotum, foreskin, testes, urethra and perineum. While absence of scarring at the scrotum or penis does not indicate absence of torture, the presence of scarring is usually indicative of sexual violence.

^{††} Guidelines & Protocols for Medico-legal care of survivors/ victims of Sexual Violence, 2014, states that “The status of the hymen is irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual intercourse. Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual violence. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.)” It also states that “the vaginal introitus has no bearing on a case of sexual violence.”

- For females, the vulva must be inspected for signs of recent injury such as bleeding, tears, bruises, abrasions, swelling or discharge and infection involving urethral meatus and vestibule, labia majora and minora, fourchette, introitus and hymen.
- Document only hymenal findings relevant to the history of sexual violence, such as fresh tears, bleeding, edema or injuries. The status of hymen in terms of torn/ intact/ o'clock positions are irrelevant. Do not comment on the size of the vaginal introitus.
- Per-vaginum examination may be carried out only when clinically indicated. Document reasons on the medico-legal proforma.
- In the case of transgender persons, examine the clitoropenis or labioscrotum.
- USG (ultrasonography) may be required to investigate genito-urinary trauma and pregnancy.
- Anal region: Tears, stains, discharge, bleeding, swelling, hemorrhoids, warts/skin tags around the anus and anal orifice may be observed. Anal fissures may be indicative of penetration, especially in the acute phase.
- Document signs of healing of injuries in the case of past sexual torture.

Systemic Examination

- Central nervous system: HCP must investigate into the possibility of motor and sensory neuropathies related to possible trauma, vitamin deficiencies and diseases. Evaluate cognitive ability and mental status. Conduct vestibular examination where history indicates dizziness and vomiting – note evidence of nystagmus.
- Cardiovascular system: HCP must examine the possibility of chest pain, palpitations, missed beats, arrhythmias, syncopal attacks, cold clammy skin, excessive sweating. HCP must also check pulse, monitor blood pressure and carry out ECG evaluation and if indicated, echocardiography to evaluate status of cardiovascular system.
- Respiratory system: Respiratory disorders may develop and preexisting respiratory disorders may aggravate during the detention period, development of tuberculosis, pneumonia HCP must evaluate possibility of pneumothorax and lesions to the lungs by use of radiography, ultrasonography, CT scan.
- Abdomen: Intramuscular, retroperitoneal, intra-abdominal hematoma, laceration or rupture of an internal organ.

Collection of Samples for Clinical Laboratory

Wherever necessary, further referral for appropriate investigation must be advised and followed up by the HCP (the referral must be documented):

- For suspected fracture/ dislocation/ injury, referral for X-Ray must be advised and documented.
- Collect blood for HIV status, HBsAg, VDRL as there are high chances of transmission of infection from perpetrators.
- Carry out age estimation only in the absence of documented age proof and in borderline cases. It must be estimated based on the mean of physical, radiological and dental age.²⁶

Collection of Samples for Central/ State Forensic Science Laboratory²⁷

Do not collect evidence mechanically; collect relevant evidence depending on nature of torture, time lapsed since the incident of torture and time of examination, activities carried out since the incident

²⁶ *Guidelines and Protocols for medico-legal care for survivors/ victims of Sexual Violence*, annexure 3, Page 56

²⁷ *Guidelines and Protocols for medico-legal care for survivors/ victims of Sexual Violence*, Page 29

(bathing, urinating, defecating, douching). It is likely that the perpetrators would have attempted to conceal evidence – seek relevant information in this regard.

For Non-Sexual Torture

- Clothes
- Stains on clothes

For Sexual Torture

Evidence is likely to be found for upto 72 hours after the sexual violence, however, it is best to collect evidence upto 96 hours -in case the person is not sure of the time lapsed after sexual violence.

Nature of swabs collected will be guided by history and nature of torture as well as time lapsed since last episode of torture.

Evidence on material outside of the body can be collected beyond 96 hours, clothing worn at the time of assault may be collected. However, if it has been washed, document this as there will be loss of evidence. Record stains, tears and smell on the clothes. Specifically describe presence of stains– semen, blood, foreign material. The healthcare provider must specifically ask the patient to preserve the clothing worn at the time of recent torture wherever possible. In cases of collection of clothing worn by the patient, the hospital must provide for a new set of clothes.

The person may be asked to stand on a large sheet of paper so as to collect specimens/trace evidences that may have been left behind from the perpetrators and also from the site of torture. The sheet of paper must be folded carefully and preserved in a bag to be sent to Forensic Science Laboratory (FSL) for trace evidence analysis and possible detection. Plain vacutainers could be used for collecting blood/ body fluids for blood grouping and drug estimation. Sodium fluoride vacutainers for collecting blood/ body fluids for alcohol estimation. EDTA vacutainers for collecting blood for DNA profiling.

All samples including clothes must be air dried (in shade) before storing. Clothes must be folded such that the stained parts do not come in contact with the unstained part. Each piece of clothing must be separately packed, sealed and labeled.

In cases where abortion is provided to the patient reporting with sexual violence, HCP may send Products of Conception (PoC) as evidence to the FSL for identifying the assailant by DNA profiling. In cases of delivery of fetus in cases of sexual violence, HCP may send blood from fetus as evidence to the FSL for identifying the assailant by DNA profiling.

Body Evidence

- When collecting swabs from dry skin, swab sticks must be moistened in distilled water and air dried (in shade) after collection to prevent decomposition/degradation of evidence. While collecting evidence from oral, anal or vaginal cavity (where presence of mucus or secretion may be present), swab sticks should not be moistened.
- Use swabs to collect blood stains on the body, foreign material on body surfaces, and seminal stains on skin surfaces.
- In the event of recent assault, collect loose scalp and pubic hair along with intact scalp and pubic hair from the survivor so as to match loose hair collected from the assailants. (If pubic hair

has been shaved, mention this in the document). Use sterilised forceps/ tweezers while plucking pubic hair for collection.

- For collecting evidence from fingernails, use small and thin tip swab moistened with distilled water so as to easily reach under the fingernails. Clipped nails to be packaged separately for each finger.
- Collect blood for grouping and DNA profiling and comparing blood stains at the scene of torture.
- Collect blood or urine samples for detection of substances ingested (drugs/ alcohol).
- Collect oral swabs from the posterior parts of the buccal cavity behind the last molars where chances of finding evidence are highest.
- Blood if collected using EDTA vials should be stored at 4 degree centigrade and should be used within a maximum of a week.
- If blood testing is assumed to take time, it should be collected as a dry stain using FTA cards. 100 microlitres of blood should be collected in the FTA cards, air dried at room temperature and packaged in paper envelopes.

Genital and Anal Evidence

Where history is indicative of sexual torture among females, HCP may take two swabs from the vulva, vagina and anal opening for ano-genital evidence.

Among males, swabs may be collected from glans penis and anus. From transgenders, swabs may be collected from clitoropenis/ labioscrotum and anus. These swabs must be collected only when indicated by history- for seminal stain/ blood / lubricant examination on body/ clothes and DNA testing.

Samples must be sent with a requisition to the FSL specifying the content of each sample, quantity (wherever possible, e.g.: amount of blood in EDTA vial), time of collection, and what each sample must be tested for. This form must bear the signature of the examining doctor as well as the officer to whom the evidence is being handed over. The numbering on each sample must be in consonance with the numbering on the requisition form. Individual samples must be packed, sealed and labeled before being handed over. In order to avoid the possibility of cross-contamination, all samples must be sealed and packaged separately.

Common pointers for collection of evidence

- While collecting evidence, always wear clean pair of gloves. Do not have the same gloves for collecting different evidence items.
- Evidence from victim and suspect should be collected separately and should always be packaged separately.
- Always air dry the stains at room temperature and package them in paper bags or envelopes.
- Plastic should never be used for packaging.
- Collection tools should always be sterilised before use.
- Collection tools should be different for different evidence items.
- All collected swabs should be air-dried at room temperature

Chain of Custody

Chain of custody must be maintained to ensure proper handling of evidence and to prevent tampering. A log must be maintained at each point that the evidence is handed over from one custodian to the next. Samples must be preserved under appropriate conditions until handed over to the next custodian.

Preservation of samples until handing over to the police is the responsibility of the health facility. These need to be handed over to investigating officer or magistrate if the examination is on a court order.

Provisional Clinical Opinion

The healthcare provider must draft a provisional opinion immediately after the examination based on the history and clinical findings of the examination. The opinion must mention relevant aspects of history of torture, clinical findings and samples that have been sent for analysis to the Forensic Science Laboratory or to the hospital laboratory. An inference must be drawn correlating history and clinical findings, mentioning signs of use of force and whether indicative of torture with adequate reasoning for conclusions arrived at.

The opinion must be drafted based on overall evaluation of all the findings rather than consistency of each finding with a particular form of torture.

Absence of positive findings does not rule out torture. Circumstantial evidence must be taken into consideration while drafting the opinion and must be explained.

Some factors that may affect presence of injuries/ evidence or positive laboratory results:

- Time lapse since the incident
- Nature of violence inflicted – intensity, frequency, duration
- Activities undertaken since the incident (post torture activities)
- Inability to offer resistance owing to fear or overpowered or intoxication or trauma leading to unconsciousness/asthenia/powerlessness/exhaustion
- Nature of the test (confirmatory/ probability – sensitive/ specific/ confirmatory tests)

For instance, most injuries heal within six weeks of infliction of torture and may not necessarily leave scars. Certain forms of torture may not produce physical signs of injury. The custodian may have deliberately delayed bringing the patient for medical care so that signs of torture may subside.

Comprehensive opinion on part of the healthcare provider is imperative in order to educate other relevant agencies, including the judiciary, on the limitations and scope of medical evidence as well as the impact of torture on the health of the patient.

The examining doctor must sign the report after framing the provisional opinion and must document his/her full name along with date and time of completion of examination.

Final Opinion

The healthcare provider must frame the final opinion upon receiving the findings/reports from the forensic science laboratory and/or hospital laboratory. Negative findings must be explained adequately with possible reasons which do not rule out the occurrence of torture.

Treatment and Care

Treatment and care include provision of first-line psychological support:

- Recognize the patient's courage to disclose details of torture against those in power.
- Assure the patient that treatment will not be compromised.

- Assess safety in terms of suicidal ideation/ attempt owing to the severity of abuse and also the possibility of revenge torture/ repeat torture.
- Address threats to life on going back into custody and document it as the person is likely to go back to the perpetrators. The facility needs to create a reporting mechanism for the doctors when they find that the person is not safe. This may include informing SHRC/ NHRC or magistrate.
- Where a trained counselor is available, provide access to offer intervention.
- The doctor must document "recommended referral to the counselor." Referral to a counselor to heal from distress or trauma caused by torture cannot be grounds to suspect/ question the patient's narration (capacity to give credible history). Attend to all health complaints identified during history taking and on examination. Antibiotics or painkillers may be prescribed.
- Clean lacerations with antiseptic and dress them with antibiotic cream. If suturing is required, provide it immediately at the nearest center.
- Wherever necessary, further referrals must be carried out immediately as the patient may not be brought back for examination while in custody. For example, suspected ocular diseases must be managed by the ophthalmologist. Where required, consultation with the physiotherapist must be arranged.
- Treat Sexually Transmitted Infections (STIs) with appropriate Post Exposure Prophylaxis.
- For women who have experienced penetrative sexual torture, where pregnancy is a possible health consequence, carry out Urine Pregnancy Test and document the result.
- HCP may prescribe Pregnancy Prophylaxis (emergency contraception) up to five days after the assault. Caution those in the window period about possible pregnancy in case they miss their next period and the need to access follow-up care.
- HCP must offer abortion as an option to those who are pregnant as a result of sexual violence. The health facility must set up a panel which can take the decision/ actions regarding abortion for those beyond the legal timeline based on medical grounds, keeping the well-being of the patient at the fore and legal provisions of the State by approaching appropriate forums/ courts through agencies/ advocates.***

Recording the Dying Declaration

- In the event that the patient is not likely to survive, the healthcare provider must record the dying declaration. Under section 32 of the Indian Evidence Act, the healthcare provider has a role in recording the dying declaration.²⁸ In the absence of a judicial/ executive magistrate, the medical officer can document the statement. Such a situation may arise when the patient reaches the hospital in a condition that arouses suspicion of violence inflicted in custody. The healthcare provider must be aware that the patient may not be forthcoming about the history owing to fear and threats. The healthcare provider must create a safe space to allow for disclosure of torture, keeping the police and/ or relatives away so that the patient does not feel threatened.

*** Women and girls should have access to safe abortions if they become pregnant after rape. The Medical Termination of Pregnancy, Act, 1971 allows registered doctors to terminate pregnancies up to 20 weeks "where the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury physical or mental health." Medical Termination of Pregnancy Act, 1971, section 3. Under the law, doctors are not limited by the 20-week period where a registered doctor is of the opinion that the "termination of such pregnancy is immediately necessary to save the life of the pregnant woman." See section 5(1) of the law. The law also says that "where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman."

²⁸ Supreme Court of India. (1872) *Dying declaration – section 32 (1) of Indian Evidence Act, 1872*. New Delhi: Supreme Court of India. Retrieved from [http://www.legalservicesindia.com/article/1682/Dying-Declaration-Section-32\(1\)-of-Indian-Evidence-Act.html](http://www.legalservicesindia.com/article/1682/Dying-Declaration-Section-32(1)-of-Indian-Evidence-Act.html)

- The HCP also has to certify *compos mentis*/ sound mind that the person is fit to give a statement by examining higher mental functions (examining consciousness, orientation to time, place and person, memory status etc.) The HCP must answer the patient's queries and provide information on the significance of the process so as to enable free-flowing, spontaneous statement with as little prompting as possible.
- The healthcare provider must ensure presence of witness – the hospital attendant can act as witness and sign on the record.
- Record the statement in the patient's words (verbatim).
- Forward a sealed copy of the statement and forward it to the magistrate within the specific jurisdiction.
- In the event that the patient survives, the recorded statement will continue to hold corroborative evidentiary value even if, for various reasons such as pressure/threats, s/he retracts his/ her statement in court.

Psychological Evaluation

Psychological evaluations are especially significant where there are no physical findings of torture as more and more methods of torture are being designed so as to leave no physical signs. The act of torture affects both psychological and social functioning of the individual. Torture often takes the form of psychological abuse and may or may not be accompanied by physical abuse. Healthcare providers must be aware that torture has psychological consequences and therefore, a psychological assessment is advisable. These consequences may vary depending on age (could be different for adults and children) and personal factors or attribution of meaning to the act.

Mental health professionals must refrain from psychologizing the problem presented through diagnosis and classification of the presenting complaint. All those who experience torture, do not necessarily undergo some form of mental illness. The mental health professional must, therefore, distinguish between distress and disease. Such an understanding of distress as being an expected outcome of torture will convey an attitude of empathy to the survivor.

Common Psychological Consequences²⁹

Category	Forms
Re-experiencing trauma	Flashbacks Nightmares Distress at exposure to cues associated with trauma (may manifest in fear of persons in authority including the healthcare provider)
Avoidance and emotional numbing	Avoidance of anything associated with the trauma Emotional constriction Social withdrawal and detachment Inability to recall important aspect of trauma
Hyperarousal	Sleep disturbances Irritability and anger outbursts Difficulty concentrating Hypervigilance/ exaggerated startled response Generalized anxiety Shortness of breath, sweating, dry mouth, dizziness, gastrointestinal

²⁹ Istanbul protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment, pp. 37-44

	distress
Symptoms of depression	Depressed mood Anhedonia – markedly diminished interest or pleasure in activities Appetite disturbances Weight loss Insomnia or hypersomnia Psychomotor agitation or retardation Fatigue and loss of energy Feelings of worthlessness Excessive guilt Difficulty concentrating and recalling from memory Suicidal ideation Attempted suicide
Damaged self-concept and foreshortened future	Feeling of having undergone an irreversible personality change Perceiving a foreshortened future (without expectations)
Dissociation, depersonalisation and atypical behavior	Feeling of observing self from a distance Feeling detached from oneself Behaviors that are atypical with respect to the person’s pre-trauma personality
Somatic complaints	Pain Headaches (which may lead to chronic post-traumatic headaches) Physical complaints without objective findings
Sexual Dysfunction	Anxiety, Depression, Premature ejaculation, Fear
Substance abuse	Alcohol or drug abuse (to suppress unpleasant feelings or manage anxiety)

Psychotic reactions such as delusions, hallucinations and paranoia may occur for a brief or prolonged period and symptoms may be either during or after the duration of torture. The mental health professional must evaluate the symptoms within the patient’s cultural context before labeling someone as having psychotic symptoms.

Neurological or neuropsychological impairment may be the result of certain forms of torture such as suffocation or prolonged malnutrition. Assessment to identify this requires specialized skill.

Psychiatric disorders as a result of torture include Post Traumatic Stress Disorder (PTSD) and depression, often existing together. Co-morbidity is often present among those with mental disorders as a result of trauma. Generalized Anxiety Disorder, Panic Disorder, Acute Stress Disorder (within one month of exposure), Somatoform Disorder, Bipolar Disorder, Phobias (social phobia) are some other diagnoses associated with torture. The healthcare provider must be aware that not presenting with psychological symptoms does not mean torture did not take place.

Given the mental health consequences of torture and trauma, the inability to recall specific details must be attributed to trauma rather than doubting the survivor’s narrative.

The mental health professional must seek informed consent for every part of the process, preparing the survivor for what lies ahead. S/he must explain the benefits and risks along with boundaries of confidentiality.

Components of the Psychological/ Psychiatric Evaluation:

- Mental status examination through documentation of person's appearance – signs of malnutrition, lack of cleanliness, use of language, presence of eye contact, suicidal and homicidal ideation, cognitive examination (orientation, intermediate and immediate recall, long-term memory)
- Thorough documentation of the complete history as narrated by the survivor
- Assessment of current psychological functioning with detailed description of affective, cognitive and behavioural symptoms
- Detailed documentation of current life circumstances (post-torture history) such as stress, separation, availability of social support, ability to carry on with routine
- Documentation of background (educational, occupational, cultural) history of past trauma (pre-torture history). This will help compare the functioning of the individual's mental health status prior to the trauma. Hence sufficient information must be elicited to be able to assess the extent to which torture has contributed to the psychological problems.
- Documentation of medical history (any additions to what has been documented by the HCP during examination) – use of medication and its side effects, aches and pains
- Documentation of psychiatric history including nature of past psychological problems, prior therapeutic use of psychotropic medication
- Documentation of history of substance abuse both before and after torture to understand the changes in patterns of use and whether it is being used as a coping mechanism
- Enquiring and documenting current level of functioning – daily activities, social role, perception of health status (including presence or absence of feeling, fatigue)

Formulation of Clinical Impression

The mental health professional must document a clinical impression immediately after the psychological/ psychiatric evaluation to include the following:

- Whether psychological findings are consistent with history of torture
- Whether psychological findings are typical reactions to extreme stress within the socio-cultural context of the individual
- Time frame in relation to torture events – position of the patient in the course of recovery
- Existence and impact of co-existing stressors on the individual
- Any physical conditions contributing to the clinical picture (e.g. head injuries)

Where required, the mental health professional may add recommendations to include further assessment and/ or care and treatment.

Impact of Torture on Children

Torture can have a direct or indirect impact on children:

- Direct experience of being tortured
- Witnessing torture of individual(s) in the child's close environment
- Torture of parents or close family members

The child's reaction to torture is likely to be influenced by the reactions of the caregivers following the event.

In cases pertaining to children affected by torture, the healthcare provider must ensure that the child receives care from a trusted person. The HCP must also be aware of behavioral manifestation of trauma among children.

In young children reporting sexual violence, anesthetics may be used to carry out the complete genital and/or anal examination.

The mental health professional must observe and document the behavior of the child in addition to verbal expression.

Healthcare providers must work with the caregivers to encourage resuming routine, not restricting mobility or overprotecting the child. All other provisions under POCSO Act should be adhered to.

Interface with the Police

The health sector plays the primary role of therapeutic care – confidentiality and privacy must be ensured throughout the course of examination. The police personnel must not be present in the examination room nor be within earshot of the procedure (to ensure privacy).

The healthcare provider must ask the patient the date of last examination carried out and seek documentation of the same wherever possible.

The police cannot sign as witness on the medico-legal form nor consent for any medico-legal examination/ procedure.

Treatment must be ensured to the patient. The police must wait until treatment and care is provided and cannot take them away in the midst of the process (Exceptions could be situations of mandatory legal provisions to produce before magistrates/ courts depending on the medical condition).

Healthcare providers are not bound to respond to all the queries on the police requisition forms and must provide appropriate responses, based on science and relevance to the case at hand. They must not give in to pressure from the police/superiors/politicians regarding what must constitute the content of the medico-legal report.

In cases where Medical Termination of Pregnancy (MTP) is being provided to patients who are pregnant as a result of sexual violence, the examining doctor (or Chief Medical Officer/ Assistant Medical Officer) must contact the police to bring the DNA kit from the forensic science laboratory coinciding with the time of conducting of MTP. The police must ensure transfer of this kit in an ice box, maintaining temperature of 4-degree celsius at all times. Proper chain of custody of this evidence has to be ensured.

The examining doctor must explain the limitations and scope of medical evidence in cases of torture to the police.

Any investigations requested for by the police which may not support treatment or evidence collection should not be implemented. Under no circumstances should the doctor make additions or deletions to the report based on illegal or unethical police demands/ requests.

The healthcare provider should uphold the ethical obligation of beneficence towards the patient. This is applicable to prison doctors too; the primary role is that of therapeutic care.

It is the ethical responsibility of the healthcare provider to take necessary steps to prevent further torture and possible custodial death. Reporting torture to the persons in whose custody the patient is currently in, is likely to further jeopardise the safety of the patient. It must, therefore, be reported to the superior officer at the hospital as well as the commissioner/ superintendent of police and national and state human rights commissions to ensure safety of the patient. In case of children, the child welfare committee must be intimated immediately.

Interface with the Judiciary

- HCPs are called to court/ judicial commissions to explain the medical aspects in cases of torture.
- It is the responsibility of the HCP to explain the presence/ absence of injuries and positive/ negative laboratory results, and also circumstantial evidence, if any.
- HCPs must interpret evidence and positive or negative findings based on medical knowledge and history offered by the patient to the doctor.
- HCP must explain time lapse, fear, being overpowered, intoxicated, injured and other circumstances due to which the patient was unable to resist the perpetrator.
- HCP must explain negative laboratory results with reasoning such as delay in reaching the hospital, nature of torture/ method of torture, activities leading to loss of evidence.
- The doctor must offer an opinion with regard to the possibility of use of force on the patient.
- Where asked to answer as "yes/ no", the HCP must take the initiative to seek permission from the presiding judge/magistrate to offer clarity or further explanation, for instance, where findings may be typical of the trauma and/ or there may be other causes for the findings observed during medical examination.
- The HCP must have an unbiased approach upholding medical ethics and ensuring information provided is scientific.

Annexure 1

Model Proforma for the Medical Evaluation of Torture and Ill-Treatment in Custody

(Modified & adapted from Istanbul Protocol: Manual on the Effective Investigation & Documentation of Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment)

I. Case information

Date & Time of exam: Exam requested by (self/authority name/position):

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

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

Subject's family name: Gender: male/ female/ other Age:

Reason for exam: Subject's ID No.:

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

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

Subject accompanied by (name/ position):

Persons present during exam (name/ position):

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

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

Handed over/ Transfer date: Handed over/ Transfer time:

Medical evaluation/ investigation conducted without restriction (for subjects in custody): yes/ no
Provide details of any restrictions:

II. Clinician's qualifications

Medical education and clinical training:

Psychological/ psychiatric training:

Experience in documenting evidence of torture and ill-treatment:

III. Background information of subject

General information: (age, occupation, education, family composition, menstruation, pregnancy, disabilities, current illness, medications being consumed, etc.)

Past medical history including diseases, drug use:

Review of prior medical evaluations of torture and ill-treatment:

IV. Allegations of torture and ill-treatment

1. Summary of detention and abuse:

2. Circumstances of arrest and detention:

3. Initial and subsequent places of detention: (chronology, transportation and detention conditions)

4. Narrative account of ill-treatment or torture: (in each place of detention)

5. Review of torture methods:

V. Physical symptoms and disabilities

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

1. Acute symptoms and disabilities:

2. Chronic symptoms and disabilities:

VI. Physical examination

1. General appearance:

2. Skin:

3. Face and head:

4. Eyes, ears, nose and throat:

5. Oral cavity and teeth:

6. Chest and abdomen (including vital signs):

7. Genito-urinary system:

8. Musculoskeletal system:

9. Central and peripheral nervous system:

VII. Psychological history and examination

1. Methods of assessment:

2. Current psychological complaints:

3. Post-torture history:

4. Pre-torture history:

5. Past psychological/ psychiatric history:

6. Substance use and abuse history:

7. Mental status examination:

8. Assessment of social functioning:

9. Psychological testing:

10. Neuropsychological testing:

VIII. Photographs/ Videographs (with informed consent)

IX. Diagnostic test conducted & results

X. Consultations/ References to other specialists (if needed)

XI. Interpretation of findings

1. Physical evidence

- A. Correlate the degree of consistency between the **history** of acute and chronic physical symptoms and disabilities with allegations of abuse.
- B. Correlate the degree of consistency between **physical examination findings** & allegations of abuse. (Note: Absence of physical findings does not exclude the possibility of inflictment of torture or ill-treatment)
- C. Correlate the degree of consistency between examination findings of the individual with knowledge of **torture methods** and their **common after-effects** used in a particular region.

2. Psychological evidence

- A. Correlate degree of consistency between **psychological findings** & the report of alleged torture.
- B. Provide an assessment of whether the psychological findings are **expected or typical reactions to extreme stress** within the cultural and social context of the individual.
- C. Indicate the **status of the individual in the fluctuating course of trauma-related mental disorders** over time, i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual?
- D. Identify any **coexisting stressors** impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
- E. Mention **physical conditions** that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

XII. Conclusions and recommendations

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

XIII. Statement of truthfulness

“I declare that the foregoing documentation is true and correct”

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

“The undersigned clinician/s personally certify that he/ she/ they was/ were allowed to work freely and independently and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities”;

or

“The undersigned clinician/s had to carry out his/ her/ their evaluation with the following restrictions:

XV. Specimens collected and handed over (please tick)

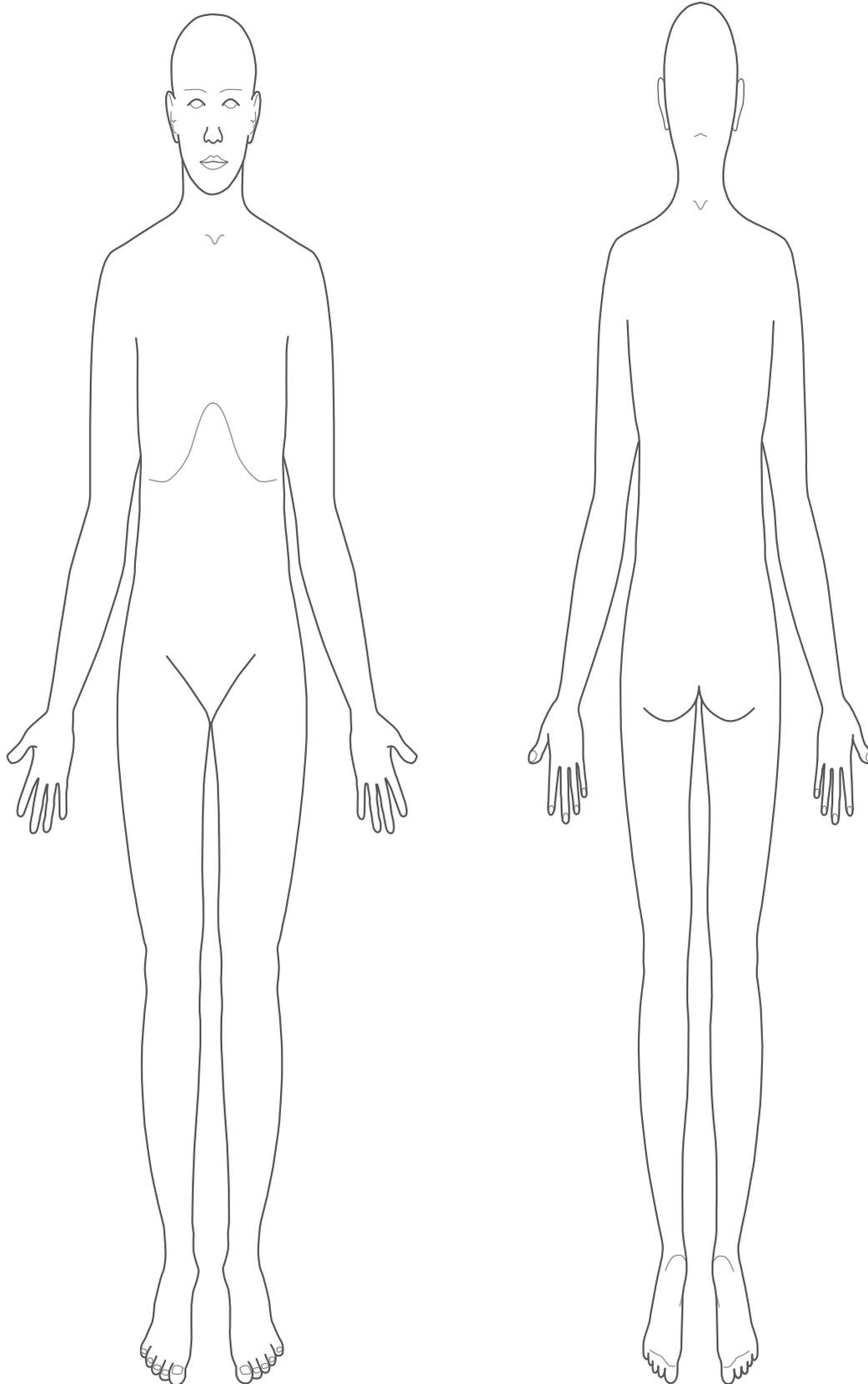
- Stomach aspirate/ Vomitus/ Body fluids/ Blood/ Urine/ Faeces, sample of blood on gauze piece (air dried), vacutainers, preservative used for chemical/ Toxicological analysis
- Specimen collected for Biopsy/ Histopathological examination (mention name of organs/ tissues)
- Body fluids, secretions in culture media or appropriate medium for microbiological and/ or Immunological examination and/ or Biochemical examination
- Clothes
- Photographs/ Video cassettes, finger prints etc.
- Foreign objects (like bullet, ligature etc)
- Slides from vagina, semen & other material, if any
- Any other
- Any other
- Sample seal with specimen signatures

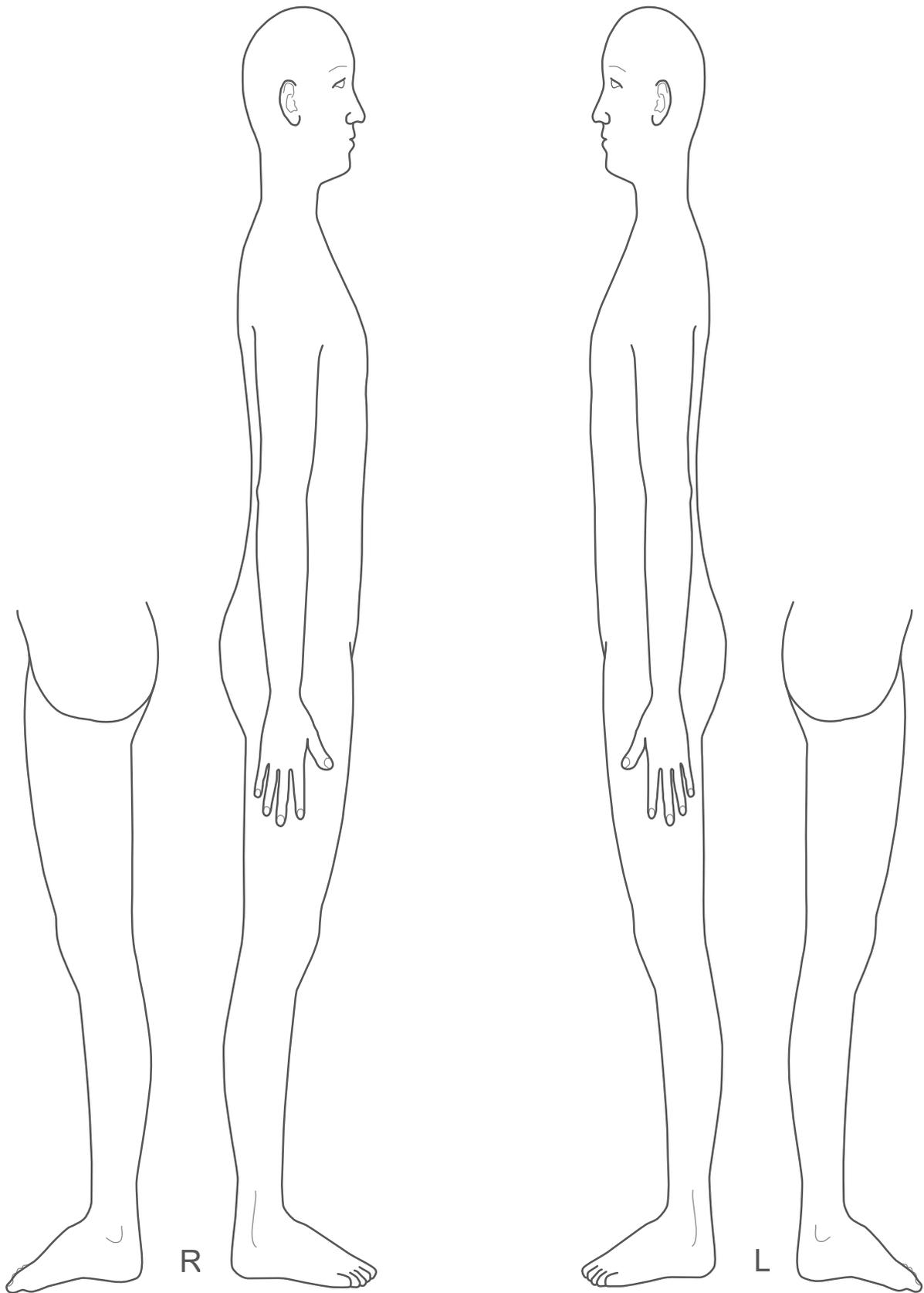
Medical examination report in original, ----- clothings & other articles which are duly packed, sealed and labelled numbers, handed over to police official number of police station whose signatures are herewith.

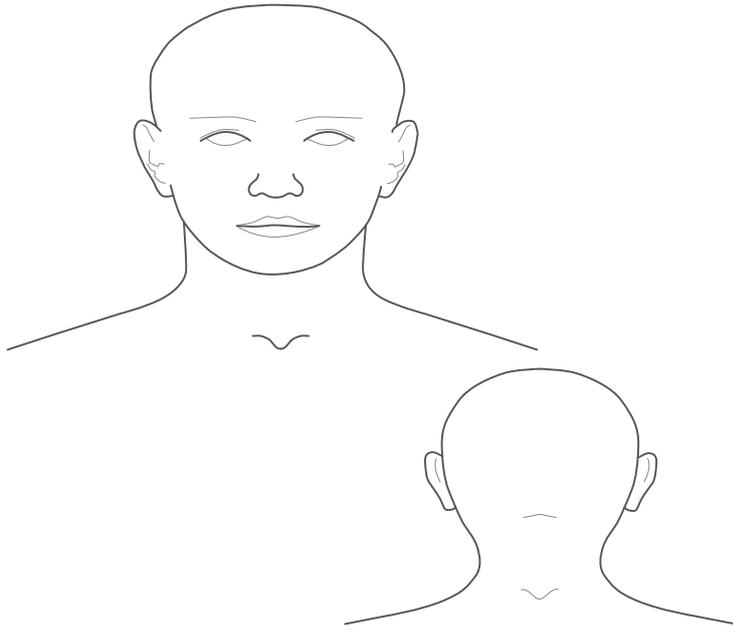
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Name of Medical officer
Designation
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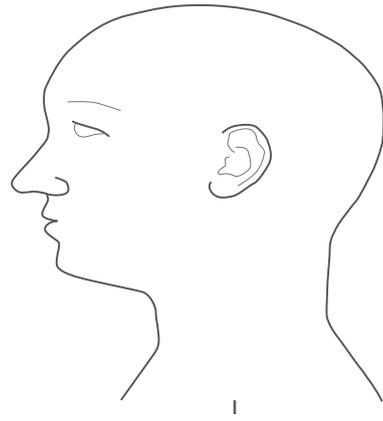
Signature
Name of Medical officer
Designation
Seal

Receiving by Investigating Officer
Signature
Name
Rank
Belt number
Police station
Date of collection

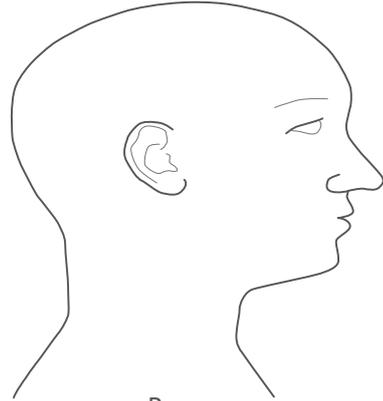




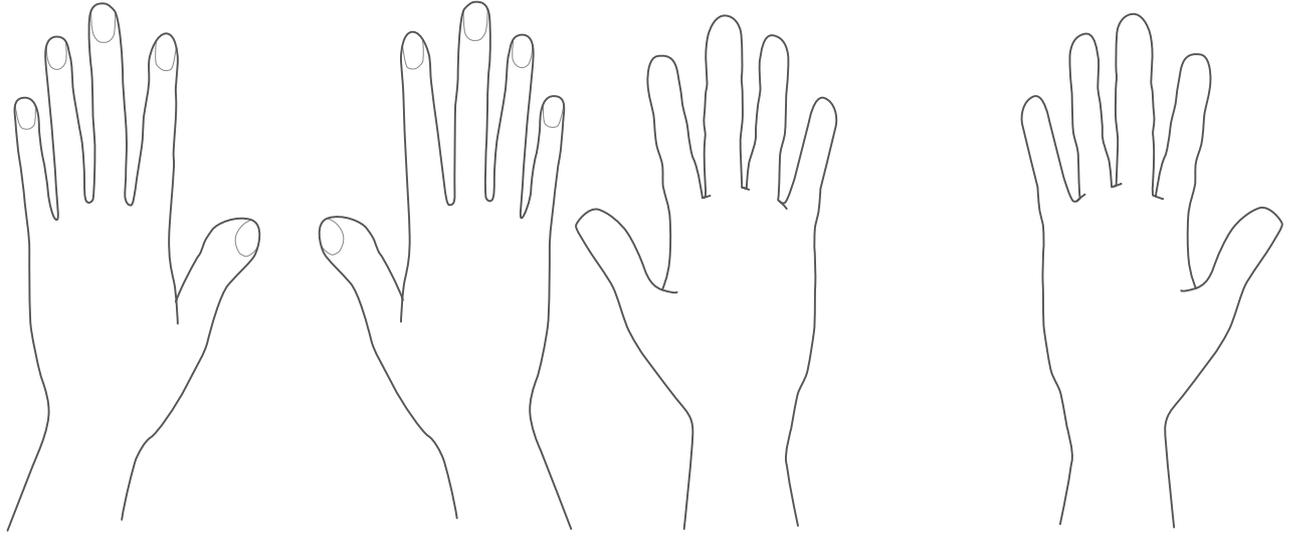




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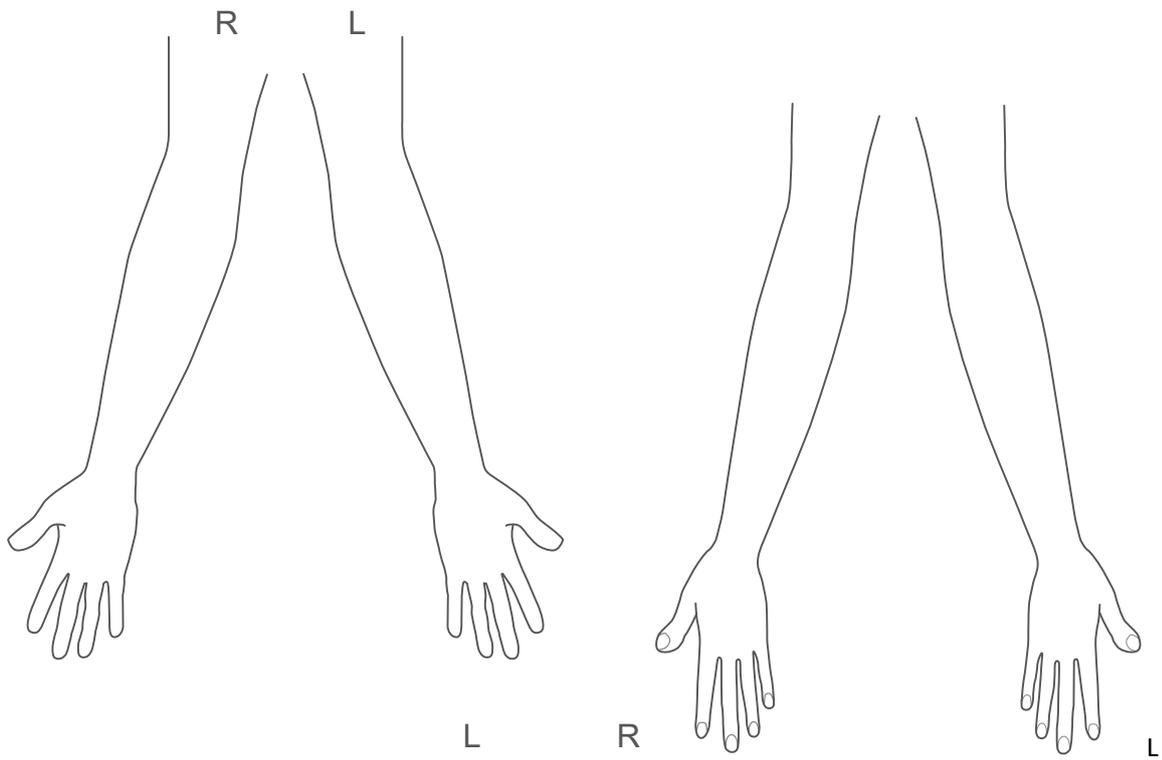


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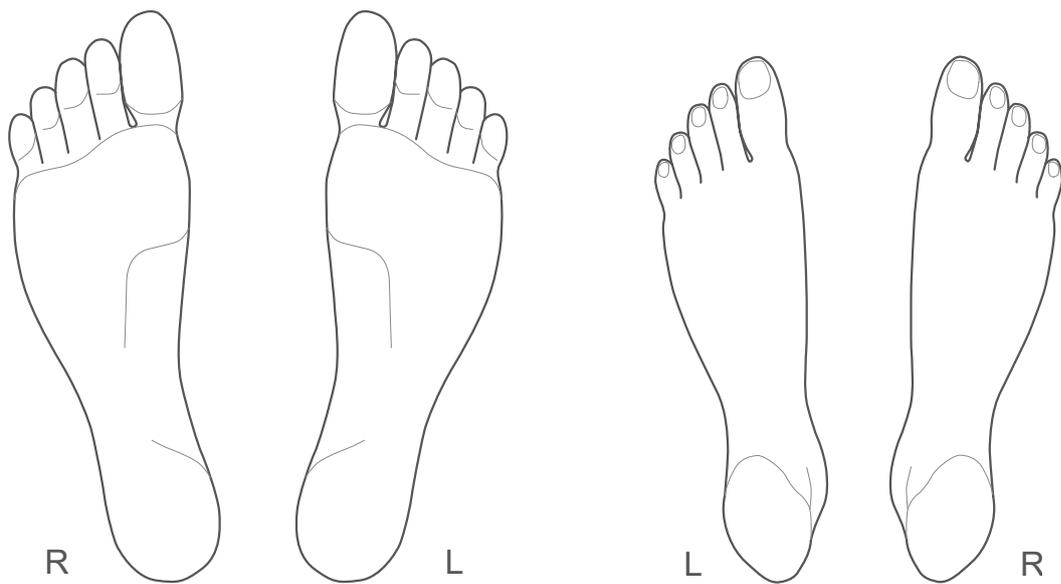
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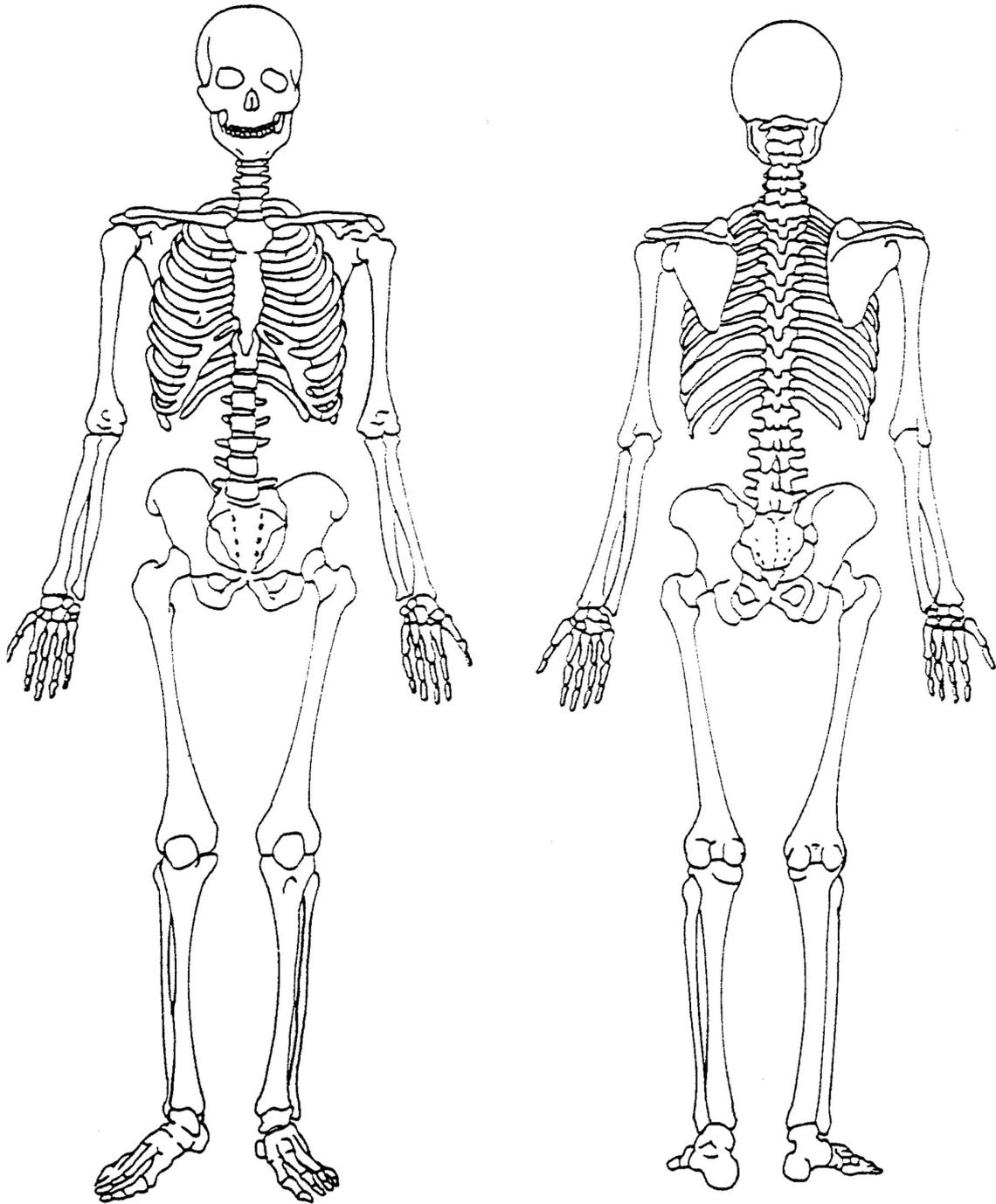
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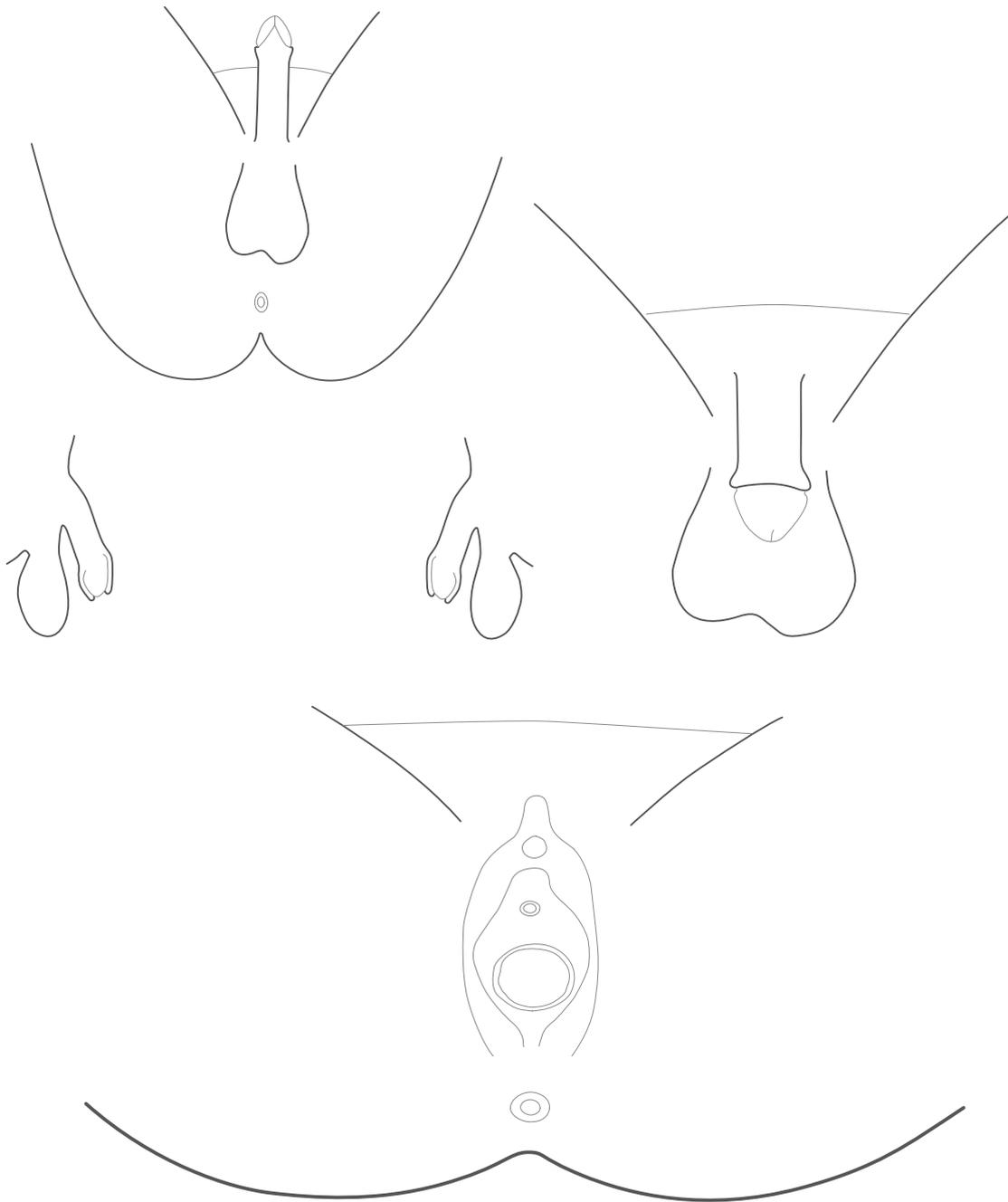
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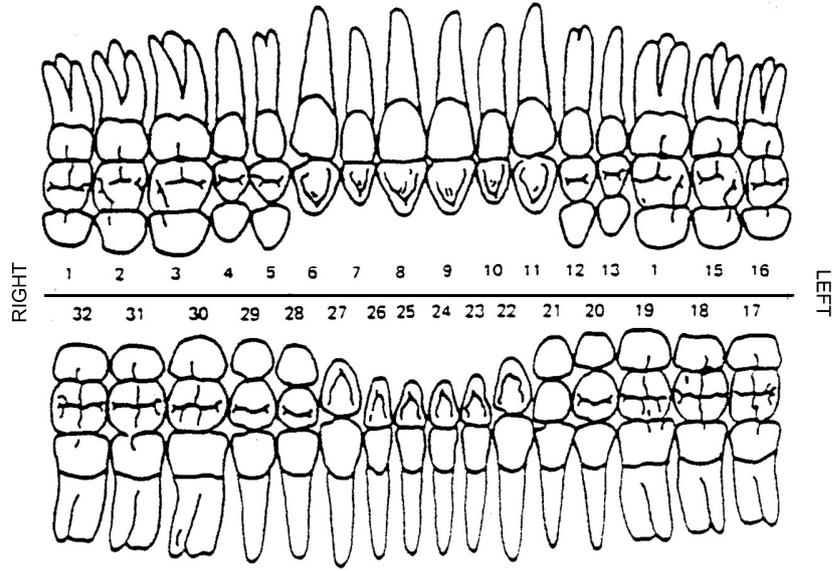






MARK ALL EXISTING RESTORATIONS & MISSING TEETH ON THIS CHART _____

Race _____



- Circle descriptive term
- Prosthetic appliances present
 - Maxilla
 - Full denture
 - Partial denture
 - Fixed bridge
 - Mandible
 - Full denture
 - Partial denture
 - Fixed bridge

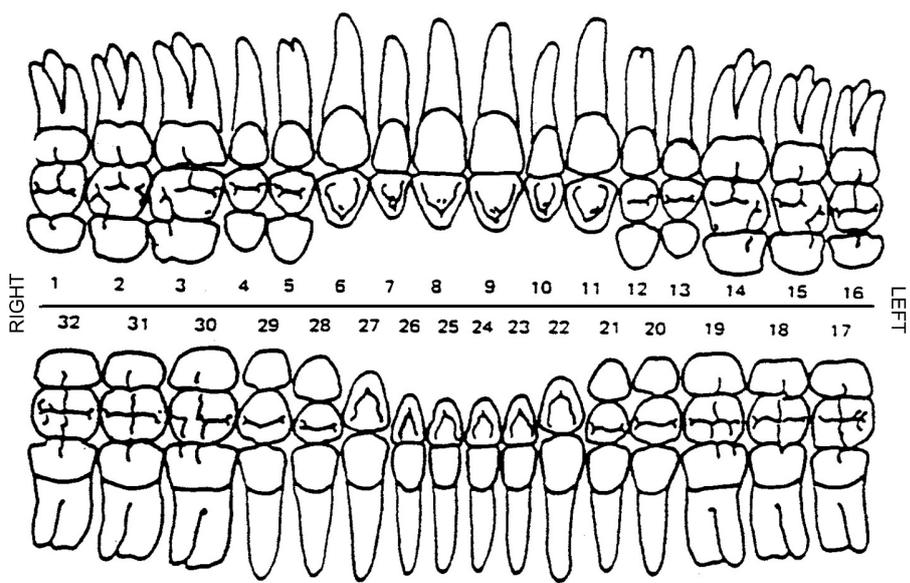
Describe completely all prosthetic appliances or fixed bridges _____

- Stains on teeth
 - Slight
 - Moderate
 - Severe

MARK ALL CARIES ON THIS CHART

Outline all caries & mark out 'X' for all missing teeth Circle descriptive term

- Relationship
 - Normal
 - Undershot
 - Overbite



- Periodontal Condition
 - Excellent
 - Average
 - Poor

- Calculus
 - Slight
 - Moderate
 - Severe