



Association Justice and Mercy



Torture

The background of the page is a faded, light blue-tinted image. It depicts a person, possibly a woman, confined within a metal cage. The person's hands are visible, wearing metal handcuffs that are attached to the cage bars. The cage is made of vertical metal bars, and there is a piece of barbed wire running across the top and bottom of the frame. The overall tone is somber and evocative of human rights issues.

26-6-2023

**International Day in Support of
Victims of Torture**



Capacity building training

The Forensic Examination of Alleged Torture Victims'

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FORWARD

The fight against torture is an essential and indispensable process that demands our utmost attention.

The commendable efforts of the “Justice and Mercy Association AJEM” have reached a significant milestone this year as we celebrate our 25th anniversary in defending human rights. Our primary focus lies in instilling a culture of mercy and cultivating compassion within the hearts and consciousness of society’s members.

The association tirelessly works towards **providing unwavering support to incarcerated individuals and their families**, both during their time in prisons and detention centers, as well as after their release. AJEM’s comprehensive approach encompasses various fields such as social, psychological, legal, and health support, with the ultimate goal of **improving the conditions of prisoners, facilitating their rehabilitation, and extending support to their families**.

Moreover, the association extends its compassionate reach to those who have struggled with drug dependence, offering assistance through opioid substitution therapy. Additionally, **AJEM operates a reception house that welcomes individuals pursuing rehabilitation through specialized programs and projects**. The association firmly believes that human dignity should prevail over societal, economic, legal, and religious considerations.

One of AJEM’s core objectives is the **abolition of the death penalty**, focusing our dedicated efforts on **combating torture and curbing cruel, inhumane, and degrading**

treatment inflicted upon individuals who are defenseless due to their loss of freedom and violation of their fundamental human rights.

It is imperative to acknowledge that **human rights** bind all people worldwide under the same umbrella of **law, legislation, and dignity**. Sadly, human beings often commit grave and disgraceful errors against their fellow humans, either intentionally or unintentionally, thereby transgressing against both humanity and the Creator.

Upon observing societal issues and closely accompanying torture cases, it becomes evident that combatting torture is a gradual and arduous process. Thus, a collective endeavor is indispensable, necessitating the **sowing of seeds of mercy and justice in every heart and conscience, along with promoting education on values and the rejection of violence and extremism**.

This discourse emphasizes the vital role of **scientific research within criminology to rectify factual omissions**. Today, more than ever, a comprehensive and periodic review is imperative to realign our course and implement effective procedures, agreements, and commitments. Only through such measures can we successfully progress in reducing torture, arbitrary detention, and other human rights violations.

Our genuine sense of “humanity” compels us to preserve life by upholding the essence, value, and role of humanity itself. By doing so, we can aspire to achieve a dignified and comfortable existence, far removed from defamation, slander, contempt, cynicism, arrogance, inferiority, violence, and torture.

*Father Nagib Baaklini,
President Association Justice and Mercy*

INTRODUCTION

Since 2009, **the Association Justice and Mercy has been cooperating with the High Commissioner for Human Rights in the implementation of a project to fight against torture and all forms of cruel and inhuman treatment.**

The project aims to prevent, protect and treat the psychological and physical after-effects of victims of torture as well as to provide support to their families.

Over the years, the program against torture led to a series of actions and activities, including: **raising awareness of violations of the rights of detainees, assisting victims of torture and their families, re-equipping police stations and training Forces Internal Security to acquire new knowledge on interrogation methods.**

As part of the program against torture, **AJEM is involved in improving the quality of services rendered and in strengthening the capacities of the working group through the performance of skills development training.** In 2020 and 2021, skills development trainings focused on the **mental health of torture victims**, including learning several therapeutic techniques that help mitigate the short and long-term psychological effects on torture victims.

AJEM psychologists participated in training sessions in 2020 to learn a new therapeutic technique 'Narrative Exposure Therapy' with the aim of using it in the

treatment of victims suffering from Post-traumatic stress disorder.

While in 2021, skills development training is carried out to strengthen the knowledge of psychologists on the techniques of **Cognitive Behavioral Therapy** that can be used in their therapeutic follow-up with victims.

In the year 2022, AJEM

highlighted the importance of the role of forensic medicine in the examination, interpretation and identification of victims of torture, and organized a training for the work team which aims to develop their knowledge of the intervention of the forensic medicine with victims of torture.

The training carried out was titled **"The Forensic Examination of Alleged Torture victims"**.

The forensic physician Dr. Nagi Azzi presented the 2 training sessions, which include in the first session a theoretical part of forensic medicine while the second session contained clinical cases taken from our interventions with victims.

Generally, the 2 training sessions included the following topics:

- Ethics, roles and responsibilities of a forensic physician.
- Forensic examination as part of a physical investigation torture.
- Application of forensic expertise in Lebanon: Comparison with Istanbul standards Protocol.
- Physical symptoms according to the methods of torture.
- Long-term clinical effects: Chronicity and sequelae.
- Somatic and psychosomatic effects of torture.



I- ETHICS, ROLES AND RESPONSIBILITIES OF A FORENSIC PHYSICIAN

A- Introduction to medicine in forensic and protected environments

Forensic physicians **owe the same ethical obligations to their patients as all other physicians**, and hence, **their primary professional responsibility is to their patients**. Those who may be accused or convicted of crime, or who may be claimants of crime, **are entitled to the same high standards of independent and impartial medical care and treatment as any other patient**.

In addition to their ethical obligations to patients, forensic physicians also have a professional role in supporting the criminal justice system. They are frequently involved in the complex medical and forensic examination of suspected victims or criminals, often leading to **providing evidence to the courts**. Forensic physicians may also be called upon to assess the fitness of individuals for detention or interview.

Sometimes, these different roles or professional commitments may come into conflict. **An obligation to respect patient confidentiality may conflict with the obligation to reveal information for forensic purposes**. Although all doctors recognize the presence of

duties additional to those they owe to individual patients, for forensic physicians, these can at times be more pronounced. Although they have developed considerable expertise at managing these competing obligations, these latter can still lead to confusion.



Forensic physicians deal with particularly **vulnerable patient populations**. They often treat and examine patients with mental disorders, or patients under the influence of or dependent upon alcohol or other drugs, frequently at points of crisis in their lives. **Managing violent, aggressive or intoxicated patients can be challenging**, including **how to balance obligations to patients with concern for personal safety and wellbeing**. The sensitive management of claimants of crime, particularly violent crime such as rape or other forms of sexual abuse, requires specific skills and can raise ethical issues.

People entering the criminal justice system **often come from abusive backgrounds**, and there is always a **risk that they will experience abuse in institutional settings**. Sometimes, part of a **forensic physician's role is to advocate on behalf of their patients**. This includes **identifying where patients are at risk and taking all reasonable efforts to protect and promote their human rights**. Forensic physicians have a **duty to speak out where they identify abusive practice or behavior**, but this can sometimes present challenges in closed institutions.

B- Leading Principles

Forensic physicians **owe the same fundamental ethical duties to their patients as all other doctors**. However, the **relationship between forensic physicians and their patients is slightly different** to the regular doctor-patient

relationship. Indeed, the forensic physician is **contracted or subcontracted to the police** to provide forensic and therapeutic services but, as a doctor, retains a clear duty of care to the person being examined or treated.

In addition to the basic duties on all doctors, forensic physicians should:

- Remember their duty of care for individuals, even where health assessments take place for reasons other than providing treatment.
- Make sure that patients are informed of the nature and extent of any dual obligations and the impact they may have on their rights and interests.
- **Provide care that is, at least, of a comparable standard to that provided in the community.**
- Seek informed consent, even if, as with an intimate body search for suspected concealed weapons, the law does not require it to be obtained.

Forensic physicians should also:

- **Respect the rights of patients** to have access to adequate information about treatment options.
- **Respect patient confidentiality** and inform patients at the time they provide information if it will be used for purposes other than their care
- They should also know what those purposes are likely to be and whether they can decline
- **Respect patients' human rights and be sensitive** to the ways in which they may be compromised. **Maintain robust standards of professional and clinical independence**
- Identify where services or conditions are inadequate and may pose a threat to health and raise concerns as appropriate
- **Be sensitive to the needs of patients** with vulnerabilities and guard against inappropriate forms of discrimination.

C- Working with dual obligations

1- Facts about dual obligations in practice

For most health professionals, these second obligations to other parties or to the wider society are usually in the background of their interest. For forensic physicians it can be different. Along with duties to patients, they have obligations to the criminal justice system and the safety of the public, including staff caring for potentially violent patients with mental disorders.

Although there is not always tension around, **there may be instances when their forensic role will not be in the interests of the individual**, and conflicts, real or perceived, may arise.

Working with these dual obligations and ensuring patient interests are correctly protected is an essential part of the role of the forensic physician. It should be known that the culture of certain institutions, particularly closed institutions, can be insidiously intimidating,



particularly where forensic physicians are professionally isolated.

Forensic physicians also have the opportunity to protect and endorse the rights of vulnerable individuals in the criminal justice system.

Professional independence and clinical objectivity are powerful tools to help **identify both deliberate abuse and poor practice** that can, over time, become abusive.

2- Managing dual obligations in practice

Keeping in mind the basic principles given above is an essential first step to responding to the tensions that arise in practice. In addition, the following points should be considered:

- Wherever forensic physicians have direct obligations to third parties, they should ensure their patients are aware of the nature of those obligations and their implications for them
- Forensic physicians hold a duty of care to their patients, irrespective of their duties to third parties, and are bound by the same ethical and legal obligations as all doctors
- Forensic physicians must maintain the highest standards of professional and clinical independence and impartiality
- A patient's right to consent should be respected, even where it is not a legal requirement
- Forensic physicians owe their patients a duty of confidentiality and information should not normally be disclosed without the patient's knowledge and consent
- Forensic physicians have a duty to speak out when they identify services that are substandard or pose a threat to the health or wellbeing of their patients

D- Consent to examination and treatment

1- Generalities

Persons in custodial settings have the same rights to accept or refuse medical care and treatment as all other patients. In all cases forensic physicians should present themselves to the person to be examined. When seeking consent for examination, doctors should clearly explain their role and their commitments to the police or court, and their significance. They should clarify that part of their role is to collect evidence for the police and no guarantees can be given that confidentiality will be maintained.

2- Consent for examination of complainants of crime

Is a vital part of the role of forensic physicians, both to secure evidence and to provide any necessary medical care and treatment. The time limits for acquiring supporting evidence and complete information about the alleged crime mean that examinations must be performed promptly.

For consent to be valid, the individual needs to know what the examination will involve, and be aware that forensic information, and any other information that may affect the outcome of the case, will be passed to the police.

Delicate discussion with the complainant is essential and where possible, patients' preferences regarding the gender of the examining doctor should be respected, particularly where sexual crimes are involved.

3- Consent for examination of a person held in custody

Examination of people in custody can be undertaken for several reasons: for the provision of care, to assess fitness for detention or interview, or for the identification of involvement in crime.

Although it is lawful for some intimate body exams to be undertaken without consent, references in forensic medicine state that doctors should only participate where the individual has given consent.



Where the latter lacks the capacity to consent, doctors should only proceed where the investigation would be in the person's best interests. In these circumstances it may be necessary to assess the individual's decision-making capacity and, where possible, delaying any treatment or intervention until the patient regains that capacity.

When individuals refuse to consent, the examination should not take place, and the refusal should be noted in the forensic physician's notes. Doctors should remain alert to the impact of any underlying pathology on the detainee's co-operation. Finally, patients held in custody should be informed that confidentiality is not absolute in circumstances where their injuries were sustained while assaulting another person.



4- Consent for examination of minors

Minors are a particularly vulnerable group in custody settings, and special care should be taken when examining them. **The relatives of minors can be present at the examination if the young person agrees.**

Wherever young persons are considered competent to understand the nature, purpose and possible consequences of the treatment proposed, they can consent to any medical examination, including for forensic purposes.

If possible, the consent of someone with parental responsibility should also be sought.

E- Privacy And Confidentiality

1- Generalities

The nature of life in custodial situations can clearly put the privacy of detainees under stress. The duty to respect the privacy of prisoners is, however, not only a professional obligation; it is also a requirement of both the common law and the Human Rights Act. Any necessary contravention of prisoners' privacy must therefore be both legitimate and proportionate. The need to safeguard the patient's privacy and dignity during examination or treatment must be balanced against the risk of danger to the forensic physician and the requirement to ensure patients' clinical needs are met. **The normal practice is to examine the prisoner with protection** - normally a police officer within discreet proximity.

Ideally the police officer should be out of immediate hearing range, although this may not always be possible. The use in certain delicate conditions of an attendant or a person employed by the police, however, could present problems of confidentiality. However, the code of practice in Criminal Procedure and Investigations state that any police officer or employee, involved in a case has a duty to record events and to pass information to the prosecutor.

2- Confidentiality

The primary objective of most examinations directed by forensic physicians is to obtain evidence for a possible prosecution, although the evidence may, of course, be used by the defense. Therefore, both accusers and suspects – should be clear about the uses that may be made of their information. However, **any information obtained for therapeutic purposes that does not amount to forensic evidence, and is not relevant to the criminal case, is subject to the usual rules of confidentiality.**

Basically, confidentiality is both a legal and professional obligation, rooted in the law and binding professional obligations. It is essential to trust between doctors and patients. Confidential

information can be disclosed where patients consent to the disclosure, where the disclosure is required by law, or where the public interest in disclosure is sufficiently strong.

Consent for disclosure will include what information is to be disclosed, the purposes of the disclosure and who it will be disclosed to. If the patient withholds consent, or consent cannot be obtained, disclosure may only be made where there is lawful authority requiring it.

3- Custody records and confidentiality

If forensic physicians record inappropriate medical details, such as the HIV status of detainees on custody records, without the patient's consent, this would be a breach of the physician's duty of confidentiality. Only the information necessary to individual's health and their need to be given medication or kept under observation should be disclosed to the police. **Forensic physicians should provide custody officers with clear and detailed directives about any medical supervision required, including the frequency of visits needed.**

They should bear in mind that police officers are not medically qualified and cannot be expected to interpret complicated medical terminology.

4- Sharing information with other healthcare providers

This is an important issue for forensic physicians and prison medical officers where it deems necessary and appropriate. This includes ensuring that a **private record of any medical treatment provided, or requested, by the forensic physician while the individual is in police custody, accompanies the individual on transfer. This so-called personal escort record (PER)** should contain data about suspected mental disorders, physical illness, substance abuse, suicidal ideation or self-harm.

The forensic physician is usually asked to contribute on the following issues:

- *physical or mental health conditions*
- *medication issues*
- *drug or alcohol abuse*

- *suicidal ideation or any history of self-inflicted harm.*

In addition to including risk-assessment information in the custody record, similar information must be written on a PER form, which must accompany every detainee who is moved from a police station to another location, such as to court or prison. It is not appropriate, for example, to record a detained person's HIV status on the form itself. However, communicable diseases that are transmissible through normal contact should be recorded on the form to safeguard those who come into contact with the detainee.

F- The Medical Role In Control And Restraint

1- Generalities

If restraint or control measures are appealed for the purposes of maintaining order or discipline, this should not involve health staff. Restraint should only ever be used as an act of care and control, not as punishment or a convenience. Any decision to restrain someone for the purposes of medical care or treatment must follow an individual assessment of the level of risk in each case. Medical authorities and guidelines state that rapid tranquilization should only be performed where equipment for cardiopulmonary resuscitation is present and there are trained staff to use it.

2- Restraint and control measures in prison

When police officers have to use control and restraint measures to manage a violent or aggressive individual, doctors and other healthcare staff must have no role in this process.

This includes supervising or advising on the use of restraint on a particular person.

All individuals must be offered the possibility to speak with a doctor or health member after every incident of restraint.

This should include evaluation and treatment of any sustained physical injuries, as well as for giving emotional support.

Various international bodies advise that the use of physical restraint against violent detainees requires certain precautions, and that:

- restraint should never be prolonged or applied as a punishment
- a record should be kept of every use of restraint or force against prisoners
- prisoners who have been subjected to force should be examined, and if necessary,

treated by a doctor as soon as possible

- if possible, medical examination should be conducted out of sight and hearing of non-medical personnel, a note should be made of findings and this should be available to the detainee
- effective inspection and complaints procedures must be in place. Detainees should be aware of the possibilities of complaint open to them.

G- The Use of Segregation or Solitary Confinement

1- Basic principles and health issues

- The use of solitary confinement must be reserved to a minimum.
- The use of solitary confinement must be proportionate to the harm it is designed to prevent or mitigate.
- Any use of solitary confinement must be lawful and the decision to use it taken by a competent authority.
- Full records must be kept of all decisions to use solitary confinement.
- There must be no automatic restrictions on, or withdrawals of, other rights owed to the individual, such as rights to visits, make telephone calls or access to resources normally available to detained persons.



This is particularly so where the individual has pre-existing mental or physical health problems. The impact on health increases with the length of confinement. Critically, those subject to solitary confinement have a considerably higher rate of suicide than the general custodial population.

The Nelson Mandela rules define solitary confinement as the confinement of detained persons for 22 hours or more a day without meaningful human contact. They define prolonged solitary confinement as any such confinement lasting for 15 days or more.

Solitary confinement, even for limited periods, presents significant risks to physical and mental health.

2- The medical role in solitary confinement

Given the risks for solitary confinement to jeopardize the health of detainees, doctors and other health professionals have a clear role to play in monitoring the health of those subject to it, particularly where it may be necessary for therapeutic reasons or the detainee's own protection.

If, however, prisoners are confined to maintain order or discipline, this should not ordinarily involve health staff – although all detainees must have access to a doctor.

Particular difficulties arise where doctors are called upon **to certify that an individual is “fit” to withstand solitary confinement**. In general, doctors should not participate in certifying fitness for solitary confinement but should speak out if they think solitary confinement is undermining the health of a detainee. Doctors should also visit prisoners in solitary confinement regularly, for the duration of their confinement – typically, on a daily basis – and raise concerns about any noted deterioration in health.

3- Solitary confinement and fundamental rights

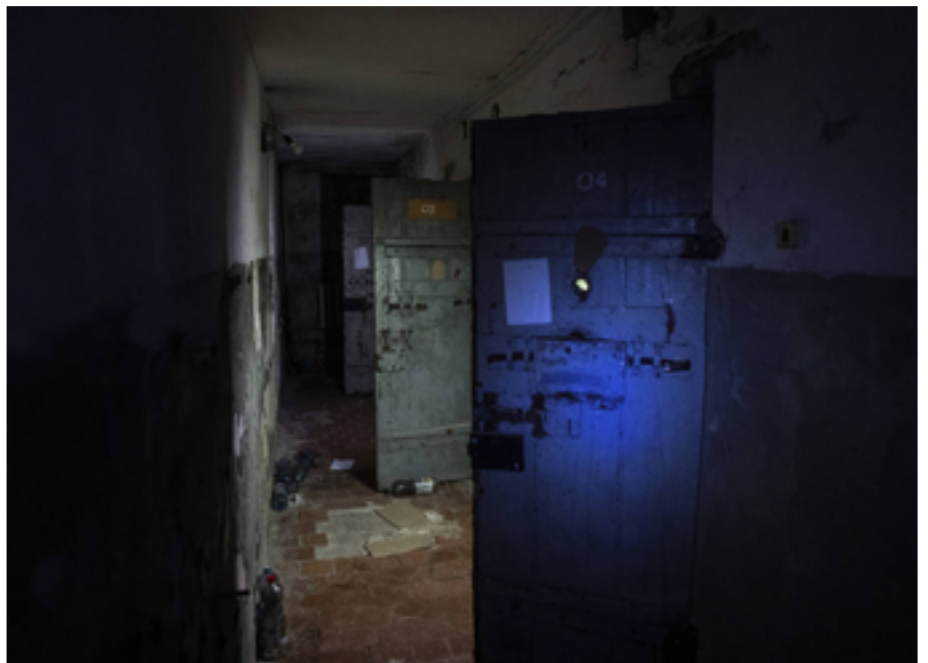
Solitary confinement raises issues both for health professionals and entities concerned with potential violations of fundamental rights in detention settings. International Bodies in particular the UN Human Rights Committee and the European Committee for the Prevention of Torture stated that **solitary confinement should only be used in exceptional circumstances, and that it may amount to inhuman and degrading treatment**. In addition, solitary confinement can have a particularly profound impact on children and young people health and wellbeing. There is a growing international consensus that solitary confinement should never be used on this particular subgroup.

H- Managing Risk and Looking after Oneself

All health professionals have a right to a professional life that is without fear of physical, psychological or verbal violence or assault of any kind. Competent authorities like the general medical council (GMC) in the United Kingdom (UK) state that: “If a patient poses a risk to your health or safety, you should take all available steps to minimize the risk before providing treatment or make other suitable alternative arrangements”.

In fact, forensic physicians following imprisoned patients may be more at risk of violence and abuse than their community or hospital-based colleagues.

Although ideally consultations between forensic physicians and their patients should take place with a maximum confidentiality, in certain instances, a police officer may have to be discreetly present. And, if the risk is very significant some form of restraint may need to be used.



Also, practicing in custodial settings can have an impact on doctors’ personal and professional wellbeing. Working in situations that can undermine the health and welfare of patients, being subject to the ongoing tensions of dual loyalties, and the sometimes-challenging needs of the patient population can all have an effect. **Doctors should remain alert to the subtle effects of institutional pressures** and their ability to undermine independent professional judgment, and in such cases, they should raise them to their medical defense organization.

I- Standards of Care

Police cells are not designed to hold people for sustained periods. They lack the necessary facilities to promote and maintain the ordinary wellbeing of detainees, such as access to open spaces and opportunities for exercise. Many police stations have inadequate washing and bathing facilities as well as insufficient lighting, heating and ventilation. These conditions of the prisoner's existence, particularly if it is prolonged, must be considered by forensic physicians. The latter would be expected to comment upon such issues and to escalate them if no action is taken.

On the other hand, doctors are sometimes required to leave medicines with the custody officer for prisoners to take later. The use of hospital-type medication charts can be helpful, provided custody staff are appropriately trained.

The forensic physician's room should be a dedicated facility similar to consultation rooms used in general practice. Given the circumstances in which forensic physicians work, security precautions will be necessary (policeman in range, bars on windows, locks from the outside...).

J- Identifying Abuse and Raising Concerns

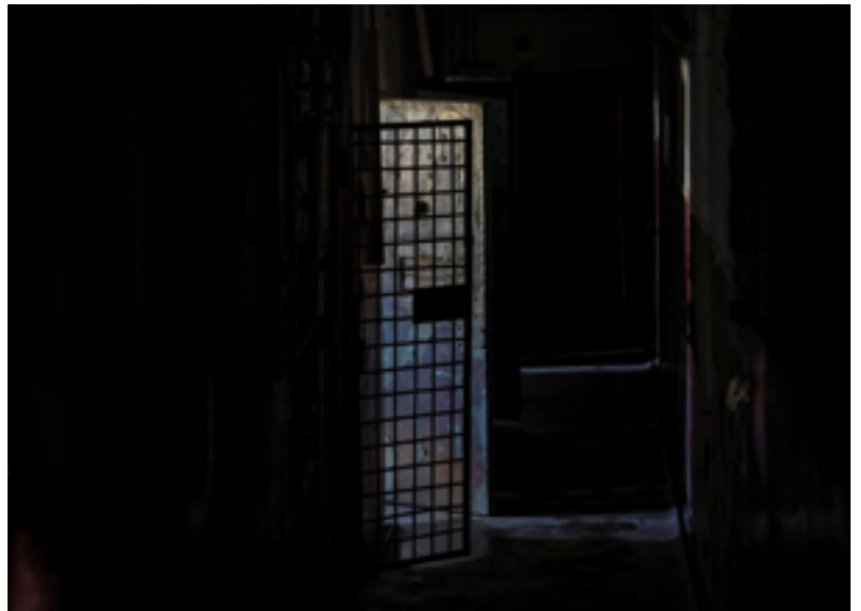
Factually, forensic physicians have made a significant contribution to the protection of vulnerable people. They have supported the victims of crime, and their forensic skills have been used to gather evidence of crime to aid prosecution.

Custodial institutions, with their focus on security and criminal justice, can harm the rights and wellbeing of detainees, which makes the role of physicians even more important.

All doctors have a duty to speak out where they believe that their patients are at risk as a result of substandard services or poor practice.

Medical authorities like the GMC state:

- **Forensic doctors must take prompt action if they think that patient safety, dignity or comfort is or may be seriously compromised.**
- **If a patient is not receiving basic care to meet their needs, they must immediately tell someone who is in a position to act straight away.**
- **If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, forensic physicians should put the matter right if that is possible. They must raise their concern in line with their guidance and their workplace policy. They should also make a record of the steps they have taken.**



K- Intimate Body Searches for Non-medical Purposes

Although forensic physicians are sometimes asked to perform intimate body searches, and in some circumstances, consent is not a legal requirement, where the individual can make an informed decision, doctors should not perform examinations without consent.

While some professionals may refuse to take on intimate body searches, it is worth considering that an individual may have no choice as to whether a search will be made but may prefer to be searched by a qualified medical professional

rather than a custody or prison officer.

L- Taking Samples

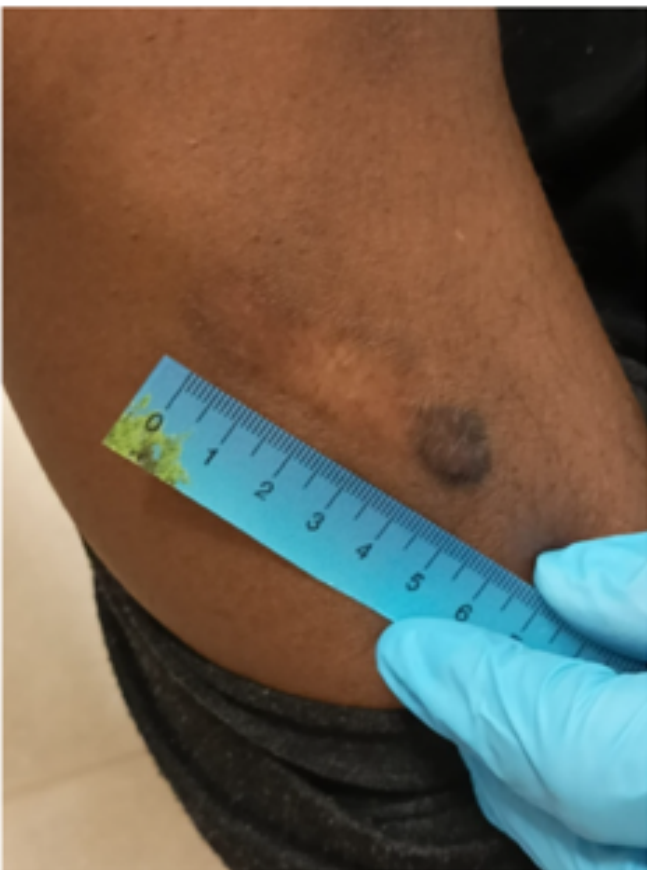
Forensic physicians are sometimes asked to take samples from detainees or from victims of crime for identification or toxicology purposes. As with such interventions, forensic physicians need to obtain the informed consent of competent individuals before proceeding.

Legally there is a distinction between intimate and non-intimate samples. Intimate samples are defined as:

- **any swab from a body orifice, other than the mouth**
- **blood, semen, urine and any other body fluid except saliva**
- **pubic hair**
- **dental impressions.**

The authorizing police officer must have a reasonable belief that taking the sample will confirm or disprove the detainee's involvement in a recordable offence.

Ordinarily, police officers take non-intimate samples, although forensic physicians may also be asked.



M- Assessing Fitness for Detention and Other Purposes

Assessing individuals for detention and interview can highlight the forensic physicians' dual loyalties.

The medical requirement to ensure, as far as possible, the health and wellbeing of the individual, can be in pressure with the needs of criminal justice. It is vital, therefore, that forensic physicians are able to make a thorough, objective and independent assessment of the detainee's condition.

As part of the assessment process, forensic physicians need to identify:

- **that the individual is sufficiently mentally competent to understand and answer questions**
- **whether the individual is mentally ill or vulnerable and requires the presence of an Appropriate Adult during the interview – whether the individual requires any special provisions during the interview.**

N- Patients with Particular Vulnerabilities

1- The mentally ill

People with mental disorders make up a large percentage of the detained population. Police stations and prisons are not ideal places to care for and treat individuals with mental disorders.

A decision to prosecute is clearly not one for forensic physicians, and they should therefore avoid being drawn into this process. That is a decision for the criminal justice authorities to make according to well defined process.

Custody officers are required to immediately call a forensic physician or healthcare professional if a person brought to or detained in a police station appears to be suffering from a mental disorder.

Forensic physicians are also frequently asked to assess fitness for interview, advise on the

need for an Appropriate Adult, and provide medical advice for the police on the individual's mental health.

All of these assessments may contribute towards a decision about whether to prosecute. Some offenders never enter the judicial system but are referred straight to hospital, without being arrested or taken to the police station.

2- Patients with alcohol-related problems or who misuse drugs

Concerning patients with alcohol-related problems, since alcohol withdrawal can be dangerous, indication should be given to hospital referral, where appropriate.

Recommendations for improving the care and management of intoxicated detainees include: the installation of closed-circuit TV in certain cells to enable remote supervision of vulnerable detainees; having medically trained personnel in custody suites during peak periods; and greater use of detoxification centers.

Concerning patients who misuse drugs, those who test positive must participate in a compulsory drug assessment by drugs specialists to determine the extent of their drug problem and help them into treatment and other support, even if they not charged. Timely and accurate assessment of both substance dependencies, including the nature and degree of dependency, need for medical support, and any underlying physical or psychiatric morbidity, is essential.

3- Patients suffering pre-existing medical conditions or with head injuries

Concerning patients with pre-existing medical conditions, police cells are not ideal settings to manage them and, in some circumstances, referral to hospital may be necessary. In particular, the management of individuals with insulin-dependent diabetes in police cells may be difficult and possibly dangerous. Doctors should then assess the potential challenges of managing such cases against the need for continued detention.

Seizures are a common complaint amongst detained persons, and are usually straightforward to manage in police custody - unless the detained person is an "unstable" epileptic, where hospital admission will be indicated.

Concerning patients with head injuries, particularly when associated with alcohol consumption, they are potentially dangerous cases to manage in police stations and are a common cause of death in police custody. In these cases, officers must be given clear instructions about what to look out for and when to call a forensic physician.



O- Providing Medical Care to People Detained under Anti-terrorism Legislation

People falling in this category can be detained without charge for up to 14 days. This extended detention in police cells can undermine the wellbeing and medical care of those detained. Police cells are not suited for sustained periods of confinement, lacking facilities for exercise and access to open spaces. They are not ideal for those suffering from serious medical conditions. Confinement for long periods can also increase vulnerability to abuse.

Consequently, forensic physicians should ensure that these detainees have a medical examination on arrival to ensure their fitness for detention and interview. A careful assessment of their medical and welfare needs is necessary, including any special dietary, hygiene, exercise, privacy or religious needs.

P- Acting as Professional and Expert Witnesses

Doctors can act as various types of witnesses, entering the court as either ordinary, professional or expert witnesses.

Doctors acting as professional witnesses are asked to comment on matters of medical fact, usually in relation to patients they have seen or treated.

Experts, on the other hand, are invited to say what they have seen and heard, and express an opinion based on all available evidence.

Detached objectivity is always required and it is not the role of the expert to plead any particular side of the case. When preparing a report as an expert witness, doctors should ensure they clearly understand what is being asked of them and request all relevant information such as any pleadings, witness statements, investigation reports or previous medical records.

Where doctors are asked to undertake medical examinations for the preparation of a report, they should make it clear to the patient that the examination is not for therapeutic purposes. Consent must be sought both for the examination and for the subsequent disclosure of information.

As a general principle, doctors should not accept instruction where there is an actual or potential conflict of interest. Should a conflict of interest arise during the preparation of a report, the doctor must notify all concerned and, if appropriate, stand back from the case.

II- FORENSIC EXAMINATION IN INVESTIGATION OF PHYSICAL TORTURE

A- Introduction

Torture is one of the most inhumane acts that an individual can inflict on another. Although torture is prohibited under international law, it exists in many countries around the world.

The Istanbul Protocol, developed over a 3-years period, is the first set of international guidelines for researching and documenting torture. The Protocol provides comprehensive and practical instructions for the assessment of persons who claim to have been victims of torture and ill-treatment, for the investigation of a case of alleged torture, and for reporting the results to the competent authorities.

This Protocol was published in 1999 by the Office of the United Nations High Commissioner for Human Rights in its Professional Training Programs. Despite its international status and recognition among justice, health, and human rights experts, awareness of the Istanbul Protocol is still relatively limited. As a result, many lawyers and health professionals have little training in researching and documenting torture, areas that require specific technical skills and knowledge.

The definition given by Article 1 of the UN Convention against Torture (UNCAT) states the following: "torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for the purposes in particular of obtaining from that or another person information or a confession, of punishing for an act which that or another person has committed or is suspected of having committed, of intimidating or pressuring that or another person, or for any other reason based on any form of discrimination, when such pain or suffering is

inflicted by a public official or any other person acting in an official capacity or at his instigation or with his express or tacit consent. This term does not extend to pain or suffering resulting solely from lawful sanctions, inherent in these sanctions or occasioned by them”.

B- The Physical Exam

A full medical profile should be obtained from the person being interrogated, including medical, surgical and psychiatric history, as well as any pre-detention injuries as well as their possible sequelae.

Physical examination in cases of torture and other related human rights violations can have two purposes:

- 1. Documentation of allegations of torture.**
- 2. treatment of health problems.**

Our session will focus on the first goal. The acute and chronic somatic consequences of torture will be described for the different body systems. A physical examination for health issues cannot be done alone; it should be combined with psychological and psychiatric examinations, as well as an assessment of social status.

a- The Skin

The examination should cover the whole body to detect possible signs of generalized skin conditions, such as vitamin A, B and C deficiency, as well as pre-torture and/or post-torture injuries – abrasions, bruises, lacerations, punctures, burns, alopecia, ripped out nails, etc. For lesions associated with torture, the location, shape, size, color, appearance (scaly, crusty, ulcerative) as well as the demarcation and elevation vis-à-vis the surrounding skin should be indicated. It is essential to take photographs when possible.

At the end of the examination, the doctor must give an opinion as to the origin of the lesions: **inflicted by third parties or self-inflicted, accidental or consecutive to a morbid process.**

Facial structures should be palpated for signs of fracture, crepitus, swelling, or pain. Motor and sensory components of all cranial nerves should be examined, as well as taste and smell.

CT, in preference to traditional X-ray, is the best means to diagnose facial fractures and establish their characteristics, verify bony alignments, and detect associated soft tissue injuries and complications. Remember that cranial and cervical spine injuries are often associated with facial trauma.

b- The Face

• The eyes

There are many forms of eye trauma, including conjunctival, subhyaloid, retro-ocular and retinal, displacement of the lens and visual field loss. Given the serious potential consequences of failure to treat or of inadequate treatment, an ophthalmologist consultation will be requested whenever there's a suspected trauma or eye



disease. The scanner is the best means to diagnose a possible orbital fracture and soft tissue damage of the globe or back globe. Magnetic resonance imaging (MRI) can helpfully complement CT for detection of soft tissue lesions, and the technique of high-resolution ultrasound offers a good alternative for the evaluation of ocular trauma.

- *The Ears*

Trauma to the auditive system, including ruptured tympanum, is a common result of severe beats. The doctor should examine the external auditive canals and the tympanums with an otoscope and describe any lesions detected.

A common method of torture, known as telefono in Latin America, involves violently beating the ears with the palm of the hand. It causes a rapid increase in pressure in the auditive canal which in turn can causes a tympanic rupture.

The examination must take place as soon as possible to detect lesions caused to the tympanum; less than 2 mm in diameter, they heal within 10 days. We may sometimes detect a fluid leak at the middle or external ear. If otorrhea is confirmed by laboratory tests, MRI or CT scan should be done to identify the location of a fracture.

Any hearing loss can be detected through simple evaluation tests. If necessary, audiometric measurements can be carried out under the supervision of a qualified technician. To diagnose fractures of the temporal bone or rupture of the chain of ossicles, a CT scan is preferably used, then a hypocycolidal tomography, and finally a linear tomography.

- *The Nose*

In the examination of the nose, one will be attentive to the alignment and to possible signs of crepitus and deviation of the nasal septum. For simple fractures, plain X-rays are enough in most cases. For complex fractures and in case of displacement of the septum, it will be necessary to carry out a CT scan. In case of rhinorrhea, it is recommended to use CT or MRI.

- *Mandible, oropharynx and neck*

Fractures and dislocations of the mandible can be the result of sustained blows. Temporomandibular joint syndrome is a common consequence of blows to the lower face and jaw. One should also be attentive to possible signs of crepitation of the hyoid bone or laryngeal cartilage that may result from blows to the

neck. Observations relative to the oropharynx, including burn injuries that may result from electric shocks, should be noted in details, as well as any gingival bleeding and other gingival lesions.

- *Oral cavity and teeth*

Examination by a dentist should be part of routine health checks for prisoners. Detainees are sometimes deliberately deprived of dental care for the sole purpose of contributing to the aggravation of cavities, gingivitis and dental abscesses. The investigator should ask the patient for a full dental history. Pulled or fractured teeth, dislocated fillings and broken dentures are all potential consequences of trauma or electric torture.

The oral cavity should be carefully examined. Tongue, gingiva and lips may have been bitten by the subject under the effect of electric shocks and these may have caused various lesions inside the mouth, as well as the forced introduction of objects or substances. X-ray or MRI can determine the extent of any damage to the soft tissues, mandibles and teeth.

c- Chest and abdomen

When examining the trunk, attention should be made, in addition to possible skin lesions, to the presence of areas of pain, tenderness or discomfort that could be signs of trauma to the



muscles, ribs or abdominal organs. In particular, the physician should consider the possibility of intramuscular, retroperitoneal and intra-abdominal hematomas, as well as lacerations or ruptures of internal organs.

When possible, ultrasound, CT scan and bone scan will be used to confirm the diagnosis. Routine examination of the cardiovascular system, lungs and abdomen should be done as usual. Detention can cause respiratory problems and aggravate those that existed previously.

d- Genito-urinary system

Gynecological examination should only be carried out with the direct consent of the patient, or postponed if necessary. A person of the same sex as the patient must be present if the doctor is of the opposite sex. Ultrasound and dynamic scintigraphy can be used to detect possible genitourinary trauma. Further details on this chapter will be given later during this session.

e- Central and peripheral nervous system

Neurological examination should include the cranial nerves, sensory organs and peripheral nervous system to detect motor and sensory neuropathies that may result from trauma, vitamin deficiency or disease. Cognitive abilities and mental status should also be assessed. In patients who report suspension torture, special attention should be made to the possible symptoms of brachial plexopathy (asymmetry of hands strength, loose wrist, weakness of the arm accompanied by variations in sensory and tendon reflexes).

Radiculopathies and other neuropathies, cranial nerve deficits, hyperalgesia, paresthesias, hyperesthesia, altered posture, altered heat sensitivity, motor function, gait and coordination are all phenomena that can result from torture. In patients reporting dizziness and vomiting, the vestibular apparatus should be examined and any evidence of nystagmus noted. On the radiological level, if possible, MRI or CT should be used, knowing that the first technique is preferable for the radiological evaluation of the brain and posterior fossae.

C- Examination and Assessment for Particular Forms of Torture

For each lesion observed, the doctor should indicate the degree of compatibility with the form of torture denounced by the patient. These indications will generally be formulated as follows:



- **Not compatible:** The injury cannot have been caused by the mentioned trauma;
- **Compatible:** The lesion could have been caused by the trauma mentioned, but it is not specific and there are many other possible causes;
- **Very compatible:** The lesion could have been caused by the trauma mentioned, and there are few other possible causes;
- **Typical:** The lesion is commonly associated with the trauma mentioned, but there are other possible causes;
- **Specific:** The lesion can only have been caused by the trauma mentioned.

Ultimately, however, the purpose of the examination is to assess all of the injuries found overall and not the compatibility of each injury with a particular form of torture.

1. Blows and other forms of bruising

a- Skin lesions

Acute lesions are often characteristic of torture, as they present themselves in particular forms which distinguish them from accidental lesions (contours, repetition, distribution on the

body).

Since most lesions heal within about six weeks without leaving any scars or other marks, a credible description from the victim of the lesions and how they progressed to healing is often the only evidence at hand supporting allegations of torture.

Permanent skin changes due to bruising are rare, nonspecific, and generally devoid of diagnostic value.

The prolonged application of tight ties around the arm or leg, most often at the wrist or ankle, can nevertheless leave sequelae, in the form of cicatricial alopecia. In this respect, there is no diagnosis that could suggest a spontaneous disease of the skin, and it is hardly imaginable that a trauma of this nature could occur under normal circumstances.

Among acute injuries, skin abrasions may present as scratches, friction burns, abrasions and other excoriations. In some cases, their outlines can provide an indication of the instrument used. Repeated or deep abrasions can create areas of hypo or hyperpigmentation, depending on skin type.

Such areas can be observed, for example, on the inside of the wrists when the hands have been tied very tightly.

Contusions and other bruises are symptoms of soft tissue hemorrhage due to rupture of blood vessels as a result of blows. Their extent and severity depend not only on the violence of the trauma, but also on the structure and vascularity of the bruised tissues.

The shape of the bruises can sometimes identify the instrument that caused them. Thus, a bruise in the shape of a rail can be associated with a blow given by means of a truncheon or a cane, for example.

As hematomas heal, they go through a range of colors from dark blue, purple, or crimson to purple, green, dark yellow, and then pale yellow, before disappearing.

However, it is very difficult to determine the precise moment of the abuse.

In addition, the hematomas that form in the subcutaneous tissues sometimes only appear several days after the shock, the time for the extravasated blood to reach the surface. If there is an allegation of abuse but no bruising, the patient should therefore be re-examined after a few days.

Lacerations, tears or crushing of the skin and underlying soft tissues are more easily observed when blows and other violent pressures touch protruding parts of the body, the skin then being compressed between the object exerting the pressure and the bone surface.

However, **violent pressure can cause such lesions on any part of the body.**

Scars that are asymmetrical or located in places where they are rarely found, as well as the presence of diffuse marks, are



all indications of deliberately inflicted injuries. Scars left by whipping commonly appear as depigmented bumps surrounded by narrow bands of hyperpigmented skin.

The only alternative diagnosis is plantar dermatitis, but this is characterized by hyperpigmentation and shorter markings.

In contrast, linear, symmetrical, and atrophic depigmentation of the skin of the abdomen, armpits, and legs, sometimes attributed to torture, are actually symptoms of striated distention and are not normally related to torture.

Burning torture is the one that most frequently leaves permanent scars. Sometimes, the marks observed make it possible to make the diagnosis. Cigarette burns often leave circular or ovoid macules 5 to 10 mm long, characterized by a hyper or hypopigmented center and a hyperpigmented periphery with relatively blurred contours.

Burns inflicted by means of objects heated to high temperatures cause marked atrophy of the skin, the contours of which sometimes make it possible to identify the nature of the object used; these marks are surrounded by narrow hypertrophied or hyperpigmented zones delimiting the initial burn zone. They can be observed, for example, after burns caused by means of an electrically heated metal bar or a gas lighter.

The presence of a large number of similar marks tends to confirm the diagnosis of torture, especially since accidental burns are generally free of the characteristic marginal zones and only rarely lead to significant tissue loss. Friction burn scars are usually distinguished by the presence of hypertrophies or keloids. In case of nail matrix burn, further nail growth is characterized by a ridged, thin and deformed nail, sometimes broken into longitudinal segments. Following an uprooting, tissue overgrowth can be observed at the level of the proximal fold, giving rise to the formation of a pterygium. Nail changes caused by Lichen planus are the only alternative diagnosis, but they are usually accompanied by extensive skin lesions. Also, fungal infections are characterized by thick, yellowish, crumbly nails that distinguish them from the symptoms described above.

Penetrating traumatic injuries to the skin can result from injuries inflicted with a sharp object such as a knife, bayonet or piece of broken glass. Diagnosis is usually easier to make in the acute stage, with later scars showing distorted outlines that are not always specific. The presence of a set of small traces of incisions with regular contours may be due to the intervention of traditional healers. Applying pepper or other deleterious substances to open wounds can cause the scars to enlarge. The dissymmetry and variable size of the scars are clear indications of torture.

b- Fractures

Fractures resulting from mechanical shocks lead to a loss of bone integrity. Direct fractures are located at the point of impact of the shock. The location, contour and other characteristics of a fracture provide clues to the nature and direction of the impact. The aspect of the lesion revealed by radiological imaging sometimes makes it possible to distinguish between an accidental fracture and a fracture resulting from a deliberate act.

The dating of relatively recent fractures should be entrusted to the care of an experienced trauma radiologist. It is preferable to refrain from any speculative judgment as to the nature and age of bone lesions of traumatic origin, which may vary according to the patient's age, sex, tissue characteristics, his state of health and the seriousness of the injury. Thus, young



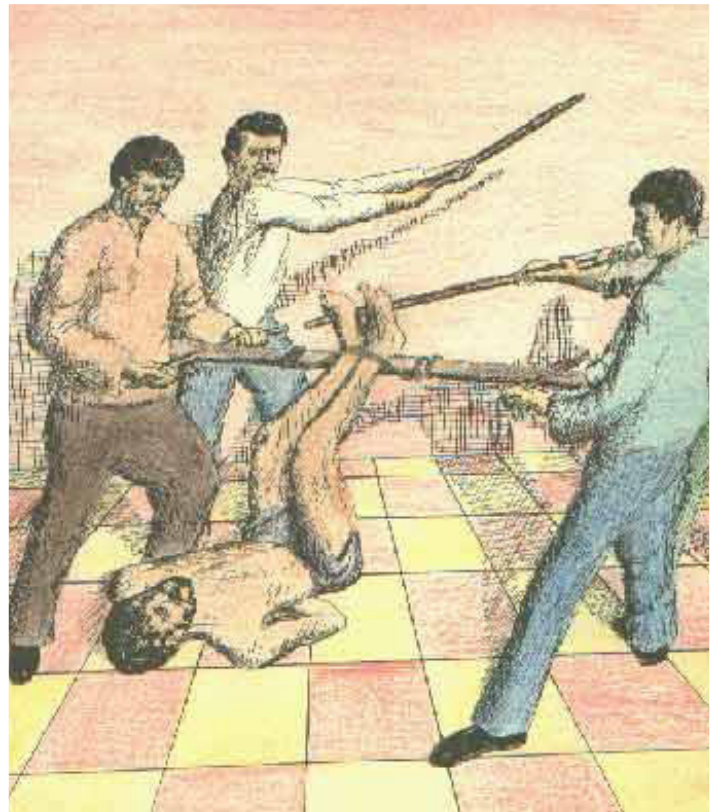
people in good health and with robust muscles resist shocks better than older people with fragile constitutions.

c- Head injuries

Beatings on the head are one of the most common forms of torture. Even minor repeated trauma can lead to cortical atrophy and diffuse axonal damage. In traumas resulting from falls, we sometimes observe cerebral lesions by repercussion (in the area opposite to that of the shock); in the event of direct trauma, any cerebral contusions will be located in the area of the shock. Scalp hematomas are often undetectable to the naked eye, unless there is edema formation. In dark-skinned individuals, the edema itself is difficult to distinguish, but it can be detected by palpation.

Victims of blows to the head may complain of permanent headaches. These are often somatic, but can also have a cervical origin. Patients may complain of pain on palpation, which will also detect diffuse or localized deformities, or areas of induration. Scarring may be observed as a result of scalp lacerations. Headaches may be the initial symptom of an expanding subdural hematoma. As they may be associated with a rapid change in mental status, it is important to carry out an urgent CT scan. In general, soft tissue edema and hemorrhage can be detected by CT scan or MRI. In some cases, it may be appropriate to also perform a psychological or neuropsychological examination.

Torture consisting in inflicting violent shaking on the subject can cause brain damage without leaving external traces, with the possible exception of bruises on the upper chest or on the shoulders, at the places where the victim was seized. In extreme cases, this treatment can cause damage similar to that seen in “shaken baby” syndrome: cerebral edema, subdural hematoma and retinal hemorrhages. Most often, victims complain of headaches, disorientation, or changes in mental status. Shaking torture sessions usually last no more than a few minutes, but they can be repeated many times over several days or weeks.



d- Trauma to the chest and abdomen

- Rib fractures are a common consequence of blows to the chest. Displacement of the ribs can lead to lacerations of the lungs and possible pneumothorax. Blows can also cause vertebral pedicle fractures.
- In cases of acute abdominal trauma, possible traces of damage to the abdominal organs

and the urinary tract will be sought, although the examination often gives negative results. Abundant hematuria is the most evident symptom of a kidney contusion. A peritoneal enema may reveal occult abdominal hemorrhage. A possible acute abdominal hemorrhage revealed by CT scan is usually isointense or at the same density as water, unlike an acute central nervous system hemorrhage, which is hyperdense. Organ damage may manifest as air, extraluminal fluid, or areas of low attenuation, which may indicate edema, contusion, hemorrhage, or laceration. Peripancreatic edema is one of the signs of traumatic and non-traumatic acute pancreatitis. Ultrasound is particularly indicated for detecting subcapsular hematomas of the spleen. Violent and repeated blows can lead to kidney failure, and renal hypertension can be a complication after kidney injury.

Falanga is the most widely used term for the repeated application of blows to the feet (more rarely to the hands or hips), usually by means of a truncheon, a segment of pipe or another similar instrument.

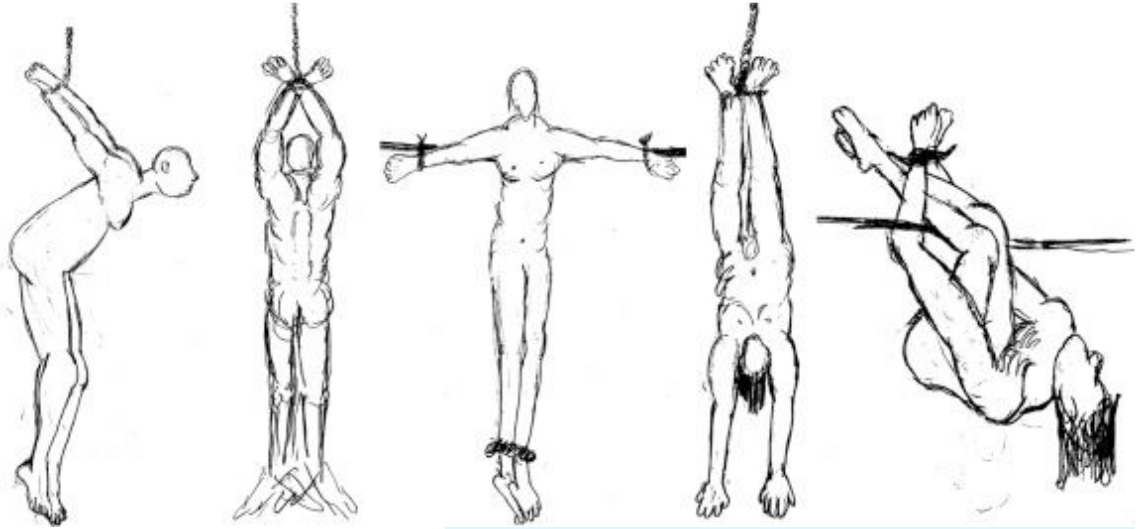
The most serious complication of falanga is compartment syndrome, which can lead to muscle necrosis, vascular obstruction, or gangrene of the distal foot or toes.

A number of post-falanga syndromes and complications can occur:

a) **Compartment syndrome:** This is the most serious complication. Edema in a closed compartment can cause vascular obstruction and muscle necrosis, which in turn can lead to fibroids, contracture or gangrene of the foot or distal toes. This syndrome is usually diagnosed by measuring the pressures in the compartment;

2- Blows on the feet

b) **Crushing of the bearings:** The soft pads located under the calcaneus and under the proximal phalanges are crushed by the falanga, either directly or by the edema following the trauma. Likewise, the connective tissue lamellae that cross fatty tissue and connect bone to skin are torn. Adipose tissue, deprived of blood supply, atrophies. The cushion effect is lost and the feet no longer absorb the shocks caused by walking;



c) **Rigid and irregular scars** in the skin and subcutaneous tissues of the foot after falanga. In a normal foot, the dermal and hypodermic tissues are connected to the plantar fascia by tight bands of connective tissue. But these bands can be partially or totally destroyed by edema following falanga;

d) **Rupture of the plantar aponeurosis and tendons of the foot:** Edema following falanga can also cause these structures to rupture. When the support function of the arch of the foot disappears, walking becomes more difficult and the muscles of the foot, especially the quadratus plantaris longus, are put under extreme stress;

e) **Plantar fasciitis:** Fasciitis can be a later complication of fascial rupture. Falanga commonly causes irritation of the entire fascia that can lead to chronic inflammation. Imaging such as MRI, CT and ultrasound often confirm trauma following falanga. But positive radiological findings can also be associated with other illnesses or injuries. Routine X-rays are recommended from the initial examination.

MRI is the most effective technique for detecting soft tissue lesions. MRI and scintigraphy make it possible to detect traumatic bone lesions that could escape routine examinations by X-ray or CT scan.

3- Suspension

Often practiced, torture by suspension can cause extreme pain, but leaves little or no visible traces. The observation of peripheral neurological failures indicative of brachial plexopathy is in itself a very serious indication for suspension torture. This can take different forms further described in the next session. **The "Palestinian" suspension can quickly lead to permanent brachial plexus damage. The "perch" can cause tears in the cruciate ligaments of the knees.**

In the chronic phase, pain and tenderness of the shoulder joints are commonly observed, which can last for years, following the excess load and the rotational movements endured. Weakness of the arms or hands, pain and paresthesia, numbness, insensitivity to touch, superficial pain and loss of tendon reflexes are some of the complications commonly seen in the acute phase. Intense deep pain may be a sign of nerve weakness which may persist in the chronic phase and evolve into muscle atrophy.

In addition to neurological damage, tears in the ligaments of the shoulder joints, shoulder dislocations and muscle damage in the scapular region can occur. Visual examination of the back reveals a “winged scapula” (prominent vertebral border) in cases of long thoracic nerve injury or shoulder dislocation.

Neurological lesions are usually asymmetrical in the arms. **Brachial plexus injuries are manifested by motor, sensory and reflex dysfunctions:**

a) Motor examination: Asymmetrical weakness, more marked at the distal level, is the most commonly observed symptom. Acute pain can make it difficult to interpret muscle strength tests. If the lesion is severe, muscle atrophy can be observed in the chronic phase;

b) Sensory examination: Total loss of sensation or paresthesia along the course of the sensory nerves is a common symptom. Positional perception, two-point discrimination, needlestick reaction, and sensitivity to cold and heat should be assessed. If, three weeks after the abuse, deficiencies are found in any of these areas, appropriate electrophysiological examinations should be performed by a neurologist experienced in the use and interpretation of these methods;

c) Examination of reflexes: Torture by suspension can cause the loss, reduction or asymmetry of reflexes. In the “Palestinian” suspension, although both brachial plexuses suffer trauma, asymmetrical plexopathy can develop due to the position in which the arms are placed (one above the other) and depending on the way which they are attached. While research suggests that brachial plexopathies are usually unilateral, this does not apply in the context of torture, where bilateral injuries are common.

Brachial plexus injuries can be characterized as follows:

a) Lower lesions: Deficiencies are localized to the forearm and hand muscles. Sensory deficits can be observed in the forearm and the fourth and fifth fingers of the hand in cases of ulnar nerve involvement;

b) Median lesions: The forearm, elbow and finger extensor muscles are affected. Forearm pronation and radial hand flexion may be reduced. Sensory deficits may be observed in the forearm and on the back of the first, second and third fingers of the hand if the radial nerve is affected. Triceps reflexes may be lost;

c) Upper lesions: The scapular muscles are particularly affected. Abduction of the shoulder, axial rotation and pronation-supination of the forearm may be impaired.

Sensory deficits may be seen in the deltoid region as well as in the arm and outer areas of the forearm.

4. Other positional tortures

There are a wide variety of positional tortures, all of which are characterized by holding the victim in an unnatural position, in contortion or hyperextension, resulting in acute pain and possibly causing damage to ligaments, tendons, nerves and to blood vessels.

As a general rule, these forms of torture leave little or no visible traces or detectable by radiological means, despite the chronic disabilities they can cause.



All positional torture affects tendons, joints and muscles. In addition to the methods already mentioned, we can cite, among many others, standing on both feet or on one foot, the limbs that can be attached along the body or the arms stretched high against a wall, the position squatting, or forced immobilization in a cage.

Pain in a particular region of the body, loss of joint mobility, back pain, pain in the hands, neck pain or swollen legs are the most common symptoms depending on the position imposed.

The basic recommendations for neurological and musculoskeletal examination are the same for these forms of positional torture as for suspension torture. MRI is the most effective radiological procedure for evaluating lesions associated with various forms of positional torture.

5. Electric shocks

In electric torture, current is transmitted through electrodes that can be placed on any part of the body. The most common locations are the hands, feet, fingers and toes, ears, nipples, mouth, lips, and genitals.

The power source can be a hand dynamo or generator, a wall outlet, a cattle prod, or any other electrical instrument. The current takes the shortest path between the two electrodes, a characteristic which is reflected in the symptoms observed. Since all the muscles located in the path of the electric current are paralyzed, a medium-intensity discharge can lead to dislocation of the shoulder and lumbar and cervical radiculopathy. However, the physical examination of the victim does not make it possible to establish with certainty the method or the precise duration of the torture, nor the force of the electric shock inflicted.

Torturers commonly use water or gels in order to increase the effect of the torture, to dilate the point of entry of the electric current into the body and to prevent the appearance of visible marks.

Electrical burns usually cause reddish-brown circular lesions 1 to 3 mm in diameter, normally free of inflammation, which may leave a hyperpigmented scar.

6. Dental torture

Dental torture can consist of breaking or pulling teeth, or subjecting them to electric shocks. It can cause, in addition to lost or broken teeth, the following symptoms: swelling of the gums, hemorrhage, pain, gingivitis, stomatitis, fracture of the jaws or loss of fillings and other fillings. Temporomandibular joint syndrome causes joint pain, decreased jaw mobility and, in some cases, joint subluxation as a result of muscle spasms resulting from an electric shock or blows to the face.

7. Asphyxia

Near-asphyxiation by suffocation is an increasingly common method of torture. It normally leaves no traces and recovery is rapid.

This method has been so widely used in Latin America that its Spanish name – submarino – has become part of human rights terminology. Normal breathing can be impeded by covering the head with a plastic bag, sealing the mouth and nose, compressing or tying the neck, or forcing the victim to inhale dust, cement, chilli, etc.

This is the “dry” variant of the submarino. It can cause a variety of complications, including petechiae, nose and ear bleeds, facial congestion, mouth infections, and acute or chronic respiratory failure.



The “liquid” variant involves forcibly submerging the victim’s head in water, often soiled with urine, feces, vomit and other impurities. It can lead to near drowning or drowning. Aspiration of water into the lungs can cause pneumonia.

Hanging and other forms of asphyxiation by ligature often leave traces of abrasion or bruising on the neck. The hyoid bone and cartilage of the larynx can be fractured as a result of partial strangulation or blows to the throat.

8. Sexual abuse including rape

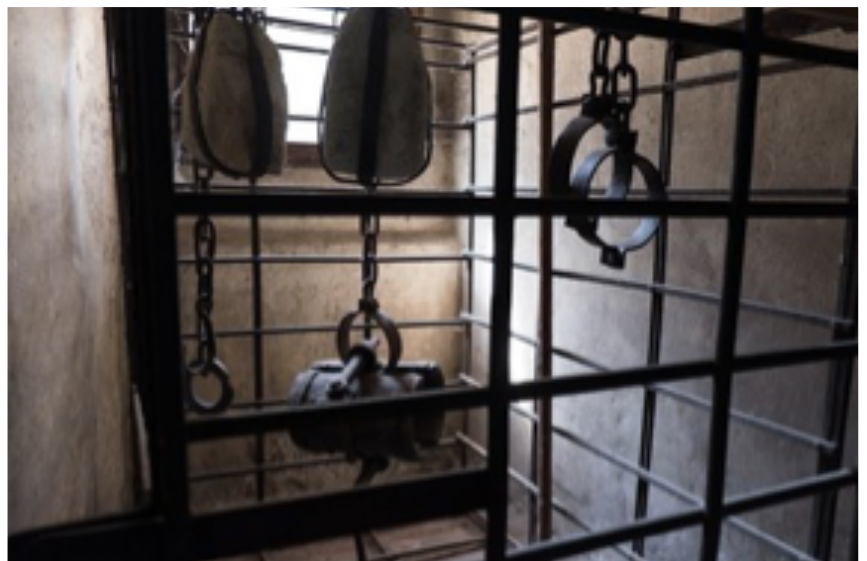
Sexual abuse begins with forced nudity, which is a constant feature of torture in many countries. An individual never feels so vulnerable and helpless as when naked. Nudity exacerbates the psychological impact of any form of torture by raising the constant threat of sexual violence, including rape and sodomy. Threats, mocking and other verbal attacks with a sexual connotation also constitute sexual abuse, **as they accentuate the humiliation.** In the case of women, touching is always traumatic and must be systematically treated as an act of torture.

The forms and consequences of sexual abuse vary depending on whether it is inflicted on men or women, but there are certain aspects common to both cases. **Rape always carries the risk of contamination by sexually transmitted diseases, in particular the human immunodeficiency virus (HIV).** Currently, the only effective HIV prophylaxis must be administered within hours of exposure – and it is rarely available in countries where torture is routinely practiced.

In men, electric shocks and beatings very commonly target the genitals. This abuse is sometimes associated with anal torture and almost always accompanied by verbal aggression that exacerbates the trauma. The torturers very often threaten men with the loss of their virility and therefore with social

degradation. This can be aggravated by the lack of intimacy in meeting natural needs. Inmates are also sometimes forced to sexually abuse each other, which can be particularly emotionally traumatic. For women, the fear of rape, given the social stigma that accompanies it, can add to the trauma, as can the fear of possible pregnancy, the loss of virginity and the fear of not being able to bear children.

When a victim of sexual abuse does not want it to be disclosed, particularly because of socio-cultural pressures, the examining doctor, the investigators and the courts are required to respect the anonymity of the person concerned. **Contacts with victims of torture who have recently been sexually abused require specialized psychological training and support.** Any action likely to exacerbate the psychological trauma of the victim should be avoided. Before undertaking any examination, it is important to obtain the consent of the person concerned and this authorization must be systematically renewed for the most intimate aspects of the examination. The patient must be clearly and comprehensibly informed of



the importance of the examination and its possible results.

a) Inventory of symptoms

A full account of the alleged abuse should be recorded. It aims to establish symptoms resulting from recent violence – bleeding, vaginal or anal discharge, pain, bruising or localized abrasions.

When the alleged facts are old, we will

direct the questions to chronic symptoms such as frequency of urination, incontinence or dysuria, irregularity of menstruation, pregnancy, abortion or vaginal bleeding following rape, sexual problems, including sexual intercourse, anal pain, bleeding, constipation or incontinence. Ideally, there should be the services of experienced psychiatrists, psychologists, gynecologists and nurses, well trained to examine and treat victims of sexual abuse.

The examination of persons subjected to such abuse should provide them with the appropriate support, advice and comfort with regard to, in particular, sexually transmitted diseases, HIV, in the case of women, pregnancy, and permanent sequelae.

Torturers routinely assert to their victims that their sexual functions will be forever altered, the victim should be reassured as much as possible, so that such a threat does not come about through autosuggestion.

b) Examination after recent abuse

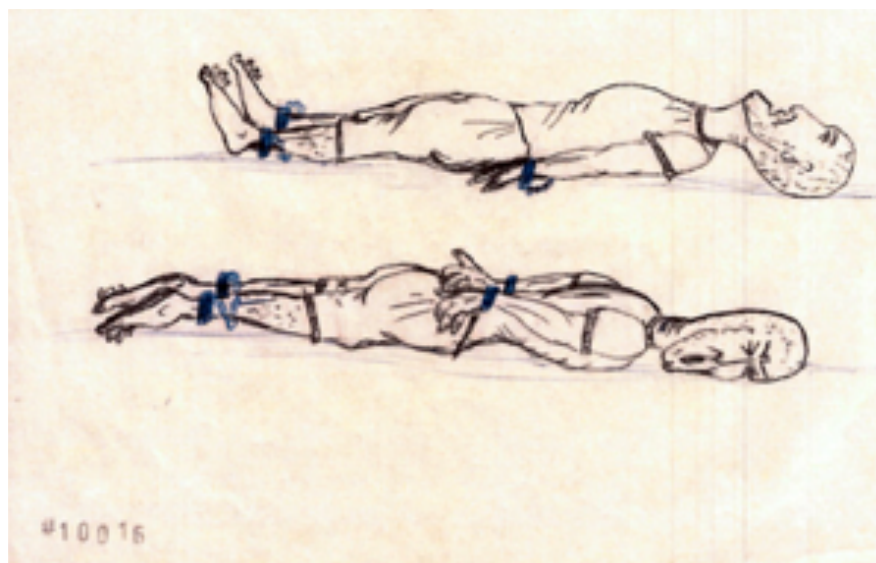
Victims of recent sexual abuse are often very upset and reluctant to seek medical or legal help out of fear, socio-cultural reasons, or the devastating nature of the abuse. Informed consent should be obtained prior to any examination, **all medical evidence of sexual abuse should be recorded, and efforts should be made to take specimens for forensic analysis.**

When the doctor belongs to the opposite sex, the victim should have the possibility of requiring the presence of a person of the same sex in the room. If the services of an interpreter are necessary, the latter may also assume this role of chaperone. Given the sensitivity of any sexual abuse investigation, a family member of the victim is usually not the ideal person to take on this role.

The doctor should perform a thorough physical examination and carefully note any signs of abuse, specifying their size, location and color. Whenever possible, these marks will be photographed and samples taken

for analysis. The physical examination should not initially focus on the genital area. **The skin should be carefully examined, looking for possible skin lesions that may result from sexual abuse,** such as bruises, lacerations, bruises or petechiae. This initial phase may help to relax the patient for the examination of the genital area.

Furthermore, in the absence of significant lesions of the genitals, lesions on other parts of the body are sometimes the most obvious signs of sexual abuse. In fact, there is evidence of damage in only less than 50% of cases, and this percentage drops to less than 30% for sodomy, whether inflicted on men or women.



Many laboratories provide all the materials needed for the samples. In the absence of an analysis laboratory, the doctor will be able to take wet samples which he will then dry in the air. These samples can later be used for DNA testing.

Semen remains identifiable for up to five days with deep vaginal swabs and up to three days with rectal swabs. **Great care should be taken in preserving samples and documenting the preservation procedure.**

c) Examination of a patient who has been abused for more than a week

In this case, the pelvic examination is no longer urgent. We can then find the most qualified person for such an examination and the most appropriate conditions for questioning

the victim. Whenever possible, it is advisable to take pictures of any residual lesions.

In the presence of women who have had children before, the chances are slim of discovering pathognomonic signs of sexual abuse. However, an experienced female doctor can learn a lot from the victim's story. It may take some time for a victim to agree to talk about the aspects of the torture that they find most embarrassing, and some people prefer to leave it for later consultation.

d) Monitoring

Many conditions, especially sexually transmitted diseases, can be contracted during sexual abuse: gonorrhea, chlamydia, syphilis, HIV, hepatitis B and C, herpes and Condyloma acuminatum (genital warts), trichomonas vulvovaginitis, Moniliasis vaginitis, Gardenarella vaginitis and Enterobius vermicularis, as well as urinary tract infections.

Appropriate laboratory tests and treatment should be prescribed in all cases of sexual abuse. For gonorrhea and chlamydia, consideration should be given to possible concurrent infections of the anus or oropharynx.

The main symptoms, which can have a physical or psychological origin, or combined, are the following:



- Aversion to people of the opposite sex or decreased libido;
- Apprehension of sexual intercourse for fear of being repulsed by a partner informed of the abuse endured or for fear of having suffered functional damage
- Inability to trust a sexual partner
- Disorders of sexual stimulation and erection
- Dyspareunia (painful intercourse in women) or sterility following a sexually transmitted disease, trauma to the reproductive organs.

e) Genital examination of women

In many cultures, it is unacceptable to penetrate a virgin woman's vagina with anything, including a speculum, finger, or cotton ball. If the external examination reveals obvious signs of rape, an internal examination can be dispensed with in such cases.

Genital examination may reveal the following symptoms:

- Small lacerations or tears of the vulva. These lesions, which can be acute, result from excessive stretching of the tissues. Normally, they heal completely, but a possible repetition can leave scars;
- Abrasions caused by contact with rough bodies such as fingernails or rings;
- Vaginal lacerations. They are rare and can sometimes be associated with tissue atrophy or previous surgery. They cannot be differentiated from incisions caused by the insertion of sharp objects.

It is rare to discover conclusive physical traces when the genital examination takes place more than a week after the alleged sexual abuse.

Especially if the woman has been able to engage in sexual activity again, or give birth to a child, the link between possible symptoms and a specific allegation of abuse may prove impossible to establish.

f) Genital examination of men

Men who have suffered torture in the genital area, including crushing, twisting or

stretching of the scrotum and beatings in the same area, usually complain of acute pain and tenderness. Hyperemia, swelling and bruising are the most common symptoms observed.

There will also be a noticeable increase in the number of red blood cells and leukocytes in the urine. When the presence of a mass is detected, it should be determined whether it is a hydrocele, a hematocele or an inguinal hernia.

Trauma to the scrotum can also cause testicular torsion which, by obstructing blood flow, leads to severe pain and swelling of the testicle. This case calls for immediate surgery.

If the organ is not quickly reduced, infarction of the testicle will follow. When this lesion occurs in detention, where medical care may be lacking, sequelae may be observed.

Individuals who have suffered scrotal abuse sometimes suffer from chronic urinary tract infections, erectile dysfunction, or testicular atrophy.

g) Examination of the anal region

Forced sodomy or the insertion of objects into the anus can cause victims of either sex pain and bleeding, sometimes lasting for several days or weeks.

Often such abuse also leads to constipation, which can be aggravated in detention by poor diet. In the acute phase, any examination other than visual may require local or general anesthesia and should be entrusted to a specialist.

In the chronic phase, various symptoms may persist, which should be reviewed. The presence of anal scars unusual in size or location should be carefully noted.

During the examination of the anus, one will be attentive to the following points:

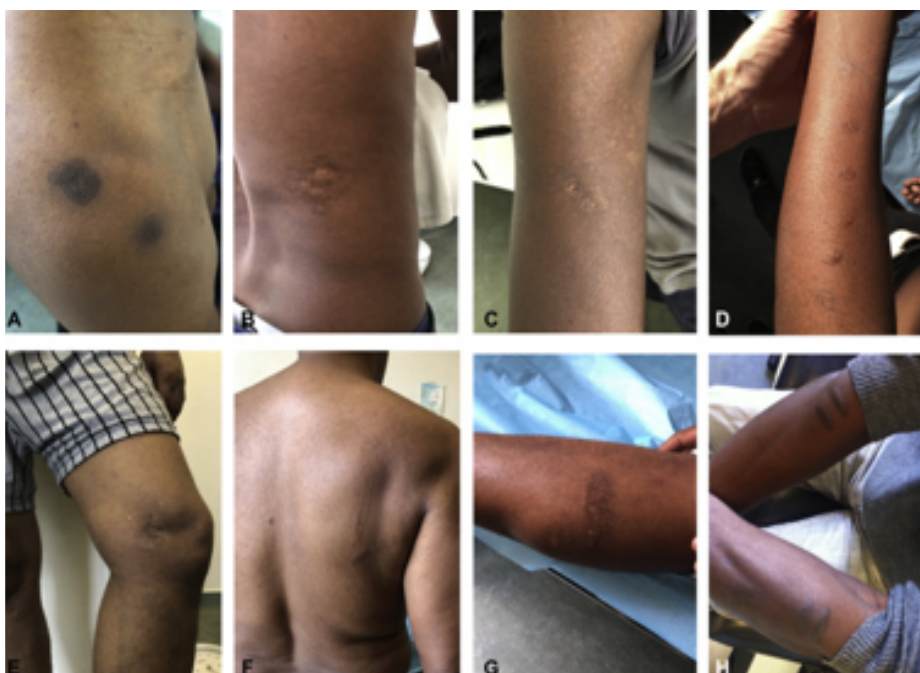
- Cracks: The fissures do not have a sufficiently specific character, since they can occur under "normal" circumstances (constipation, lack of hygiene). Observed in the acute phase (within 72 hours), however, they can be considered as probable symptoms of penetration;
- Rectal tears, with or without hemorrhage;
- Abnormally smooth, fan-shaped areas of skin. The presence of such scars outside the midline may be indicative of penetrative trauma;
- Excoriations resulting from healing trauma;
- Purulent discharge: In the event of an allegation of penetration, systematically take samples for the detection of gonorrhea and chlamydia, even in the absence of discharge.

D. Specialized Diagnostic Tests

They do not represent an essential element of the clinical assessment of alleged victims of torture. Most of the time, a medical history and physical examination are sufficient.

In some cases, however, **these tests can provide useful evidence, for example, when an action is brought against law enforcement officials or for damages.**

A positive test can then decide the outcome of the case. If, on the other hand, diagnostic tests are performed for therapeutic reasons, their results



should be included in the clinical report.

As with physical observations, the absence of a conclusive result of a diagnostic test does not allow the inference of the absence of torture.

Similarly, there are many circumstances where diagnostic tests cannot be performed for technical reasons, but their absence does not invalidate an otherwise duly established report.

E- The medical certificate

When a doctor writes a medical certificate of a person who claims to have been tortured, it is extremely important that the doctor specifies the degree of consistency with the history of torture.

A finding that mentions the causal link to the alleged history of torture should be based on a discussion of possible differential diagnoses (nontorture-related injuries - include self-harm - and illnesses).

The causal link should be indicated as follows:

1. High degree of causality
2. Compliant with alleged torture, moderate degree

3. Compliant with alleged torture, mild degree

4. The lesions observed are unrelated to the history of torture

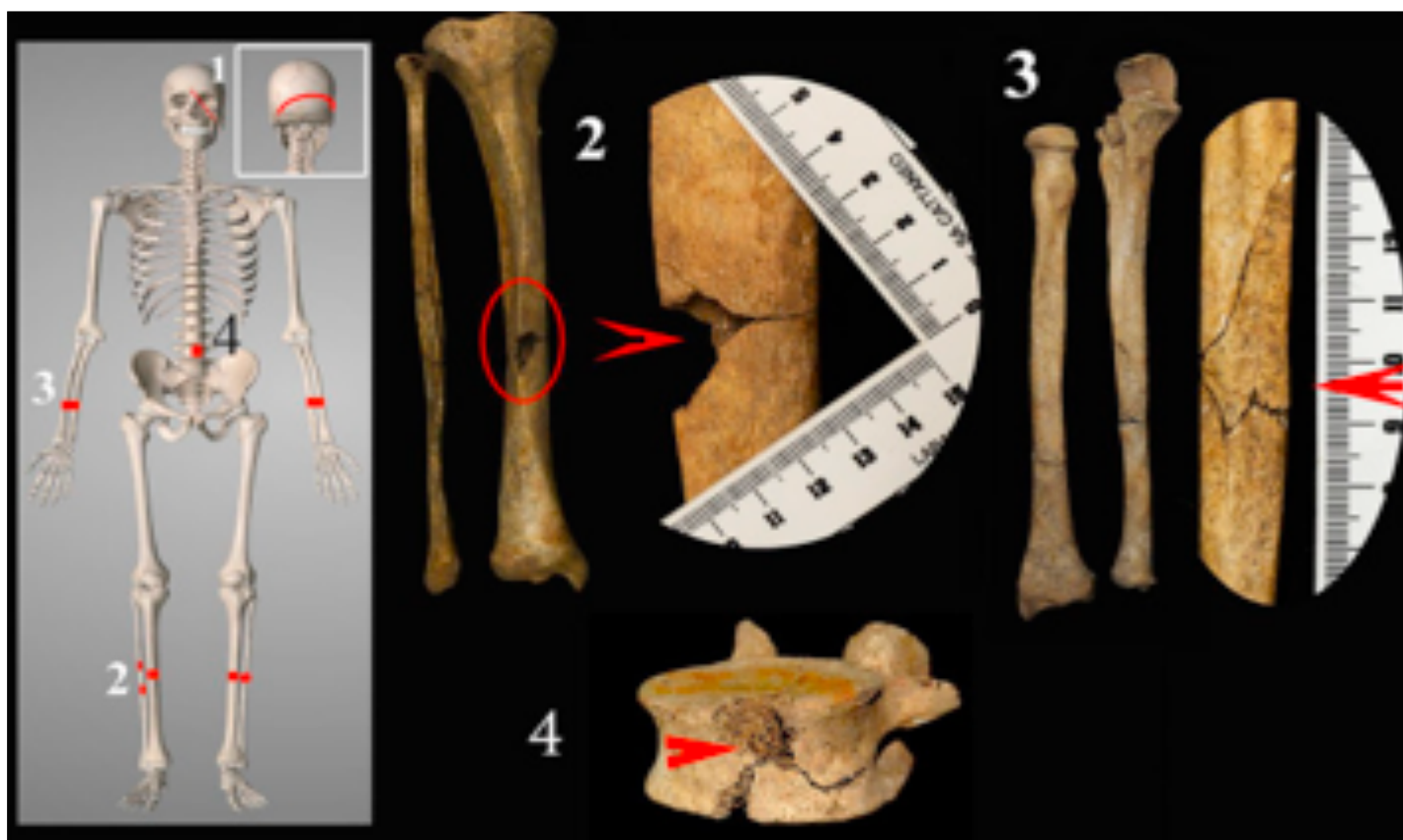
Different methods of physical torture leave different physical scars.

Therefore, a very important part of the physical examination requires a detailed account of the alleged methods of torture to which the person was subjected.

Many torture victims may have problems remembering the exact details of their torture, and sometimes give inconsistent stories during repeated interviews.

It's also important to consider mental issues that can have serious health implications.

Prolonged stress conditions have been shown in many studies to have somatic consequences through neuro-humoral and other mechanisms.



ANNEXE IV

Directives pour l'évaluation médicale de la torture et autres mauvais traitements

Les présentes directives se fondent sur le *Manuel pour enquêter efficacement sur la torture et autres peines ou traitements cruels, inhumains ou dégradants* (Protocole d'Istanbul). Elles ne doivent pas être appliquées de façon rigide, mais en tenant compte du but de l'évaluation et des ressources disponibles. L'évaluation des éléments de preuve physique et psychologique de la torture et autres mauvais traitements pourra être effectuée par un ou plusieurs cliniciens, en fonction de leurs qualifications respectives.

I. Informations générales

Date de l'examen: Examen demandé par (nom/fonction):

Numéro du cas ou rapport: Durée de l'évaluation: heures minutes

Prénom du sujet: Date de naissance: Lieu de naissance:

Nom de famille du sujet: Sexe: masculin/féminin

Motif de l'examen: Numéro de pièce d'identité du sujet:

Nom du clinicien: Nom de l'interprète (le cas échéant):

Consentement en connaissance de cause: oui/non

Dans la négative, pourquoi?

Personne accompagnant le sujet (nom/fonction):

Personnes assistant à l'examen (nom/fonction):

Le sujet était-il soumis à une contrainte pendant l'examen? oui/non

Dans l'affirmative, précisez la nature et la raison:

Rapport médical transmis à (nom/fonction/numéro de pièce d'identité):

Date et heure de la transmission:

Évaluation/enquête médicale conduite sans restrictions (pour les sujets en détention)? oui/non

Dans la négative, précisez la nature des restrictions:

II. Qualification du clinicien (pour témoignage judiciaire)

Études médicales et formation clinique
Formation psychologique/psychiatrique
Expérience des enquêtes sur la torture et autres mauvais traitements
Expérience au niveau local dans le domaine des droits de l'homme s'appliquant à l'enquête
Publications, conférences et cours de formation pertinents
Curriculum vitae.

III. Déclaration concernant la véracité du témoignage (pour témoignage judiciaire)

Exemple: «J'ai personnellement connaissance des faits rapportés ci-dessous, à l'exception de ceux fondés sur des informations extérieures que je tiens pour véridiques et sur mon intime conviction. Je serais prêt à témoigner en justice sur la foi des faits établis et de mon intime conviction.»

IV. Profil du sujet

Informations générales (âge, métier, études, situation familiale, etc.)
Antécédents médicaux
Examens médicaux antérieurs basés sur les allégations de torture et mauvais traitements
Profil psychosocial avant détention.

V. Allégations de torture et autres mauvais traitements

1. Description résumée de la détention et des sévices
2. Circonstances de l'arrestation et de la détention
3. Différents lieux de détention (chronologie, transferts, conditions de détention)
4. Récit des séances de torture ou autres mauvais traitements (pour chaque lieu de détention)
5. Examen des méthodes de torture

VI. Symptômes et infirmités physiques

Décrire les symptômes et infirmités aigus et chroniques, leur évolution et le processus de guérison

1. Symptômes et infirmités aigus
2. Symptômes et infirmités chroniques.

VII. Examen physique

1. État général
2. Peau
3. Visage et tête
4. Yeux, oreilles, nez, gorge
5. Cavité buccale et dentition
6. Poitrine et abdomen (y compris signes vitaux)
7. Système génito-urinaire
8. Système musculo-squelettique
9. Système nerveux central et périphérique.

VIII. Profil/examen psychologique

1. Méthodes d'évaluation
2. Etat psychologique actuel
3. Profil psychologique après la torture
4. Profil psychologique avant la torture
5. Antécédents psychologiques/psychiatriques
6. Usage et abus de substances toxiques
7. Examen de l'état mental
8. Évaluation des fonctions sociales
9. Tests psychologiques (voir chap. VI, sect. C.1, pour les indications et limitations)
10. Tests neuropsychologiques (voir chap. VI, sect. C.4, pour les indications et limitations).

IX. Photographics

X. Résultats des tests de diagnostic (voir annexe II pour les indications et limitations)

XI. Consultations

XII. Interprétation des observations

1. Éléments de preuve physique
 - A. Établir le degré de cohérence des symptômes et infirmités physiques aigus et chroniques mentionnés avec les sévices allégués.
 - B. Établir le degré de cohérence des résultats de l'examen physique avec les sévices allégués. (Note: l'absence d'observations physiques n'exclut pas la possibilité qu'il y ait eu effectivement torture ou autres mauvais traitements.)
 - C. Établir le degré de cohérence des résultats de l'examen physique avec la connaissance des méthodes de torture employées localement et de leurs effets usuels.
2. Éléments de preuve psychologique
 - A. Établir le degré de cohérence des observations psychologiques avec les sévices allégués.
 - B. Indiquer si les symptômes psychologiques constituent des réactions prévisibles ou caractéristiques d'un stress extrême dans le contexte socioculturel du sujet.
 - C. Indiquer la chronologie et l'évolution des troubles mentaux liés au traumatisme (situation dans le temps par rapport aux événements, stade de guérison).
 - D. Identifier les éventuels facteurs de stress concomitants (persécution persistante, migration forcée, exil, perte de la famille et du rôle social, par exemple) et leur impact potentiel.
 - E. Mentionner les problèmes physiques qui pourraient contribuer au tableau clinique, notamment les possibles lésions de la tête subies lors de la torture ou de la détention.

XIII. Conclusions et recommandations

1. Formuler une opinion sur le degré de cohérence de tous les éléments de preuve mentionnés plus haut (observations physiques et psychologiques, informations recueillies, photographies, résultats de tests diagnostiques, connaissance des méthodes locales de torture, rapports de consultations, etc.) avec les sévices allégués.
2. Rappeler les symptômes et infirmités qui continuent d'affecter le patient par suite des sévices allégués.
3. Signaler les examens complémentaires et traitements jugés nécessaires.

XIV. Déclaration de bonne foi (pour témoignage judiciaire)

Exemple: «Le soussigné certifie, sous peine de sanction ou parjure aux termes des lois de ... (pays) que les déclarations qui précèdent sont exactes et véridiques. Fait le ... (date) à ... (lieu), ... (État ou province).»

XV. Déclaration de restrictions à l'évaluation/investigation médicale (pour les sujets en détention)

Exemple: «Les cliniciens soussignés certifient qu'ils ont pu travailler librement et de manière indépendante et qu'ils ont été autorisés à s'entretenir avec le sujet et à l'examiner en privé, sans aucune restriction ni limitation, ni sans aucune forme de contrainte de la part des autorités de détention.» ou: «Les cliniciens soussignés ont dû conduire leur évaluation avec les restrictions suivantes: ...»

XVI. Signature du clinicien, date et lieu

XVII. Annexes

Copie du curriculum vitae du clinicien, schémas anatomiques pour l'identification des actes de torture et autres mauvais traitements, photographies, rapports de consultations et résultats de tests diagnostiques, entre autres.

Pour obtenir des renseignements complémentaires, s'adresser au: Haut-Commissariat des Nations Unies aux droits de l'homme, Palais des Nations, CH-1211 Genève 10 (Suisse).

E-mail: publications@ohchr.org

Internet: www.ohchr.org

F- Pitfalls

There are three possible major pitfalls to consider:

1. Victims can't always tell what they went through
2. What victims say may not always be the truth
3. They may not be informed of the time of onset of a disease that is unrelated to torture, and may therefore incorrectly suggest its relationship to torture.

III-APPLICATION OF FORENSIC EVALUATIONS IN LEBANON: COMPARISON WITH THE STANDARDS OF THE ISTANBUL PROTOCOL

Case no. 1:

- 28-year-old male.
- Use of substances: Tobacco (x) Alcohol (x)
- Cannabis consumption since year 2019 and until the day of his arrest.
- In May 2021, the victim was arrested and transported to the place of detention where the authorities physically tortured the victim for a period of a day and a half, in order to obtain confessions about his crime.
- The victim was beaten with sticks on his back, knees and thighs. Besides, the victim was tortured using electric wires on his knees.
- After his acts of torture, the victim had diffuse pain on the injured parts of his body, for a few days. However, his back pain (level of the thoracic vertebrae) has persisted since then, worsening with exposure to heat or cold. It should be noted that the victim declares having had a mass in his dorsal region (hematoma? hygroma?), some time after the acts of torture.



- Physical illness: heart disease since the year 2019 = aggravating circumstances
- Medication intake: 1. Bisoprolol 5mg since the year 2019. 2. Diclofenac (NSAIDS) for 1 year to relieve her pain, however it persists. Medical examination: no physical signs are observed objectively.

Case no. 2:

- 27-year-old female.
- No substance abuse.
- In August 2021, the victim was arrested and transported to the police station where the authorities physically and psychologically tortured her, on a daily basis and for a period of one week in order to obtain confessions about her crime.
- The victim was humiliated in her dignity and suffered beatings and kicks on various parts of her body, mainly her stomach, which resulted in an abortion because she was pregnant (early pregnancy).
- This act of torture caused severe abdominal pain and bleeding that decreased in intensity over time.
- Our intervention with the victim was after 3 weeks of the act of torture. For his part, the team doctor examined her, declaring the urgent need for an abdomino-pelvic ultrasound, Complete blood count and a gynecological consultation.
- Note that the victim declared that she was pregnant for the first time (primiparous)
- The victim did not suffer from any physical illness before her arrest.

Case no.3:

- 24-year-old female.
- Absence of substance use.
- The victim was arrested and transported to the place of detention in July 2021. While incarcerated in solitary confinement, the victim was assaulted and raped by an officer (full unprotected sexual intercourse). Subsequently, the officer was arrested and the victim was examined by a doctor.
- Our intervention with the victim was carried out 4 months after the acts of torture suffered. However, the victim tells us that she has had pain in her arms and knees since the torture incident.
- The victim mentions that she was also sexually abused during her childhood.
- The victim did not suffer from any health problem.



Case no. 4:

- 38-year-old female.
- No substance abuse.
- The victim was arrested at his home where he suffered torture by police officers: bandaged hands, beatings, slaps, got hit with cables, kicked and got burned with cigarettes on her body.
- Our intervention took place after 2 weeks of torture during which the victim complained of body aches and burn scars on his body. Also, her mental health was affected and she was self-harming (banging her head on the wall).

- Physical health: old history of gastric reflux.

Case no. 5:

- 22-year-old female.
- No substance abuse.
- The authorities tortured the victim during her arrest in August 2022: kicks and hand blows on her chest and stomach, slaps on her face, and cigarette burns on her right arm.
- During our intervention in September 2021, the victim complained of pain in her chest which she claims to have had following the acts of torture she suffered from.
- The doctor declared after examining her that there were traces of trauma all over her body.
- No previous history of health problems.

Case no. 6:

- 49-year-old man.
- No substance abuse.
- In August 2022, the victim was arrested and tortured during interrogations for a few hours: beatings with iron sticks, plastic pipes, kicks and hand blows on his face and body.
- Subsequently, the victim suffered from a broken tooth, swollen eyes for 14 days with severe muscle pain.
- No previous history of health diseases.

Case no. 7:

- 22-year-old male.
- Substance use: Tobacco only (5cig/J).
- The victim was arrested and transported to the place of detention where he suffered torture for a period of 2 days with the aim of forcing confessions: trampling on his toes while removing his shoes, insults, humiliations, slaps and boxes on his stomach and chest.
- The clinical examination identifies injuries to the toes of the right foot.
- Physical problems: visual disturbances.

Case no. 8:

- 31-year-old male.
- Substance use: tobacco (x) Alcohol (x) Cocaine (>1g/d) since 2015 until the day of his arrest.
- The victim was arrested and transported to the place of detention where she suffered torture: threats, insults, beatings on her legs and genitals, cigarette burns, solitary confinement for 4 days
- Our intervention was carried out 13 days after the acts of torture suffered. The victim complained of a broken tooth, burn scars, back pain and pain in his genitals.
- Health problem: the victim has a single kidney history.



Case no. 9:

- 31-year-old male.
- Use of substances: Tobacco (1.5 packets per day) Alcohol (x) Cannabis (2 cigarettes/day) started 1 year before his arrest.
- During his arrest, the victim was kicked on his body, electrocuted on his genitals, with insults and threats.
- During our intervention, 2 months after the acts of torture, the victim complained in particular of persistent back pain and of a mass in the left foot.
- The victim did not suffer from any health problems prior to the abuse.

Case no. 10:

- A 14-year-old minor.

- Substance use: (x)
- The victim was arrested and transported to the place of detention where he suffered physical and psychological torture in order to obtain confessions about his crime: slaps, beatings on his body, trampling on his head, humiliation and threats.
- Our intervention took place 2 weeks after the acts of torture during which the victim complained of muscle pain and bruises on his body.
- Previous health problems (x).

The degree of torture in the above Lebanese cases is as severe as described in literature in matter of risk on the detainees' life and health wvOften the abuse was perpetrated on victims with comorbidities, special circumstances such as pregnancy, or a history of alcohol or substance abuse. This usually constitutes aggravating circumstances for the acts of torture perpetrated, and subsequently the sentence deserved by the torturers should be more severe. The time for intervention of the medical examiner(s) is delayed, as well as that of official bodies governed in particular by the United Nation Human Rights, and this may denote a negligence and bad intentions on the part of the security instances to inform, so that medical and psychological care is taken in time before it's too late for the victims.

Similarly, **this delay in informing may denote an attempt to delay for hiding the traces of abuse often incurred several months in advance according to the cases mentioned above.**

Furthermore, we note that the judicial authorities in Lebanon are not taking sufficient measures -compared to what is required through the Istanbul protocol- to order an expert report aiming to establish the facts of a genuine torture that took place and which deserves to take judicial actions against the perpetrators, whoever they are, and as high in the hierarchy of law enforcement as they may be. From here we may conclude that the political situation in Lebanon and the consecutive lack of efficiency and impartial decision process of its institutions -particularly the judiciary- are probably playing a negative role in this regard.

IV- PHYSICAL SYMPTOMS ACCORDING TO TORTURE METHODS WITH THEIR LONG-TERM CLINICAL EFFECTS: CHRONICITY AND SEQUELS

A- DERMATOLOGICAL MANIFESTATIONS AFTER ALLEGED TORTURE

1- Macroscopic Changes

Acute lesions can lead to health consequences, for example pain and secondary infections, including healing problems, especially when located in an area with venous or arterial insufficiency.

Scars located near a joint can induce contracture, reduced mobility of the joint and pain during activity. Apart from this, scars, although of cosmetic importance, may bother the patient. They can also be a memory of the torture and aggravate the change of identity induced by the torture.

A detailed history of the alleged torture and the related symptoms it induced is important in assessing the significance of the lesions observed on the skin.

Information about the position of the victim and that of the torturer, as well as information about the shape of the instruments in contact with the skin are necessary. In cases where there are no lesions or the lesions are not characteristic, a typical history may be the only support for the allegation of torture, as for example in some cases of electric torture.

The examination should include the entire surface of the body to detect signs of:

1. skin diseases
2. injuries unrelated to torture
3. injuries related to torture

The sequelae of torture in relation to the skin can be:

1. lesions that result from direct physical injury
2. the occurrence of new, or aggravation of already existing skin diseases, caused by physical or psychological trauma.

It is extremely important that the doctor state the degree of consistency with the history of torture (Allden et al. 2001).

Acute lesions are often characteristic because they show a pattern of inflicted wounds that differ from non-inflicted wounds, for example in their shape and distribution on the body. Most lesions heal fairly quickly, leaving no or only nonspecific scars. A characteristic history of acute injury is then important. Likewise, a history of the development of the injury until healing is important.

a- Description of skin lesions

This description should include the following points:

1. Location (use body diagram) symmetrical, asymmetrical
2. Shape: round, oval, linear, etc.
3. Dimension: use a ruler
4. Color (see next slide)
5. surface: scaly, crusted, ulcerative, bullous, necrotic
6. Periphery: regular or irregular, peripheral areas
7. Demarcation: abruptly, poorly
8. Level relative to surrounding skin: atrophic, hypertrophic, normal

The color change is mainly due to the breakdown of hemoglobin (local biligenesis) over time. We can thus observe the following successive colors:

- Livid red: recent, less than 2 days old
- Dark red, purple: J2-J3
- Blue: J3-J6
- Greenish: J7-J11
- Yellowish: D12-D17
- Disappearance in 20 to 30 days

b- Blunt trauma

Blunt trauma can leave bruises or lacerations with extravasation of blood into the skin and subcutaneous tissue. In some cases, they reflect the shape of the instrument used, for example: a stick (Rasmussen, 1990).

Two parallel linear lesions ("trail line bruises")



result from a blow with a stick (Knight, 1991a). The hemorrhagic surfaces often extend along the body during the following days. **The lesions change color from dark red, to dark purple, to brown, to green, to yellow, to a hyperpigmented brown, and then disappear.**

Violent blows to the soles of the feet, "Falanga", can leave bruises in the arches of the feet and swellings that extend from the arch to the intermediate structures of the feet and ankles (Bro-Rasmussen and Rasmussen, 1978).

Blunt trauma often leaves no scar or uncharacteristic scars (Cohn et al., 1978). **Whipping or beating with canes or batons may, however, leave characteristic, asymmetrical, linear, straight or curved or "tramline"-shaped scars, showing a pattern of external affliction** (Danielsen, 1992; Petersen & Rasmussen, 1992; Forrest 1999).

Scars may be hypertrophic with a narrow, regular peripheral area representing an arrow line bruise or an inflammatory area that appears around necrotic tissue in the acute phase (Figure 1).

Differential diagnosis could be plant dermatitis, usually dominated, however, by shorter scars, with a narrow zone of hyperpigmentation in the periphery.

Prolonged application of tight ligatures may leave a linear area extending circularly around the arm or leg, in a case with lack of hair that indicates cicatricial alopecia (Danielsen and Berger, 1981). This particular form does not pose a differential diagnosis.

Figure 1. Long, straight or curved, linear scars in a asymmetrical pattern on the back (Danielsen, 1992).



Figure 2. Symétrique, atrophic, depigmented, changements linéaires sur le dos typique de distensae du striae (Danielsen, 1992).



c- Cutting trauma

Sharp or cutting trauma, for example that caused by the use of a razor blade, knife or bayonet, gives **characteristic ulcerations and usually leaves recognizable scars**. In some cases, self-affliction should be considered, particularly when the scars are localized to the wrist (Danielsen, 1992, Petersen & Rasmussen, 1992). If pepper is applied to open wounds, scars may become hypertrophic (Danielsen, 1992).

A differential diagnosis could be the work of traditional healers, tattoos of the scars of the African ritual or artistic on the body (Nancke-Krogh, 1985).

d- Thermal injuries

Burning with cigarettes, hot instruments or hot fluids leaves acute burns of varying degrees. Burning is the form of torture that frequently leaves scars often of diagnostic value. Cigarette burns often leave 5-10 mm wide, circular, macular scars with a depigmented center and a relatively indistinct hyperpigmented periphery (Kjærsgård and Genefke, 1977).

Dermatological conditions, e.g., sequelae of pustules, may be a differential diagnosis.

Burning by the transfer of greater energy charges to the skin than that caused by the crushing of a cigarette on the skin produces **atrophied and very marked scars**. They present a narrow, regular, hyperpigmented and hypertrophic periphery, which arises from the inflammatory zone that surrounds the necrotic tissue in the acute phase (Danielsen, 1982). When their shape reflects the shape of the instrument used, their size is related to the rate of energy transferred to the skin.

A differential diagnosis could be sequelae to abscesses, but such scars usually do not show the typical, narrow area in the periphery (Petersen & Rasmussen, 1992).

A scar that follows the alleged torture of burning with a blazing metal rod placed through the calf region was originally suggested to represent changes induced by venous insufficiency. The scar was boat-shaped, and was placed across the surface of the calf; she had an atrophied center and a narrow regular area of hyperpigmentation in the periphery (Fig. 3) (Danielsen, 1995) ≠ In contrast, venous insufficiency leaves indistinctly limited hyperpigmentation and ulcer scars located distally on the lower leg (Fig. 4) (Danielsen, 1995).



Figure 3. Une cicatrice en forme d'un bateau, a placé à travers le veau avec un centre de l'atrophie et une zone étroite, régulière d'hyperpigmentation dans la périphérie (Danielsen, 1995).



Figure 4. Insuffisance veineuse avec distally de l'hyperpigmentation indistinctement limité sur la jambe inférieure (Danielsen, 1995).

e- Corrosive injuries

Corrosive wounds, caused by an acid thrown against a victim, generate linear scars a few centimeters wide, with a depigmented center and a regular, narrow, and hyperpigmented zone in the periphery, localized on the thighs and buttocks (Gordon and Mant, 1984). They were arranged in an asymmetrical pattern, mainly directed obliquely down the legs. They showed signs of external affliction consistent with fluid running down the legs, and they indicated sequelae to necrotic areas as expected following a corrosive injury.

f- Electrical injuries

The electric current follows the shortest route between the two electrodes through the tissue with the lowest resistance, i.e., blood vessels, nerves and muscles (Danielsen, 2002). When using high voltage stun weapons, the current flow cannot, however, be limited to the path between the electrodes (Amnesty International, 1999).

In some of the cases, the electric torture leaves sharp lesions on the skin. Contrary to lesions caused by burns, these lesions do not usually reflect the shape of the instrument used, but appear in segments in the influenced regions, since the current selects regions with low resistance (Dyhr-Poulsen et al., 1977, Danielsen et al., 1978, Danielsen et al., 1978).

Line lesions that result from linear application of the electrodes may also be seen. The crusts probably correspond to an electrical injury and may contain metal deposits from the electrodes (Thomsen, 1984, Jacobsen, 1997)

Differential diagnosis may be insect bites or scratching.

Many red lesions a few mm wide have been seen following the use of a battery-operated electric instrument (TAT-Groupe contre la Torture 2001). Contact dermatitis may be a differential diagnosis.

Red macular scars, approximately 1 mm in diameter, were observed four weeks after "Picana" (Kjærsgaard and Genefke, 1977). Eight weeks later, many of the scars were gone. The remaining scars were small, white or red-brown spots.



Among the skin diseases that leave pigmented scars is lichen planus, which leaves scars approximately 2 mm wide.

Electrical torture has been reported to cause 6-8 mm wide, irregular, red-brown keloid scars on the helix of both ears (Bork & Nagel, 1997) Picana or Electric cattle prod.

g- Skin diseases

An example of a skin disease that is psychologically induced by torture may be the concomitant event of an urticarial rash. Physically induced skin diseases may be the development of psoriasis or lichen planus in the traumatized area, such as a "Koebner reaction" (Danielsen, 1992). However, such skin changes have little diagnostic significance in connection with torture.

If a victim consents, a 3-4 mm biopsy can be done under local anesthesia. It can be useful to confirm an allegation of electrical torture (Danielsen et al., 2003; Thomsen et al., 1984; Karlsmark et al. 1990).

Lesions that were excised a few days after the alleged electric torture showed segmental changes and deposits of calcium salts on cellular structures, consistent with the influence of an electric current, but with only a moderate degree of reactivity.

A biopsy taken five days after alleged electrical torture by the use of a battery powered electrical instrument, probably delivering high frequency alternating current where concurrent heat development dominates, showed nonspecific changes with a subepidermal bulla, consistent with thermal injuries.

Toxic contact dermatitis could be a differential diagnosis, the support to the history of torture being of a slight degree.

Abnormal findings do not rule out the possible use of electric torture. The use of high frequency ultrasound can be useful to discover the location of calcium deposition to select an area for biopsy (Danielsen, 2002).

B- THE MUSCULOSKELETAL SYSTEM

Symptoms related to the musculoskeletal system are the most frequently reported physical complaints at the time of torture, as well as at later stages. The associated signs and symptoms in the acute phase are similar to other types of acute trauma which cause **damage to soft tissue (muscles, cartilages, tendons, ligaments, nerves and vessels) and distortion/dislocation of joints and fractures** (Rasmussen, 1990 Forrest, 1999, 2002).

Pain is the dominant symptom in relation to the musculoskeletal system in the chronic phase. The clinical picture is that of localized or diffuse pain in muscles and joints.

As well as pain related to the spine and pelvic girdle. **Neurological complaints mainly in the form of sensory disturbances and radiating pain** (Rasmussen, 1990; Edston, 1999; Moreno & Grodin, 2002).

Typical findings in the musculoskeletal system in the chronic phase are:



- Increased muscle tone
- Radiating pain, especially in the muscles of the neck and shoulder girdle, muscles in the lower back and pelvic girdle, and muscles of the lower extremities; tendinitis around the shoulder joint, elbow, knee and ankle joint
- Pain and restriction of movement in peripheral joints, cervical and lumbar spine
- Plantar pain and compensatory gait (Rasmussen, 1990; Skylv, 1992; Forrest 2002)

The clinical examination of the musculoskeletal system can be done:

1. To support conclusions consistent with the allegation of torture, and/or
2. For the purpose of rehabilitation.

Often, victims of torture exhibit diffuse symptoms that require careful examination of many structures guided by medical history; and knowledge of torture and the methods of torture applied are a prerequisite for the examination.

1- Possible Damage to the Musculoskeletal System after Physical Torture

a- Soft tissue injuries

Acute stretching of a muscle causes partial or complete tearing of the muscle-tendon unit. These injuries are usually referred to as stretch-induced injuries or muscle strains.

A direct, non-penetrating blow to the muscle

body is another common mechanism for muscle injury. Such muscle contusions can cause **considerable damage to muscle structure and function.**

The initial pathology shows many similarities in strains and bruises.

- Immediately after the injury, there is an interruption of the architecture due to the rupture of muscle fibers, as well as the injury of the connective tissue structure and the formation of hematomas.
- Within two to three days, an intense inflammatory reaction develops. Pain and disability in the acute phase are mainly due to this inflammation, and bio-mechanically the muscle is very weakened.
- During the first week, evidence of muscle regeneration can be observed. Regeneration of muscle cells and fibroblasts, forming a scar next to the injured area. The combination of regeneration and healing results in a healed muscle that has more or less small muscle fibers in the injured area, as well as an increased level of collagenous tissue between the fibers.

The majority of muscle injuries heal without leaving any specific trace, but very often victims of torture present with muscle dysfunction in the chronic stages.

Typical, but nonspecific, findings are: increased muscle tone, restricted degree of stretch in movement, tension points, and musculotendinous inflammation (Skylv, 1992).

b- Muscle tone

The variation in muscle resistance under finger pressure is known as muscle tone or muscle tension, and is described on a continuum of high (hypertonicity) and low (hypotonicity).

Several causes can lead to changes in muscle tone, and these are grouped into three main categories:

1. From an organic cause, for example a neurological disorder
2. Mechanical cause, e.g., overload
3. From psychological causes, for example

conditions of prolonged stress

c- Musculo-tendinous inflammation

It is the body's reaction to tissue injury caused by pressure, friction, repeated loading or overloading, and external trauma. This reaction leads to impaired and painful mobility of the affected part. It can occur in joints, tendons, tendon and muscle attachments, bursa and periosteum.

Inflammation of the muscle-tendon insertion to the bone (teno periostitis) is characterized by localized tenderness to pressure on the affected insertion and increased pain at the insertion site, during a contraction against resistance (isometric test). Inflammation of the tendons (tendinitis) and bursae (bursitis) is characterized by tenderness, swelling and crackles which may be present during the acute phase.

d- Ligament injuries

Exceeding the normal range of motion of a joint or loading it with traction, as in hanging and other types of torture positions, can damage ligaments. An inflammatory reaction with swelling, pain and dysfunction of the joint would be present in the acute phase.

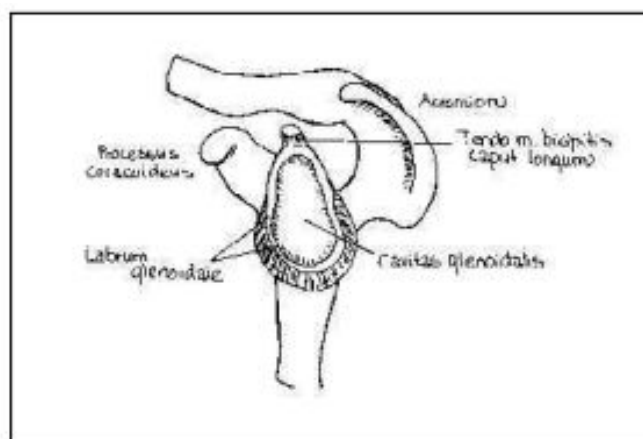


Figure 5. Section frontale à travers l'articulation de l'épaule.

- In a first degree distortion, the ligaments are sprained without macroscopic rupture, and there will be no mechanical instability in the joint.
- In second degree distortion, there will be partial macroscopic rupture of the ligaments, leading to mild mechanical instability in the joint.
- In a third degree distortion, the ligaments will be completely torn and the joint will clearly be mechanically unstable.

The healing of ligaments and tendons is considerably slower than that of muscles. Full recovery with normalization of function takes

examination.

a- Suspension by the Arms

It is practiced either separately or in combination with other forms of torture, such as beatings and electric torture. The victim is tied at the wrists and suspended for an extended period by one or both arms. This form of torture is extremely painful and causes immense strain on the shoulder joint and the soft tissues surrounding it.

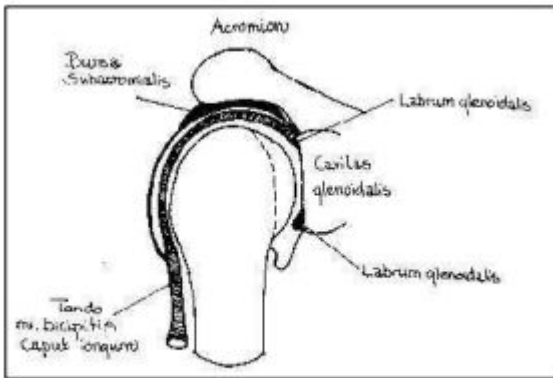


Figure 6. Stabilisateurs statiques, glenoidale du labrum.

months. Joint pain and dysfunction are very common complaints during the chronic phase. Specific clinical tests can be used to diagnose joint instability and direction of instability.

The shoulder is a complex joint that includes four joints: the glenohumeral joints, the sternoclavicular joint, the acromioclavicular joint and the "scapulothoracic" joint. Normal shoulder function requires optimal coordination between these four joints. The bony anatomy of the glenohumeral joint allows for the greatest possible range of motion found in any other joint in the body, sacrificing joint stability for mobility. (Fig. 5) Additional stabilization is therefore provided by:

2- Possible Lesions and Assessment of the Musculoskeletal System after Specific



Figure 7. Suspension avec les bras en flexion avancée.



Figure 8. Suspension palestinienne. L'articulation de l'épaule au maximum étendue, tournée vers l'intérieur.

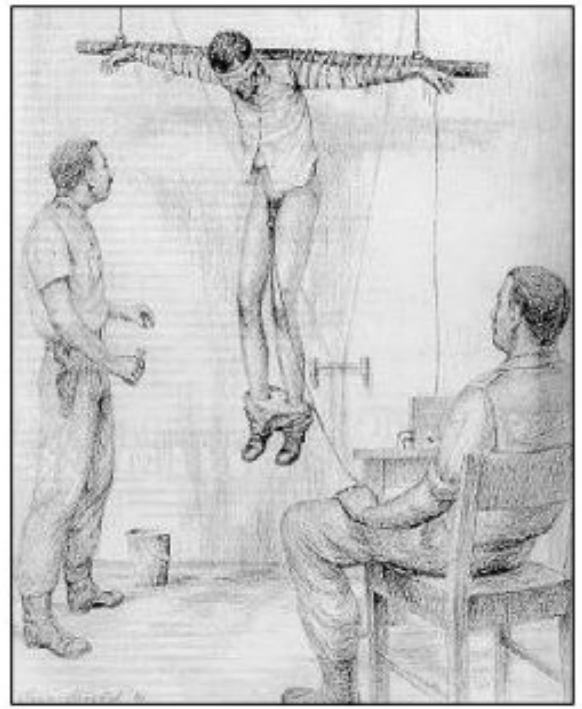


Figure 9. Crucifixion. L'articulation de l'épaule en abduction.

Forms of Physical Torture

Suspension by the arms and the falanga are described below, as they serve as examples of the variety of injuries that can occur and which require special attention on clinical

1. Static stabilizers: the glenoid labrum, joint capsule and ligaments (Fig. 6)
2. Dynamic stabilizers: the muscles in particular the rotator - the deltoid and the long head of the biceps; the "scapulothoracic" joint; and neuromuscular control

which ensures constant awareness of the place and movement of the joint (proprioception).

During suspension by the arms, in forward flexion (Fig. 7), the shoulder joint is maximally flexed and slightly rotated outward. This position creates maximum bone contact between the articular head and the joint cavity which helps the stability of the joint.

In the Palestinian suspension (Fig. 8), the shoulder joint is maximally extended, there is internal rotation, and the loading of the whole-

Acute Signs and Symptoms

Symptoms in the acute phase are severe pain in the neck, shoulder girdle and shoulder joint, with loss of function in the upper extremity. Sometimes one or both shoulder joints can become dislocated during torture (Forrest, 2002).

Neurological lesions indicative of plexus injury are common: radiating pain and reduced muscle strength in the upper extremities, accompanied by sensory disturbances, typically in the form of paresthesias and decreased sensation.

On neurological examination, common findings are reduced muscle strength, loss/reduction of tendon reflexes, and sensory disturbances along the sensory nerve (Allden et al., 2001).

Symptoms and signs in the chronic phase

Many torture victims who have been exposed to arm suspension, particularly Palestinian suspension, develop chronic disability with pain, reduced shoulder function, and permanent neurological deficit, indicative of partial brachial plexus injury, most often involving sensory functions.

Systematic reviews - including radiological assessment of potential shoulder joint injury caused by suspension - are, however, not available.

body weight rests on the weak-looking anterior part of the shoulder joint; which places the pull on the brachial plexus. Automatically, the lower plexus, and subsequently the middle and upper plexus fibers, will be damaged if the pulling force is severe enough.

If the suspension is of the "crucifixion" type, the shoulder joint being in abduction (Fig. 9), the force of the traction will be placed at the origin on the fibers of the central plexus which will probably be the first damaged (Allden et al., 2001).

Therefore, the pathogenesis of chronic symptoms and dysfunctions of the shoulder is not fully understood. However, neurogenic pain due to plexus injury plays a major role (Thomsen, Eriksen & Smidt-Nielsen, 2000; Moreno & Grodin, 2002).

In the late stages, typical complaints are:

- pain in the neck and shoulder girdle;
- deep pain in the shoulder joint during activities, especially concerning aerial movements (abduction, internal rotation) and lifting objects,
- a reduced range of motion in the shoulder joint,
- a feeling of instability in the shoulder joint,
- sensations of blockages during movements.

The clinical assessment of torture victims suspended by the arms should include:

- 1. Examination of shoulder function:** passive and active range of motion, joint stability, accessory shoulder joint function, including scapula function
- 2. Soft tissue examination:** muscle relief, muscle tone and degree of stretch, tender points and radiating points, tendonitis, shoulder impingement,
- 3. Neurological examination:** muscle strength, tendon reflexes and careful examination of tenderness, including vibration sensation, position sensation, colon differentiation and touch, pain and thermosensation.

b- THE FALANGA

Acute signs and symptoms
The immediate effect of falanga (repeated applications of blunt trauma to the soles of the feet) is bleeding and swelling in the soft tissues of the feet, as well as severe pain. The typical diagnosis is swelling of the feet, discoloration of the soles due to hematoma formation and several degrees of skin lesions (Amris & Prip, 2001 a; Allden et al., 2001). Extensive ulceration and gangrene of the toes due to ischemia have been described, but are not common. Fractures of the tarsals, metatarsals and phalanges are reported to occur (Forrest, 2002). Acute changes such as edema and extravasation and blood resorption resolve spontaneously after a few weeks, but soft tissue damage may be permanent.



pads The heel pad is normally a firm elastic structure that covers the calcaneus. It has a complex internal architecture that consists of large, tightly bonded cells surrounded by septa of connective tissue that also contains the nerve and vessels that supply the tissues. Because of its structure, the heel pad is under constant hydraulic pressure and maintains its shape during weight overload and while standing.

After falanga, the heel pad may appear flat and wide, with tissue shifting laterally during weight loading. This is observed on inspection from behind, with the torture victim in a standing position. On palpation, the elasticity in the heel pad is reduced and the underlying bony structures are easily felt through the tissues. The pathophysiology of reduced elasticity in the heel pad is probably due to tearing of connective tissue septa, leading to deprivation of blood supply and secondary atrophy of fat cells with loss of absorptive capacity of shocks.

Damaged soles are not pathognomonic for falanga, but they are also described in other conditions unrelated to torture, for example injuries in long-distance runners and patients with fractures of the heel bone. **It should also be emphasized that on clinical examination normal insoles do not eliminate exposure to falanga.**

Changes in the plantar fascia The plantar fascia

Symptoms and signs in the chronic phase

The majority of victims subjected to falanga complain of pain and deterioration in walking. Usually there are two types of pain:

- A numbing, bothersome, deep pain in the feet, which intensifies with weight bearing and muscle activity, extending up the legs
- A superficial burning, aching pain in the soles of the feet, often accompanied by sensory disturbances; frequently also a tendency for the feet to alternate hot and cold, suggestive of autonomic instability.

Walking speed and distance are reduced. Typically, the torture victim is able to walk a limited distance during which the pain will increase and make muscle activity impossible.

At rest, the pain disappears and the victim can resume walking. The etiology and pathogenesis of persistent pain and disability after falanga are not completely understood. Several theories have been advanced (Rasmussen, 1990; Skylyv, 1993; Allden et al., 2001; Amris & Prip, 2001b), and most likely a combination of trauma mechanisms is responsible.

Shock reduction and absorption in the heel

extends from the calcaneus and up the front of the foot. It strengthens the longitudinal arches of the foot, helping the foot muscles while walking. **Changes in the plantar fascia are present in some victims of torture after falanga and are probably due to repeated direct trauma to this superficial structure. After falanga, the fascia may appear thickened with an irregular surface on palpation, and tenderness may be observed anywhere along the entire length of the fascia, from its beginning to the insertion.** Interruption of the plantar fascia has been reported, based on the finding of increased passive dorsiflexion in the toes on clinical examination (Skylv, 1992; Forrest, 2002).

Closed compartment syndrome

It is defined as painful ischemia, and circulatory disorder related to an **increase in pressure and volume within a specific muscle compartment**. In the acute form, with rapidly increasing pressure, for example that caused by bleeding inside the compartment, the symptoms are alarming and the consequences severe with necrosis of the tissues involved if left untreated.

Chronic compartment syndromes can occur as a result of an increase in muscle loading and/or compartment narrowing. Clinically, this condition presents with pain that intensifies with load and ultimately renders sustained muscle activity impossible. The pain subsides after a short period of rest, but recurs if muscle activity is resumed - a picture not much different from that seen in impaired gait after falanga.

C- THE NEUROLOGICAL SYSTEM

Acute neurological problems of the central nervous system are associated with violent blows to the head. Of 200 victims of torture, 58% had received severe blows on the head and as a result 1/4 of them lost consciousness (Rasmussen, 1990). **Headaches were the frequently reported symptom, and present in more than 50%**

of those examined. A considerable correlation between violent blows to the head and headaches has been demonstrated. There was also a significant association with the **presence of vertigo in 20% of people.**

Violent shaking can produce brain damage identical to that seen in shaken baby syndrome: **cerebral edema, subdural hematoma, and retinal hemorrhages.** The first fatal example of "shaken adult syndrome" was reported by Pounder and Path (1997).

Acute peripheral nervous system symptoms are reported to be more often due to handcuffs or tight ropes on the wrist. Brachial plexus injuries, especially the lower roots, have been reported after suspension, and damage along the spinal nerve has been reported after "Palestinian suspension" (Forrest, 2002).

Many long-lasting symptoms, such as **loss of concentration, headaches, memory impairment and vertigo,** could be explained by organic, chronic brain damage (Abildgaard et al., 1984) and require neurophysiological evaluation to assess the specific symptoms. However, it should be borne in mind that many of these symptoms are also related to PTSD. (Reference §185 of the Istanbul Protocol).



D- CARDIOPULMONARY MANIFESTATIONS

Acute symptoms include dyspnea, chest pain, cough, expectoration and palpitations. Blows to the chest can cause

ribcage injuries - including rib fractures - and severely reduce breathing.

The consequence is often pneumonia. The “submarine” (method of asphyxiation) is associated with the potential risk of producing acute lung symptoms, due to inhalation of contaminated water. Harsh conditions of imprisonment, probably often in damp, cold and dark cells facilitate **pneumonia, bronchitis or pulmonary tuberculosis.** And **Electrical torture can produce cardiac arrest if current passes through the heart** (Danielsen et al., 1991).

In an additional **study of 22 Greek torture victims**, (Petersen et al., 1985), lasting **symptoms of tachycardia attacks, palpitations and/or dyspnea - also combined with anxiety - were found in 6/22.** As for **pain in the chest - including angina and muscle pain - was found in 5/22,** and **chronic bronchitis** (cough, dyspnea on exertion) **in 8/22 people.** These findings highlight the importance of further studies on victims of torture. Considerable ECG changes have been observed in American soldiers in detention in camps in Serbia (Corovic, Durakovic, Zavalic & Zrinscak, 2000).

G- MANIFESTATIONS OF THE OTORHINOLARYNGOLOGICAL SPHERE

Beating is the type of torture that carries a high risk of damaging hearing, especially in the form of “telefono” in which both ears are beaten simultaneously with the palms of the hand.

The “Telefono” produced immediate, as well as long-lasting symptoms in the ear (Rasmussen, 1990). It produces a shock wave against the eardrum, probably very similar to that produced by explosions. Kerr (1978) describes the following clinical findings after blast injuries in Belfast:

“Usually, sensorineural deafness occurs accompanied by **ringing of the ears.** In mild cases this ringing of ears and deafness may heal completely within a few hours. Severe cases

almost never heal completely. Perforation of the tympanic membrane is common and occurs in the middle tensa which is the lower five-sixths of the tympanic membrane. These perforations vary in appearance and may be linear tears, small holes, or partial defects. Occasionally there are also damage to the ossicular chain.

High frequency sensorineural hearing loss occurs with normal hearing retention at speech frequencies. Hearing loss can occur up to six months after an explosion.” This involves reassessing these subjects after this period, also known as “consolidation”.

H- OPHTHALMOLOGICAL MANIFESTATIONS

Acute eye symptoms in torture survivors are **conjunctivitis, probably caused by the dirty fabrics used to blindfold the eyes, which victims often have to wear for days and nights non-stop.** Very few lasting eye symptoms



possibly related to torture have been reported. Perron-Buscail, Lesueur, Chollet, and Arne (1995) observed opacities in the cornea 10 years after electric torture in the eyes, which influences vision.

(Reference §177 of the Istanbul Protocol)

I- GYNECOLOGICAL MANIFESTATIONS

Sexual violence is frequently a hidden problem. Women of any age can be raped, including women over 60 or even children (WHO, 1996). It is important to note that sexual violence and rape are just a few of the many traumas that women have endured, and the physical consequences are often accompanied

by psychological and social consequences. Barriers to seeking medical care can be reduced by **ensuring sufficient numbers of female paramedics, and by training health professionals who work with refugees and victims of torture** to recognize victims of sexual violence and rape. Prior to the gynecological examination, the purpose of the examination should be clear: is it to identify treatment needs or is it to document alleged sexual abuse? In the case of documenting human rights abuses for legal purposes, it is essential to gather detailed information. It is important that the alleged victim gives their consent. A safe and confidential environment should be ensured. **A detailed gynecological and obstetrical medical history should be taken**, including questions about sexual activity, menstruation and contraception.

Immediately after a woman is raped, sperm can be detected. She may have wounds on her body. The vulva, vagina, anus and urethra should be carefully examined and special attention should be paid to the perineum. The presence and conditions of the hymen should be noted. (Knight, 1991b). Most acute symptoms disappear over time.

Later, women may present with complaints of vaginal bleeding, decreased sexual desire, genital irritation, pain during intercourse and urinary tract infections (Campbell, 2002). Sexual torture can leave traces in the musculoskeletal system, structural injuries, functional disorders and dysfunction of the pelvic joints in women. **Medical care providers should always consider sexually transmitted diseases after rape.**

Soldiers, even in peacetime, have an STD infection rate two to five times higher than that of the civilian population. **The chance of infection is therefore considerable for women who have been raped by soldiers** (Machel, 2000). The consequences of pregnancy and delivery, as well as of unsafe abortion, must be considered.

The most frequent complications are incomplete abortion, sepsis, hemorrhage and intra-abdominal injury, such as uterine perforation (WHO 1998).

J- EXAMINATION OF CHILDREN

Many cases of child torture have been reported by the human rights organization, it is feared that these cases are only the tip of the iceberg (Amnesty International, 2000). **Torture and sexual abuse of children are in fact widespread**, especially in ethnic conflicts (Southall & Kamran, 1998). The child, girl, is doubly susceptible to violence, because of her sex and her age (Chinkin, 1998). Children can be victims of secondary torture because of violence or torture perpetrated against one or more of their parents, as they can also be primary victims.

There are many reports that children have been subjected to the same methods of torture as adults, they may show physical symptoms similar to adults. However, little is known about the physical consequences of typical torture on children. What are the implications of torture on a growing body? How does torture affect a child's development?



After a traumatic event, children may suffer from enuresis and - less commonly - encopresis (Kaffman & Elizur, 1983; Simpson, 1993). Enuresis is quite common in school-aged children. It occurs more often in boys than in girls. There is a strong association with a family history of nocturnal incontinence.

Regressive enuresis (occurs after children were previously dry) can be triggered by stressful events.

Physical and urinary examination are indicated to rule out organic damage, but organic pathology can be found in only a very small number of cases. Possible differential diagnoses are urinary tract infections (especially

girls) and diabetes. Encopresis is less common than enuresis. This is a problem that in most cases develops as a result of long-standing constipation. It can represent emotional issues. As in the case of enuresis, organic defects are rarely found, but should be excluded.

Shaken Baby Syndrome has been described as occurring only in very young children, rarely older than two years.

However, symptoms similar to shaken child syndrome were diagnosed in an adult who had been shaken during questioning (Pounder & Path, 1997). There has been no systematic study of morbidity among the many people who were shaken during interrogation.

Children should be examined in an age-appropriate context. Nevertheless, the health professional should realize that for many children in the world, the end of childhood is the age of 18, after which they become adults. The history of their violence should be respected and should be taken seriously.

However, **they often prefer to stay silent, walk away and hide and bury their experiences** (Protacio-Marcelino, de la Cruz, Balanon, Camacho, & Yacat, 2000).

Children may react to trauma with depression, sleep disturbances, nightmares, worry, fear, nervous disorder, and feelings of guilt (Pynoos, Kinzie, & Gordon, 2001).

V- SOMATIC AND PSYCHOSOMATIC EFFECTS OF TORTURE



The somatic effects of torture have been described in details during this training program, and their long-term clinical effects seem to weight more by themselves psychologically on the victims. Because these chronic symptoms hurt by themselves and by perpetuating through their persistence the excruciating memories that the victims spend the rest of their lives trying to forget.

And in addition to the physical pain and/or the functional impotence that the victims keep, is grafted a **psychic pain which is added to the trauma from the psychological experience of the episodes of torture as repetitive as they are humiliating.**

From here arises the reality of the psychosomatic nature of torture because this

meaning explains better what the victims of torture endure. Torturing is hurting the soul more than the body because the former -according to what has been presented- is in fact hurt twice and repetitively, acutely and chronically.

While some brain structures and functions appear altered in torture survivors, it is unclear how torture exposure influences functional connectivity within and between core intrinsic brain networks. In a study by Liddell et al., 37 torture survivors (TS) and 62 non-torture survivors (NTS) participated in a resting-state fMRI scan.

This study found that torture exposure affected functional connectivity within and between core intrinsic brain networks. Group differences were not attributed to torture severity or dissociative symptoms.

Mapping of disrupted connectivity between these identified networks that underpin vital metacognitive and self-referential emotional processes provides critical insights into the long-term impact of torture on functional brain systems.

Finally, this study provided a critical step in MRI mapping the neural signature of torture

exposure to guide treatment development and selection.

Some studies found that torture did not predict posttraumatic stress disorder (PTSD) and is associated with **more complex symptoms and that torture survivors are more resilient than other refugees**. The goal of this study by Kira et al. was to recheck the validity of these findings. It conducted a secondary analysis of data of 502 Syrian refugees, of whom 123 were torture survivors.

Authors measured cumulative stressors and traumas (CST), PTSD, identity salience (probability that a given identity will be invoked in social interaction), post-cumulative trauma-related disorders, posttraumatic growth (PTG), and physical health.

Torture survivors may develop PTSD because of traumas other than torture. The results clarified some of the mechanisms that linked **high identity salience and PTG in torture survivors**, even though they have worse physical health, higher trauma load, and mental health symptom severity, compared to other refugees. **Torture survivors' stronger collective identity empowered their PTG.** However on an individual basis the effect of torture is what we already exposed earlier in this program.

The effects of torture on dissociation and executive control function are alarming and need a particular focus on treatment. A recent study confirmed the direct effects of torture on higher working memory and inhibition deficits, in addition to its indirect effects on them via mental health symptoms (Kira et al., 2020).

There is a pressing need for cognitive training to enhance their executive functions, critical to their mental health treatment.

Several studies have reported **cognitive training efficacy in improving cognitive control** (e.g., Han, Chapman, & Krawczyk, 2018). Such cognitive interventions should be **part of the standard treatment protocol for treating torture survivors** and may be essential for PTSD and depression treatment protocols.

Innovations and experimentation on cognitive training with torture survivors and refugees are desperately needed. Additionally, treatment should include secondary torture survivors (e.g., family members).



VI- CONCLUSIONS

- **Forensic physicians owe the same ethical obligations to their patients as all other physicians, especially concerning privacy and confidentiality**, and should seek informed consent from them regardless of legal obligations.
- Forensic physicians also have a **professional role in supporting the criminal justice system**, providing evidence to the courts and assessing the fitness of individuals for detention or interview.
- This dual obligation to respect patient confidentiality may conflict with the obligation to reveal information for forensic purposes.
- Forensic physician has to **deal with violent patient population** and this implies self-protection and that of other staff.
- The forensic examination should be **attentive, extensive, take into consideration the previous state of health of detainees** because it's capital in detecting and evaluating the degree of harm possibly afflicted in detention. This is paramount to be able to confirm a case of torture in front of the court of justice.
- There are specific findings in different bodily systems that link physical signs and symptoms alleged by the complainants of torture and abuse to the means of torture used, with five known degrees of compatibility.
- **Torture exerted by law enforcement typically use means that don't leave specific, if any, visible bodily traces or scars.** However, their functional consequences are profound and long lasting (e.g. suspension and falanga tortures). This may be to cover up their acts that shouldn't theoretically happen and to escape later prosecution. And here comes

the role of the forensic physicians to determine what's previous to the detention to what is acquired during detention and its compatibility with the victims allegations.

- **Institutional torture is a fact in Lebanese prisons and at least equal in severity and frequency to what is happening in custody in other countries.** There is obviously a delay to contact forensic physicians and other official bodies treating with human rights.
- **Institutional torture in the Lebanese prisons seems to target more detainees with comorbidities, women often with pregnancy, or people with a history of alcohol or substance abuse.** Therefore, this constitutes an aggravating circumstance for the acts of torture perpetrated, and the sentence deserved by the torturers should be more severe.
- It is necessary to recall the psychosomatic nature of torture because this meaning explains better what the victims of torture endure. **Torturing in fact is hurting the soul more than the body.**
- Finally, **the moral and emotional suffering of torture lasts a lifetime** with the burden it constitutes on the subject himself, his family and the community, especially if legal, medical and institutional measures are not taken adequately.





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