

FORENSIC MEDICINE AND ETHICS

*A workshop on the application of forensic
skills
to the detection and documentation
of human rights violations*

**DURBAN, SOUTH AFRICA
3 to 5 July 1998**

FINAL REPORT

**Amnesty International
AI Index: ACT 75/12/99
December 1999**

Contents

Summary and acknowledgements	i
Background	1
Workshop objectives	1
First Day: Death Investigations	2
Investigations of deaths: in custody, in “confrontations”, the buried body	2
Introductory Overview: Advocate Neville Melville	2
The “crime scene” :Senior Superintendent Clifford Marion, South African Police Service	4
Legal, ethical and humanitarian aspects of autopsies: Ms Jenny Powell.....	6
Understanding and documenting external signs of trauma: Prof. Derrick Pounder	8
The Autopsy: An overview: Professor Mahomed Dada	11
Comments from Professor Peter Vanezis.....	13
Group discussion on autopsies	15
Grave Sites: The Buried Body: Professor Jørgen Thomsen.....	17
Grave Sites and the Buried Body - the South African experience: Dr Steve Naidoo	18
Second Day: the Living Victim	20
International and regional experiences of documenting torture and ill-treatment: Overview of the effects of different torture methods: Professor Jørgen Thomsen	20
Comment by Mr Peter Jordi	21
Comment by Mr Tony Reeler	22
Taking a Medical History: Technical, Ethical and Human Rights Aspects: Dr Ling Kituyi.....	23
Comment by Ms Nomfundo Walaza	25
Sexual Assault: Rape as Torture by Dr Lorna Martin.....	26
Physical Documentation and Testing: Overview by Professor Peter Vanezis	29
Court Testimony: by Chris MacAdam	31
Court Testimony: a medical viewpoint: by Prof. Shabbir Wadee	32
Issues for the future	35
Final address.....	36
Appendix 1: Program	37
Appendix 2: List of participants	43
Appendix 3: Workshop evaluation: questionnaire and results	45

Forensic Medicine and Ethics
A workshop on the application of forensic skills to the detection and
documentation of human rights violations
Durban, South Africa
3 to 5 July 1998

Summary

From 3 to 5 July 1998, at the Holiday Inn in Durban, South Africa, some 70 medical and legal professionals, human rights activists and others drawn from six African countries and from Europe, participated in a workshop on the application of forensic medicine to the documentation and investigation of human rights violations.

The workshop covered a wide range of issues relating to both dead and living victims. The countries represented comprised South Africa, Kenya, Zambia, Zimbabwe, Lesotho, Swaziland, the UK and Denmark. The participants were predominantly forensic pathologists, general practitioners, nurses and clinical psychologists, but also included lawyers, police officers, police complaints investigators and officials from two South African provincial departments of health. It was a successful and stimulating event which the overwhelming majority of participants enthusiastically endorsed.

This report summarises the discussions which took place over the period of the workshop and includes details of the program, a list of participants, and a summary of the workshop evaluation.

Acknowledgements

Many individuals and organizations contributed to the outcome of this event. Funding for the workshop came from the Danish Medical Group (DMG) of Amnesty International Denmark and the International Secretariat of Amnesty International (AI-IS)¹. The host organizations were the Department of Forensic Medicine at the University of Natal Durban and a Durban-based non-governmental organization, the Independent Medico-Legal Unit (IMLU). From February 1998 a broad-based committee, which included AI-IS staff, members of the DMG, the Department of Forensic Medicine (Durban), IMLU, the South African-based Health and Human Rights Project, and two UK-based professors of forensic medicine, had worked together to develop the program, agree upon the presenters and chairs for the different sessions, and also the profile of potential participants in relation to the workshop's objectives. The bulk of the preparation tasks, including securing the individual participants, was carried out by the AI-IS Medical Coordinator, James Welsh, and the AI-IS South Africa researcher, Mary Rayner, with assistance from their team members. A paid Durban-based professional conference organizer, Margaret Simpson, was responsible for making the arrangements at the conference venue and booking the accommodation and flights for the participants.

This report is based on detailed notes taken by Claire Thomas, of the AI-IS human rights education team, and edited by James Welsh and Mary Rayner.

¹Total expenditure for the workshop amounted to £23,804.73.

Forensic Medicine and Ethics
A workshop on the application of forensic skills to the detection and
documentation of human rights violations
Durban, South Africa
3 to 5 July 1998

Background

Human rights monitors have documented over many years the inadequacy and inconsistency of medico-legal investigations of suspected human rights violations in southern and East Africa. Concerned professionals in the region have made clear the need for strengthening both technical skills and ethical awareness amongst medical practitioners involved in the investigation of suspicious deaths and suspected torture and ill-treatment of prisoners. In view of this need, Amnesty International, the Independent Medico-Legal Unit (Durban), the Department of Forensic Medicine at the University of Natal, Durban, and the Health and Human Rights Project, Cape Town, as well as forensic pathologists from Scotland (Professors Peter Vanezis and Derrick Pounder) and Denmark (Professor Jørgen Thomsen), collaborated in the organization of a workshop for medical and legal professionals and human rights activists in July 1998. The workshop on forensic medicine and ethics was intended to contribute to addressing the needs expressed by those working on these issues, including sharing information, strengthening contacts and increasing awareness of forensic medicine as a human rights tool.

The meeting took place over two days and one evening and covered a wide range of forensic and ethical issues relating to investigations of deaths and documentation of trauma inflicted on the living person. The first evening was given to welcoming speeches by Professor Mahomed Dada, Professor Jørgen Thomsen and Professor JR van Dellen (Dean of Medicine), and a keynote address given by Dr Barney Pitsoa of the South African Human Rights Commission. The evening concluded with a mock trial organized by Professor David McQuoid Mason, Professor Dada and Dr Steve Naidoo of the University of Natal Durban Departments of Clinical Law and Forensic Medicine, with the participation of members of these departments. The case used in the mock trial illustrated many of the issues relating to forensic and medical evidence which were the subject of the workshop.

The full program is given as an appendix to this report, along with a list of those who participated. A summary of the participant evaluation is also attached.

Workshop objectives

- Sharing of information on developments in the field of forensic medicine in relation to (a) the investigation of deaths in police custody, or as a result of police action and suspected politically-motivated killings; (b) the diagnosis of victims of torture and ill-treatment and (c) the preparation of reports for legal purposes.
- Facilitating and strengthening contact among medical and legal professionals and human rights advocates within the East and Southern African sub-regions and internationally.
- Increasing awareness of the role of forensic medicine in the protection of human rights.

FIRST DAY: DEATH INVESTIGATIONS

The goal of the first day was to examine the legal and technical aspects of investigating deaths (determining cause and manner of death and identifying the victim) whether such deaths occur in a custodial setting, or in conflicts or other circumstances, and the specific problems associated with the buried body. Those speaking included Advocate Neville Melville, Head of the Independent Complaints Directorate, Pretoria; Senior Superintendent Clifford Marion of the South African Police Service; Ms Jenny Powell, former Director of the Independent Medico-Legal Unit; Professor Derrick Pounder, Head of the Department of Forensic Medicine, Dundee, Scotland; Professor Mahomed Dada, Head of Department of Forensic Medicine, University of Natal, Durban (UND); Professor Peter Vanezis, Head of the Department of Forensic Medicine and Science, University of Glasgow, Scotland; Professor Jørgen Thomsen, Head of Department of Forensic Medicine, Odense, Denmark; and Dr Steve Naidoo, Department of Forensic Medicine, UND.

The contents of individual presentations given in this report are summaries rather than verbatim records.

Investigations of deaths: in custody, in “confrontations”, the buried body

Introductory Overview

Advocate Neville Melville²

The focus of this workshop is the question of state abuses—the use of unlawful or excessive force by state agencies. My impression is that this is a universal problem. In South Africa the Truth and Reconciliation Commission is looking at some of the abuses of the past: the involvement of medical practitioners in these abuses is frightening. It is a positive step that these problems are now being addressed by the government.

Abuse by state agencies raises a number of issues: the question of redress; lobbying; public condemnation; international political pressure; action in civil courts; claims for damages; writs of habeas corpus -- above all, the whole area of prosecution in the courts on criminal charges or in an international criminal court, which is being proposed.

The South African system is, in essence, accusatorial or adversarial, with two opposing sides and an impartial referee. The goal is to arrive at a decision closest to the truth via competing accounts. (The other main system used elsewhere is the inquisitorial system whereby the judge or other inquirer(s) seeks after the truth without adversarial combat between prosecution and defence).

In the South African system, the investigative body (police), the prosecutor (justice department) and judiciary are all separate. This is modelled on the English system. But now all of these people are beginning to work more closely together. In small towns the boundaries disappear altogether. The police can initiate an investigation, or a complaint can be generated as a result of

²Director of the Independent Complaints Directorate (ICD), a statutory body in South Africa established to investigate complaints against the police.

the work of the investigative body.

The ICD operates separately from the police service in South Africa. It is a statutory body set up with a mandate to ensure that complaints against police officers are investigated properly: complaints such as criminal allegations or misconduct which would be a breach of police officers regulations. The ICD can recommend prosecution or changes to the systems. Complaints can come from anyone: some arise from deaths in custody, others come from the police, others from NGOs.

Evidence is collected in the form of sworn statements; plans; photos; medical records. The suspect is given the opportunity to comment on the charges. The Attorney General is called upon to make a decision on whether to prosecute. In court, evidence is adduced through witnesses who are called to testify. Exhibits are also submitted. Both medical evidence and other expert opinion is provided by witnesses. The court is guided by this evidence but not necessarily bound by it. The defence might have contradictory evidence and is given the opportunity to rebut the evidence of the state. The prosecution must show that their evidence establishes guilt beyond reasonable doubt. The defence must show that the version given by the accused person may—in the view of the reasonable person—be true.

It is very important that the evidence of the state is substantial and evidence from medical or forensic personnel can be decisive. For example, fingerprints of the accused at a crime scene can be more useful than evidence of an eyewitness.

Where there is a matter of disputed evidence, it is often difficult to get to the bottom of the case. The opportunity of getting evidence early on in the case is seldom made up for later. Early collection of evidence is very important.

In the South African situation, it is a problem that the police have control over what happens in the investigation of deaths in which the police may be implicated. An informal inquest takes place and a magistrate signs a certificate saying he is satisfied as to the cause of death. There is often secrecy surrounding cases. The late Dr Jonathan Gluckman made recommendations that the medical practitioner should report direct to an ICD-like body if torture is suspected. The police have agreed to this suggestion and it is going to be discussed with the Ministry of Health.

The ICD would like to see that all deaths in custody give rise to a complete post-mortem examination. At the moment the police are not obliged to order this.

Discussion

A question was raised as to whether politicians had been invited to attend this workshop as they were the ones to introduce necessary reforms in this area.

It was agreed that there is a need for action to bring about changes to legislation. But because of limited capacity to campaign, we must look for areas where we can have the most impact.

A participant from Zimbabwe expressed surprise that in South Africa there is a proposal to change the forensic autopsy service from the Ministry of Safety and Security (police) to the Department of Health. In Zimbabwe they have the exact opposite.

Dr Shareen Akoojee of the KwaZulu Natal Department of Health commented further on the process of trying to move control of the mortuaries to the Health Department. Discussions on this change started before 1994. The thinking behind this change in the system was that the Health Department had the capacity to undertake such services and that it would avoid compromising the independence of medical practitioners and limit the possibility of intimidation. In KwaZulu Natal discussions are on-going.

One participant from Zimbabwe said that all pathologists are employed by the Department of Health and the mortuaries are also under the control of the same Department. The police do not

give histories and do not accompany the bodies. Interest in post mortems is academic and not so much for judicial purposes.

Another Zimbabwean participant suggested that there was serious political manipulation of the process.

A participant from Kenya stated that in that country the mortuaries are run by the city councils. The police bring in the cases and pathologists are seconded from the Ministry of Health. They are currently trying to form a body with real independence.

The “crime scene”

Senior Superintendent Clifford Marion, South African Police Service³

Prior to 1994 abuses carried out by the police and corruption in the South African Police Services (SAPS) was covered up but after the election in 1994 the impression was given that everything was now going well. The ICD and anti-corruption units had been set up to tackle these problems.

My presentation concerns the issue of deaths in custody involving police or other state institutions. What is important to remember is that a number of those whom the police arrested, prior to the 1994 elections, were arrested for political crimes. Very little or no evidence was available to the police to secure prosecution. The police decided to take the law into their own hands. They often used methods that infringed people’s rights in order to extract information.

Of the methods used by the police to get people to confess, the most common method is the tubing method. A tyre is cut and then used to smother the person, with a blanket being wrapped around the body to prevent bruising.

Electric shocks are also used by the SAPS. Two wires are connected to sensitive parts of the suspect’s body. The victim would have burn marks under the arms or testicles.

On occasions there would be an alleged suicide. The police would use the threat of hanging to get a confession, but sometimes this would go too far and the person would die. Or in high buildings the policemen might hold you out of the window.

Blunt instruments are used on people to cause internal injuries and bleeding. Such injuries are less noticeable on people with dark skin. Other torture methods were used and shooting and straightforward assault were also common.

All these forms of torture have in certain cases resulted in the death of a suspect. The police culture of not saying anything, not knowing anything and not hearing anything, still exists today. The brotherhood still exists: they will never implicate their colleagues in crimes.

There are a number of cases where bodies are never found. Police come back and report that a suspect has escaped. In fact the body has been dumped in the next jurisdiction but information is not shared between jurisdictions.

Death in custody - the crime scene. The scene of the crime might be a police office, police station or a place known to the police where people are questioned. Crime scenes of this nature are difficult to investigate. Police sweep the scene first before calling anyone in. The people that should come to the scene are the ICD, the forensic field worker, the district surgeon or pathologist and the investigating officer. This is what should happen, but it does not. There is often a delay of days or even a week before the ICD is called in. If a death in custody happens, it should be

³Senior Superintendent Marion is a member of the SAPS who has worked with special investigation units concerned with political violence in KwaZulu Natal.

reported straight away.

Preservation of the crime scene is very important. The first policeman on the scene should cordon off the area and make sure nothing is touched. Only the four people mentioned just now should be allowed on the scene.

Preservation of the evidence is also important. Ensure that no injuries are inflicted on the body during transit to the mortuary. Preserve relevant exhibits.

Lastly, independent forensic laboratories should deal with all evidence at the scene.

Discussion

A participant from Zimbabwe asked what action is being taken to try and redress the situation.

The Ministry of Correctional Services (South Africa) has taken a very hard line with regard to abuse and torture in custody/prison. The problems are being addressed although it is a close knit fraternity and it is difficult to prosecute the police service itself.

One participant said that in 1994 to 1996 he saw a lot of putrefied bodies that had been kept in a funeral parlour in the Eastern Cape. In one case, a body was kept there for six months.

In response it was agreed that there has always been this problem in the Eastern Cape. It is correct that there are a lot of putrefied bodies. This could be due partly to a lack of resources. Although even in the remains of a decomposed body there is often evidence of foul play which can be recovered.

Senior Superintendent Marion pointed out that the lack of resources is not general throughout the country. The resources are distributed evenly. However in the past, people used the resources for private purposes.

A participant from Zimbabwe commented that sometimes there is a deliberate delay by the authorities. There were cases in Zimbabwe where injured persons needed hospital treatment. Because the police had caused the injuries, they would not give letters of authority for the people to get the treatment they required. By the time they got to the hospital, most of the evidence was gone.

Dr Faizel Randera (Truth and Reconciliation Commission) agreed that a lot of information about police behaviour had come to light during the hearings of the TRC. The majority of amnesty applications come from ex-liberation fighters, not from the police. There are still many human rights violations taking place. What is happening within the police force? The ICD is very small and cannot deal with all the complaints. What is happening within the police to break down this long-standing culture?

Senior Superintendent Clifford Marion responded that South Africa is going through a process of change as a result of the previous situation. However the police service is still conservative. There are very few people who are willing to make changes. The hierarchy is still conservative. Change must be made by more liberal-minded people. This behaviour will be phased out as time goes on. The management of the police is going to be 50% black by the year 2000. Also, there are policemen who will not tolerate this type of conduct.

A participant from Zambia commented that in his jurisdiction there is a situation where police sometimes say that a suspect has led them to the place where a body was found. They even take photos of the suspect pointing at the body. Experience tells us that when the police do not know the killer they arrest a few people. They take them to the bush. One of them is told that he can go free and then they kill him as he tries to leave by shooting him in the back. The others are intimidated into giving evidence. Courts have admitted evidence obtained in this way.

A nurse informed the meeting that he recently attended a course in clinical forensics in

Kimberley. This is a positive step in South Africa. Usually no reference is made to the role of the nurse in these cases, but often it is the nurse who is given the task of looking after suspects. Sometimes the nurse is expected to give evidence in court without having the relevant skills to do so. This program for training nurses in clinical forensics has been set up. We need nurses in general in South Africa to be part of the bigger team.

An advocate from Lesotho stated that the methods of torture and cover up referred to in the presentation are also used in Lesotho. Whilst forced confessions have not been admitted by the courts, the courts have inadvertently encouraged these practices.

Legal, ethical and humanitarian aspects of autopsies **Ms Jenny Powell⁴**

Questions of a legal, ethical and humanitarian nature arise frequently in cases of non-natural death. I have chosen to present some general principles, particularly because South African case law will not necessarily agree with other jurisdictions.

The autopsy is very important for the whole legal process. If one is able to enforce one's rights and have access to justice one must have evidence to prove one's case. Evidence from an autopsy is fundamental. It is important that the autopsy is performed well and is properly documented so that the relatives of the deceased can prove their case.

The Role of the Autopsy

When required in law: This will differ in different jurisdictions although the principles will be essentially the same. There are very many laws relating to autopsies. These make it mandatory in certain circumstances to conduct an autopsy. Essentially the reasons are that it is in the public interest.

The law most commonly used in South Africa is the Inquest Act, the purpose of which is to deal with deaths that apparently occurred from non-natural causes. Relevant sections of this Act are:

Section 3 - investigation of the circumstances of certain deaths

Section 5 - which gives details of who may be present.

A second important piece of legislation is the Human Tissue Act, section 8 of which spells out when further investigation into a death is necessary.

There are also other relevant Acts applied in South Africa.

The general principle is that similar legislation will exist in other countries for non-natural death and this will relate to community interest.

Other circumstances: where an individual contemplates that there will be litigation. Or where there are suspicious reasons for the death. This is where human rights bodies might want to be involved in monitoring the autopsy.

Who are the bearers of rights in the context of autopsies?

The law in South Africa does not assign rights to the dead person. The idea of the natural person does not extend as far as a dead person. We do take cognisance of the rights of the dead in the sense of their wishes before death.

⁴Formerly coordinator of the Independent Medico-Legal Unit, which was founded in 1994 just before the first non-racial national elections.

Family rights. Families have rights relating to the burial or the right to be represented at the post mortem. This extends to the next of kin.

Third party rights: The public interest and the community is represented by the State. But should one wish for an independent observer the position in South Africa is that anyone who has a substantial or peculiar interest in the case may arrange for an independent observer by first getting consent from the magistrate or doctor dealing with the matter. For example, there may be an accused person who might want to get involved to ensure proper documentation of the evidence.

Consent: Who consents to performance of the autopsy?

Family consent is not possible in each and every case but this does not mean that steps should not be taken to obtain such consent. The deceased may have provided consent before his death. The next of kin acts where consent from the family is required. There are statutory requirements where authorisation is to be sought but if there is any doubt, it is better to err on the side of caution and seek necessary consent.

Minimum competence levels: From the legal perspective it is very important that the autopsy is properly carried out. The person doing it must be aware that the matter is likely to end up in court. Documentation of the findings is extremely important. There can be very long delays before cases are heard. If cases are properly documented, it makes it much harder to contest the findings. It is important to be certain about one's findings and to be prepared to stand by them.

Ethical considerations: Family consent should be obtained as much as possible. There should be support for the families of the deceased. They may wish to allay their suspicions. One must take cognisance of religious and community values. Sometimes burial must take place on the same day. It is important to try to accommodate these interests but without jeopardizing public interest. Public interest in general overrides the individual's interest.

Second autopsies: sometimes there is a need for a greater level of expertise. Or if the family wants to be represented. It is appropriate at the second autopsy for the first practitioner to be present. It does not help if the case gets to court and there is a conflict of opinion. The Inquest Act does not preclude the presence of interested third parties.

Discussion

An attorney from Swaziland expressed interest in the legal basis of the rights of the family members of the deceased, when that person died in suspicious circumstances. In Swaziland, practitioners are hampered by the fact that there is no Bill of Rights or Constitution. The Inquest Act does not provide for the rights of families. The pathologist is employed by the police department which also causes problems. There is a conspiracy to conceal information between the police, the prosecution and also, unfortunately, the government pathologist. Lawyers have difficulties obtaining post mortem reports. Attendance by family members at an autopsy is out of the question. Having a family-nominated pathologist is also not permitted. Rights of the family members is crucial when one applies to court to enforce access to post mortem reports. But where can one find such rights?

Ms Powell replied that she had never had to look into what rights are provided for in the common law. Interpretation as to which family member can consent, there is a lot of case law in South Africa which relates to this in the context of the Inquest Act (even if this Act is inadequate). A Post Mortem Act is currently being drafted. Family rights must be very clearly spelled out in this next Act.

Professor Peter Vanezis asked how they get permission. Are there obstructions put in the way of carrying out independent investigations?

Ms Powell replied that since 1994 it has become more possible since IMLU was set up.

People are becoming more aware of the need for independent investigation. Sometimes they encounter problems in rural areas. As far as the State is concerned, at the level of magistrates in some areas they have never heard of it. But we have never had the right refused, although often the first response from the magistrate is unhelpful.

There are also issues regarding disclosure and confidentiality which arise concerning the presence of independent witnesses at an autopsy. There are ethical and legal matters coming up daily.

A South African advocate commented that the Criminal Procedure Act recognized the right for a family member to institute a private prosecution against someone responsible for unnatural death. The common law also recognized the right to sue for damages. Neither of these can be exercised without proof of unnatural death.

Ms Powell responded that the person they want to prosecute also has the right to oppose vexatious litigation so the litigants must have the evidence. Clearly they can institute civil litigation. According to principles of natural justice, where you want to give the person the right to have a private prosecution you must give him the right to get the evidence. Otherwise it is not a right in reality.

Professor Derrick Pounder said that medico-legal death investigation is an intrusion by the State into an essentially private matter. There is a need to balance the private interests of the family with the rights of the State.

A Kenyan pathologist commented on the issue of consent which, in Nairobi, is very contentious. The family has to give consent for autopsy. Often for religious reasons they want the funeral to be held on a Friday or a Saturday. On a Friday there will be about 30 autopsies to do. Sometimes the police will tell you that they cannot locate the relatives. Pressure is also put on the forensic services when the ten day detention period is running out, and the police need the results of an autopsy in order to charge a suspect.

Concerning second autopsies: the issue is who should be present? Do they have the appropriate knowledge and expertise? This poses problems to the government pathologist.

Understanding and documenting external signs of trauma on the body Professor Derrick Pounder⁵

This presentation was intended for people who are not experts in forensic medicine.

Professor Pounder made the link between the broad picture of death investigation and specific injuries. He showed slides of some specific injuries and discussed how they should be assessed from a logical perspective, and also how to make an evaluation of an autopsy report to see whether it is logical and sensible.

The universal goals of death investigation systems:

⁵Professor Pounder is Head of the Department of Forensic Medicine at the University of Dundee, Scotland.

- Identification [who?]: Old injuries, previously documented, might help identify an individual.
- Time of death [when?]: Where there are injuries on the body, one can ask: when did the injury occur? For example, did it occur around the time of death or post mortem?
- Place [where?]: Injuries can often tell you something about the location of the death. For example, some injuries might bleed profusely and yet at the alleged place of death there might or might not be signs of blood.
- How: In the case of violent death, the pattern of injuries usually provides the information about how. The overall pattern of injury is what we are interested in.

Courts are also interested to know what happened. Certain things perhaps can be excluded based on the medical evidence. Sometimes injuries can help you determine what or what did not happen.

Investigative process: Here is a model in which you can place the autopsy and the injuries.

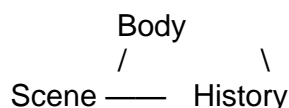


Fig. 1. The “Golden Triangle” of forensic investigation

You can tell from the **scene** of the crime what were the events immediately preceding death. **History** includes: past medical history; social; psychiatric; possibly criminal. Finally you examine the **body**.

Each of these three elements is equally important in the death investigation. A failure in one area will likely lead to a failure in the investigation. It is important to look at the injuries to the body in the context of the scene and the context of the history.

There is no standard autopsy. It is infinitely variable. What you do is based on information from the scene and the history. You need to bring all the information together.

You can judge the quality of the autopsy by each of the three elements of the investigation and also the degree to which they are integrated. An investigation will be compromised even if the work is done thoroughly where there is no attempt to integrate the information.

The “golden triangle” is a way to judge the standard: how competent is each of the three elements but also how are they integrated.

As part of the history, one should also include local knowledge concerning common practices in that particular police force or that particular group of policemen. Epidemiological information of that type is particularly important.

The 5 ‘W’s’ is the goal but one needs to have all three elements of the triangle in order to draw

valid conclusions.

Injuries are classified in order to organize them. And to get information from them, we must know the type of injury first.

There are broadly two groups of injuries which are most common: blunt and sharp injuries. In addition to these there are shot wounds and burns. Blunt injuries are of three types (see table): bruises, abrasions and lacerations; sharp injuries are of two types: cuts and stabs.

A **bruise** is a rupture of a blood vessel with bleeding into the tissues. Bruises are unreliable witnesses. They tell you “maybe”. Sometimes bruises do not appear immediately. Determining the age of bruises is difficult. You can relate the age of one to another but you cannot say how old they are. A bruise might not occur at the site of injury. They are irregular shapes and do not reflect the shape of the object that caused them. The degree of force is difficult to assess.

Categories of injuries		
Blunt injuries: bruises abrasions lacerations	Sharp injuries: cuts stabs	Other: burns gunshots

A graze occurs when a surface layer of skin has been lost. One can divide grazes into two sub-categories. An **abrasion** for example would be caused by a brick being dragged across the skin piling up skin. A tangential type of gliding abrasion can show which direction the object that caused the abrasion came from. The second type is a 90 degree abrasion which does show the shape of the object that caused it. This is an imprint abrasion.

Laceration is tearing of the skin. One characteristic is that the margin is ragged. It is possible to see bruises at the site or abrasions. There are tissue bridges in the depth of the wound.

It is very common for people to talk about all cuts as lacerations. There are often problems with the medical documentation. Laceration is a blunt force injury. Lacerations do not bleed as much as incised wounds because of the crushing.

Incised wounds have a sharp edge. There is no abrasion at the margin and no trace evidence in an incised wound whereas abrasions and lacerations often cause trace evidence.

A “defensive injury” (wounds to the arms which are held in a defensive position) can occur in an accident. You must always be careful of any assumptions you are making when giving an opinion.

A **chop wound** is an incised wound with a thick blade. It gives the characteristics of an abrasion. You can tell the weapon had a sharp edge but also know that it had a thick blade.

A **stab wound** causes internal bleeding. The wound is deeper but not necessarily very evident externally. The amount of external bleeding is limited.

Forensic evidence corroborates evidence from the scene. It is important to make the link between the injuries and the scene.

Discussion

Does having the history and information from the scene affect the independence and impartiality of the pathologist?

Professor Pounder responded that in scientific death investigations you cannot just make a diagnosis from physical examination. It requires the maximum amount of information.

The question of a forensic investigator being biased because of partial police account of events is relevant in the case of South Africa where police surgeons are not experienced. Many general practitioners (GPs) and pathologists are also inexperienced.

Professor Pounder replied that it is important to treat all information with scientific scepticism. There is a difference between bias and having a well-informed scientific approach.

Professor Vanezis pointed out that the source of information and the reliability of that source is important. It is also important to keep an open mind. It is a process of teamwork.

If you contrast scientific evidence with legal opinion, frequently the court weighs both of these evenly. There is a need to get out of the accusatory process where people are called on either side, and to have instead a balanced view.

Professor Mahomed Dada commented that in court you tend to answer the questions put to you. You cannot give your own opinion unless it is specifically asked from you. It is often useful to have a pre-trial consultation to see what you can agree on. This can then be presented as common cause or accepted fact.

The Autopsy

An overview

Professor Mahomed Dada⁶

We cannot make progress in life until we know where we are coming from. We tend to look at things on the basis of background. When in Nepal on holiday a local person commented that “many people come looking, but very few people see”. This is applicable to the autopsy.

The word “forensic” comes from the Latin “forensis” - which means a place where we have dialogue. The current forum is in a court of law.

Concept of disease: initially it was thought to be caused by magic or was related to religion. Autopsies were not done in order to find out a reason for death.

In Babylon/Etruria autopsies were used for divination purposes. Disease was thought to be caused by imbalances in body humours.

Professor Dada then gave a historical overview of the development of pathology.

Role of the Autopsy: An autopsy has several possible functions:

- to determine the cause of death
- to correlate clinical diagnosis and clinical symptoms
- to determine the effectiveness of therapy
- as a vehicle for genetic counselling
- to compile public health statistics
- to educate student pathologists

What is an unnatural death? As far as South Africa is concerned, there is no specific list which says what is unnatural and what is not—with one exception: deaths under anaesthesia. In South Africa, deaths occurring in the following circumstances must be subject to post-mortem examination.

1. Deaths due to the application of force on the body and physical and chemical factors. The force applied may be direct or indirect, with or without complications.

⁶Head of the Department of Forensic Medicine at the University of Natal, Durban.

2. In South Africa, if you die under anaesthetic this should be regarded as unnatural. There is no time limit.
3. Sudden and unexplained deaths.
4. Death normally due to natural causes but which in medical practitioner's opinion was due to an act of omission.

Features of Medico-Legal Autopsy

The forensic pathologist should perform a complete autopsy and in particular should:

- observe all findings and overlook nothing
- preserve all information in written and photographic records
- maintain the chain of evidence, accounting for the whereabouts and security of all relevant materials
- provide a professional, objective, written report without prejudice, advocacy or theory

Medico-Legal Pitfalls

Some pitfalls for those carrying out autopsies include:

- being unaware of autopsy objectives
- performing an incomplete autopsy
- misinterpreting post mortem changes, artefacts and iatrogenic lesions
- producing undesirable artefacts
- destroying evidence
- failure to examine adequately.
- not taking adequate specimens
- having to work with mutilated or decomposed bodies unsuitable for post mortem

In South Africa, it is not the doctor's function to decide on cause of death. This is done by an inquest magistrate or judge. From a legal perspective it is important to note that there is a difference between the cause and the mechanism of death (see table).

An important philosophical point underlying our work is that death is an inevitable fact of living. It is not a failure of science, medicine or technology.

Formulation of the Cause of Death	
Primary cause of death:	Main factor leading to death
Underlying cause of death:	Factor provoking the immediate cause of death
Contributory cause of death:	Any factor contributing to the death
Mechanism of death:	Pathological or mechanical processes leading to death
Manner or mode of death:	Natural or unnatural (homicide, suicide, accident)

Comments from Professor Peter Vanezis⁷

I agree it is important to bear in mind something which is undervalued in autopsy - the interconnection that the autopsy has with society. We tend to be focussed on what is required in the judicial system. Often we find that the poor relative is down the line when they should be the primary consideration. Broadly in the case of unnatural death where there is anyone else concerned with the death, it is the duty of the pathologist to explain to the relatives what happened.

Natural and unnatural death. I would tend to give this a bit more overlap. For example, death from a mosquito bite in Glasgow would be regarded as unnatural while, in tropical areas, as natural. The death of a person frightened by a robber who has a heart attack: is it natural or unnatural? Or death from pathogenic *E. coli* - is food poisoning natural?

Responsibility. It is important that the pathologist takes full responsibility. None of the responsibility of the dissection should be done without a pathologist present. You need to work out a system - train some good anatomical technicians whom you can trust and can work with. This delegation of tasks makes for more effective work and is totally different from having a policeman doing the dissection.

Information. Concerning the problem of receiving enough information when doing autopsies: I would refuse to do an autopsy if I lacked adequate information. Otherwise this is a dangerous precedent to set if people want to bury the body quickly.

Visiting the crime scene: A retrospective visit is always a good idea. It always helps when you have injuries which do not fit with the information given.

Discussion

Professor Dada clarified that medico-legal post mortems are done under the Inquest Act in South Africa. Consent is not required legally. It is often not sought. The Human Tissues Act says that an autopsy can be done on any patient who is dead. In cases of patients who die of communicable diseases we often do not get consent. Only doctors employed by the Department of Health do the post mortems. These are doctors working part time for the State or doctors employed by the State. However a private pathologist can get permission from the magistrate to attend an autopsy.

A question was raised concerning suspected extra-judicial execution which when reported is not followed up. Professor Dada responded that in such cases non-governmental organizations (NGOs) make it possible for private pathologists to be present. Although in South Africa pathologists generally do not put an opinion about whether it was torture in the "comments" section of the report since the courts have discouraged doctors from writing down such opinions

Both Professor Thomsen and Professor Vanezis advocated writing such suspicions in the report. They also recommended that doctors in this situation should get in touch with NGOs. Another possibility would be to contact the World Medical Association. The WMA has expressed concern in cases where doctors may not be allowed to express themselves freely.

Professor Dada commented that the Medical Association in South Africa (now known as the

⁷Regius Professor of Forensic Medicine and Science at the University of Glasgow, Scotland.

South African Medical Association) was historically part of the problem. Now there is the possibility that we might go forward. Medical associations previously could not be persuaded to act.

A participant from Kenya gave an example of a case where the cause of death might be natural, but torture could have contributed to the death. In such a case, it is very important to make some comments about any contributory factors, especially in cases of medical misadventure.

Professor Vanezis pointed out that torture also involves acts of omission. Delay in seeking medical treatment might be one of them.

In Zambia, lawyers discourage pathologists from giving an opinion on their findings. It is up to the judge to find the legal cause of death. The judge will make conclusions about the cause of death. In Zambia pathologists are discouraged from giving an opinion.

Another participant commented that in Zimbabwe they do not have a coroner. There is a system whereby the pathologist is required to state whether the death was natural or unnatural. There are sometimes situations where the cause of death cannot be determined at the time of the autopsy. In those situations, the magistrate will not give a certificate of death. Pathologists are required to give a comment as to whether the injuries are consistent with the history. With regard to consent for the autopsy, this is not sought except in the case of medical interest - i.e. when someone wants to do an autopsy for medical research purposes. Many times the relatives have not wanted an autopsy to be carried out. We try to ensure that consent is sought.

Prof Pounder commented on the issue of the pathologist giving an opinion. He pointed out that it is only the pathologist who fully understands the significance of the observations. He must communicate this in writing to have a permanent record of his opinion. If it is transmitted verbally, information may be changed down the line or misinterpreted. If the judiciary are uncomfortable they can say that the part of the report containing the opinion should not be put into the transcript of the trial.

A participant from Zambia disagreed, stating that the judiciary is only interested in the medical cause of death. Conclusion on liability should be left with the magistrate.

A pathologist stated that in South Africa, the Attorney General does not want any opinions of the doctor put down on the report. It is possible for pathologists to make comments handwritten on their copy of the report if they want to bring something into court including where the injury is inconsistent with the history as recounted by the lawyer. But there is a need to lobby the Attorney General concerning what actually goes on the report.

A doctor from Kenya gave an example of a death in police custody where the primary cause of death is pneumonia. But in doing the autopsy, the pathologist can see that there are very many other injuries. These could be contributory to the cause of death. If there is no comment linking the contributory factors with the cause of death, this is a problem. A lawyer would not be expected to have the necessary expertise to make a link.

Dr Steve Naidoo (UND) commented that he also is not supposed to put down a comment, but he felt he had to do it. He resorted to writing a letter to the magistrate to communicate his opinions. If we are not allowed to express an opinion it is a sad state of affairs. The phrasing of the cause of death in the report is extremely critical. There has to be a way to give expert opinion. We must ask for the rules to be modified.

A South African participant commented that he has had to grapple with the decision whether or not to prosecute. When the post mortem report is finished, he would often send a note to the pathologist asking him to look at the ballistic report, or the murder weapon, and ask him to give an opinion.

A doctor from Cape Town said that on preliminary documentation they write down the cause

of death as “unascertained”. This ensures that the docket comes back and they then have the opportunity to contribute a considered comment.

Group discussion on autopsies

Participants split into two groups of doctors and non-doctors. The doctors’ group focussed on exchanging experiences and concerns⁸.

The non-medical group were to examine the role and strategy of the autopsy and how to interpret and critique the findings. To facilitate this discussion, Professor Pounder presented some real-life cases using slides.

The first slide showed a case from India in which an opposition politician had been arrested by police. He allegedly admitted a link with a paramilitary organization. He was shot and killed. The slides showed the soles of his feet which were burned - this is a common method of torture in India. Interpreting this finding shows the value of local knowledge. A lesion was present on the right arm with a powder mark from a contact wound evident.

Professor Pounder pointed out the necessity of avoiding creating “scenarios” and to concentrate on keeping the interpretation scientific.

Further slides were shown of two cases from Yugoslavia. Two men who were found dead in their village. Only photographs were available - no other information. The photographs showed that the shots were fired at close range, suggesting an execution-type killing.

A slide was shown of another case, showing a bruise to the centre of the chest and a mark under the arm. The cause of death was a heart attack. But these marks indicate a possible suspension by rope.

It is important not only to give an opinion, but also to state with what degree of certainty you hold that opinion.

History also includes local knowledge.

Professor Pounder gave the example of Spain where a report was written about the epidemiology of alleged methods of torture. The patterns of torture in the different police forces were substantially different. The European Committee for Prevention of Torture has used this report. It is important that such information is published.

A participant asked whether it is the case that a series of contributory things combine to cause a death? Professor Thomsen responded that this is often a possibility. It is important to list all the contributory factors very carefully. Chronic neglect plus acts of commission.

Professor Pounder stated that environmental conditions are always very difficult to document. For example, in a case of hypothermia. It is difficult to establish the relative significance. The more subtle the trauma, the less likely you are to be able to prove it.

Professor Thomsen added that dehydration is difficult to substantiate and that other factors such as environmental conditions, hypothermia, denial of food and drink are difficult to prove, as is exhaustion due to the deceased having been tortured.

Professor Vanezis questioned the participants concerning a situation where the pathologist sees that nothing is being done about a particular case. Would the participants think it right to go to the press with their findings? Several participants said that some steps to expose the facts were necessary including media exposure and contacting international NGOs.

⁸*This discussion was not minuted.*

A nurse from the Northern Cape Province pointed out that many nurses do not know what to do with information that they are getting from the people that they see. It is an ethical issue arising from the nurse/patient relationship. When getting a case history from a patient, what do you do with information that you receive?

A participant from Zimbabwe suggested that NGOs can document these cases. They often produce anonymised reports and these can be used for research purposes into the pattern of violations. In many African countries it is GPs who are at the front line of documenting this information. We need independent agencies who can publish anonymous reports.

Professor Thomsen pointed out that there are some authorities in the country who are supposed to be there to protect you, but who also torture you. This is where the NGOs have a role to play. But unfortunately many people do not know about NGOs. These things can only be solved at universal, global, international levels. The media might also be able to help to draw attention to the problem.

A Kenyan participant raised the issue of the high incidence of torture in North East Kenya. Many cases are not reported. In Kenya the police are even trained in how to torture people. People do not know their rights or about proper judicial proceedings. Now people are being educated, but they are still afraid of reporting cases. The media aspect is a problem in Kenya. Nowadays it is impossible to get cooperation from the media at all.

Several speakers pointed to the need to involve the community and one said that there was a professional gulf between lawyers and doctors. Professor Pounder said that he thought it possible through existing networks to tap into resources. If you just have some photographs - minimal information - someone with expertise in the area might see something even with limited evidence. In the modern world, you do not even need to have experts in the same country. He did not think the lawyers and medical practitioners are really so far apart.

A South African human rights monitor followed by saying that there is a need to take a step further towards community groups grappling with such problems with the pathologist playing more of an activist role. Professor Pounder pointed out that one's standing as an expert pathologist can be compromised by becoming an advocate. The danger is that you lose your credibility.

A South African attorney stated that it is important to fight good cases where resources will be properly spent. Lawyers need access to independent credible experts. But also they need some medical knowledge: not how to dissect a brain but some basic techniques - ways of seeing and looking to help with analysis, to know when to involve an expert. There is a need for compilation of diagnostic methods for the lay person.

Professor Pounder pointed out that because forensic medicine is a science in itself, if you are not an expert, you will miss things. But you can look at what you see basically as the medical evidence and compare it with other information. Look for inconsistencies.

Professor Vanezis said that cases should be directed towards someone who is a true medical expert. Professor Thomsen agreed and said that you need to trust the specialist and go to the specialist for expert help.

GRAVE SITES
The Buried Body
Professor Jørgen Thomsen⁹

⁹Head of the Department of Forensic Medicine at the University of Odense in Denmark.

Gaining access. The first issue is gaining access to a burial site. My experience is that it depends very much on the area and the situation. Is there a war going on? Are there identifiable authorities? In El Salvador, the so-called Justice of the Peace gave me authorization to examine bodies. In the Philippines permission was given by MPs. In Cambodia it was the Governor. Elsewhere it may be the police, military or a lawyer.

Finding the grave site. There are many different approaches to finding the grave site. Look for a change in the vegetation, a change in the contour of the earth. Aerial photographs are useful. During the Cold War satellite photos were taken of the whole world and I have seen graves being located this way. Other methods such as sonar radiography have been tried. But the best way of finding a grave site is to know where it is.

Ethical and human rights aspects. To comment on the ethical and human rights aspects of disturbing the peace of a grave. Sometimes people have been buried without any religious ceremony. Relatives want the opportunity to bury them again with due ceremony. Families will often demand an exhumation. In this case a request to do an autopsy will come from the relatives. They want to be certain that it is their relative and to know what happened to him. They can then finish the grieving process. To know the fate of one's relatives is very important. If you do not respect the wishes of the relatives things can go very wrong and this will affect your work.

I do not have time to talk about anthropology. But it is an important part of forensic medicine nowadays. You can detect so many things from bones - the person's age, size, stature, whether a woman had given birth. The changes in the body following death (and burial) are summarized in the table on the following page.

Factors in determining rate of decomposition: You can never be very exact when saying how long a body has been in a grave. There are so many factors that will influence the decomposition. The pH value of the water; the temperature and humidity; whether there are animals or vegetation in the area; the type of clothing the person was wearing and whether they were placed in a coffin or not. A lot of research is being done into decomposition in different conditions.

Professor Thomsen then presented a series of photographs which were taken in former Yugoslavia. The photos showed the bodies of some of the 200 victims who were found in a mass grave. At the exhumation, archaeological methods were used. A new morgue was built for the purpose of examining the bodies - financed by Physicians for Human Rights. All of the remains were x-rayed and a bullet was found in practically all of them. There were soft parts on most of the bodies. As thorough a dissection as possible was carried out. Personal effects and documents were often found on the bodies - sometimes hidden in their socks. These were helpful in the identification.

Post mortem changes in the body

The principal changes following death are the following:

1. Putrid odour
2. Lividity visible [discolouration resulting from cessation of circulation of blood]
3. +/- rigor [rigidity or stiffening of the body]
4. Green colour of abdomen
5. Drying of peripheral parts (fingers, toes, nose, lips)
6. Skin slippage

7. Gas formation due to degenerative processes
8. Bullae [large vesicles containing serum or pustulent fluid]
9. Swelling of bodies
10. Adipocere/mummification [production of waxy fat which acts to preserve body]
11. Skeletonization to various degrees

Bone specimens were taken for DNA testing. Families helped to create a pre-mortem database including information about clothing, old fractures and scars. Such cooperation with the relatives is extremely important. They saw it as a necessary step to knowing the fate of their loved ones.

Grave Sites and the Buried Body - the South African experience

Dr Steve Naidoo¹⁰

I did not claim to have any expertise in the type of work we were doing. My work was general forensic pathology but I have an interest in skeletons. I will limit discussion to my experience of working with the Truth and Reconciliation Commission. The investigative responsibility was the TRC's. Whether there were formal applications for amnesty or whatever the circumstances this led to six or seven exhumations.

The lack of records was a problem. Institutions often made it difficult to get information. The shortest post mortem interval was 10 years and the longest was 14 years. Many were buried as paupers or under assumed names.

There were many problems getting correct identification. Sometimes perpetrators who had applied to the TRC for amnesty had pointed out burial sites. Sometimes the investigators just had a vague reference to disposal of a body in a witness's statement. Authorization for exhumation came mainly from magistrates though sometimes the local authorities had to be approached.

As much information as possible was gained from the investigator. It was contracted to the local authority with experience who could do an exhumation properly. Earth moving equipment was used in one case where we could not find out the exact location of the grave. We had no experience of exhumations but just followed the basic principles we were taught.

A "cadaver dog" was used in one or two situations to find a body. The area surrounding the site of the body was often bushy. In some cases bones were lying on the surface of the ground. We were not told in all cases how deep the body was buried.

In one case an amnesty applicant mentioned the use of lime to bury the body. This was used to accelerate decomposition and to take away the odour. When we found traces of lime we knew we were looking in the right place. We used careful brushing to clear the soil and to show the position of the body in the grave. Hair samples were taken from the bodies. We used a metal detector before removing the body and found bullets in the grave.

To remove the body we dug a trench around it. We tried to lift the entire slab of earth with the body contained in it by placing a sheet underneath. Skeletal assembly was carried out at the scene. Proper record keeping was vitally important including times, names and opinions as well as findings. The chain of custody of the human remains was also very important. We had to be very careful to avoid breaking the fragile bones. Photography was also used for documentation.

The families were asked to submit anything that could be used to help identify the body.

¹⁰Senior Lecturer, UND Department of Forensic Medicine.

The body was divided into eight areas and each area was x-rayed. A full inventory of bones, identifying features and injuries was made. Drawings and photos were taken. Dental charting was also carried out.

Even in the skeletalized remains ossified cartilages were found. Unfortunately they did not have a proper repository for the remains. There is a need to have a dedicated laboratory for this.

Discussion

Professor Vanezis confirmed that the same techniques would have been used in communities even where they knew who was in the grave.

Professor Pounder pointed out that it is often helpful to involve the University Departments of Archaeology. Archaeologists are used to documenting in three dimensions, whereas forensic specialists usually document in two dimensions. Professor Vanezis agreed and said that archaeologists are very useful when trying to find graves, preserving artefacts and bringing out the body from the grave.

One participant asked about the relationship of the forensic investigators with the families of those thought to be buried in graves.

Professor Thomsen replied that in Croatia they had kept in close contact with the relatives. An office was set up to take care of their needs. Relatives were able to come in and ask questions. Most of the bodies were eventually identified. Dr Naidoo explained that in the South Africa situation, interaction with the families was encouraged in all cases. It was the best way to approach the identification problem. The team was very careful in the way they dealt with the relatives who just wanted to know that something was being done.

SECOND DAY: THE LIVING VICTIM

International and regional experiences of documenting torture and ill-treatment: Overview of the effects of different torture methods

Professor Jørgen Thomsen

Professor Thomsen referred first of all to the Declaration of Tokyo (World Medical Association, 1975). The definition of torture given in this declaration does make reference to the responsibility of the “authorities”. However the United Nations definition of torture is based on the act being carried out by the authorities.

Torture methods are not usually very sophisticated (see table below). There is a tendency towards torture methods that will not leave a trace. Whenever particular torture methods are detected, the perpetrators will react by changing their method. It is a constant struggle between documentation and development of torture methods. We hope that in the end documentation will stop torture. It is impossible to measure the preventative effect, but we have to believe it.

Some methods of torture or other cruel treatment:

- beating and kicking
- being forced to watch or listen to torture of loved ones
- burning
- dental torture
- electrical torture
- exposure to bright light
- extreme sensory deprivation
- falanga
- forced feeding - eg of excrement
- genital or anal trauma
- isolation
- mock execution
- mutilation
- pharmacological torture
- prolonged forced standing
- sexual humiliation/violation
- shower with icy cold water or hot oil
- sleep deprivation
- starvation - dehydration
- submarino - wet [immersion of head in dirty water]
dry [placing of plastic bag over head]
- suspension by wrists, ankles or knees
- telefono [simultaneous beating of ears with flat hands]
- threats to family

Medical examination. Psychiatric examination of victims is most important. The physical

examination is the smallest part of the examination. You need to build the person's confidence before they will tell their story. Sometimes they may have symptoms but do not mention that they were tortured. Usually it takes several hours before they are confident enough to tell you their experience.

If you are not a psychiatrist, it is difficult and the interview may also cause trauma to the victim. Nevertheless, the person is usually relieved to be talking about their torture experience. A physical examination should be carried out to see if there are marks or scars which could support the story of the victim. The mental effects do not prove that torture took place.

In reporting you have to take care to state only what you are able to state. If you make mistakes, the regimes doing the torturing will take advantage.

Comments by Peter Jordi¹¹

Mr Jordi has a lot of experience of recording evidence of torture - mostly from a civil law perspective. If someone comes to the Law Clinic just after having been tortured it is much easier to win a case. Even a two week delay causes problems.

The procedure followed at the Law Clinic is:

1. An interview is carried out to establish what happened. There are different patterns of torture in different police units, even to the point of being "diagnostic" as to which people are involved. This immediately is indicative of whether the person is telling the truth. Two very common methods of torture are electric shocks and smothering with a car tyre inner tube. Common areas of the body to be tortured are the genitals, arms and toes. Blindfolding during interrogation has been held by the Privy Council in England as unlawful. Confession in these circumstances is not admissible.
2. An inspection is made for injuries - for example, bruising, lesions, ruptured ear drums, urological dysfunction, psychological harm. Post traumatic stress is also evidence of torture.
3. After the interview, the person is taken to a photographer. It is important not to rely solely on the person to tell you about their injuries. Check everywhere on the body. Note that police photographers have been found to be unreliable.
4. The person is taken to a GP for an urgent medical consultation and appropriate samples are taken and tests made (for example to gather evidence of electric shock treatment). It is very important to act quickly to collect the medical evidence.
5. Samples must be carefully preserved.
6. The chain of evidence must be carefully recorded.
7. There must be proper consultation, exploring of the event, asking appropriate questions. Then a full statement must be taken.
8. Collection of client's evidence.
9. Inspection in loco.
10. Inspection of the place of detention.
11. Finding and interviewing witnesses.
12. Obtain prior statements made by the client.
13. "Anton Piller" search. (A court-ordered search of a police station without prior notice.)
14. Publicity.
15. Laying criminal charge?
16. Follow up evidence.
17. Medical consultations with specialists, depending on the nature of the injuries.

¹¹Director, Wits Law Clinic, University of the Witwatersrand, Johannesburg.

18. Police and other records: the importance of discovery.
19. "Similar fact" evidence.
20. Court proceedings - institute action for damages.
21. Suspension of police officers.

Comment by Tony Reeler ¹²

There has been a focus on prevention - documenting current torture and how you deal with it. In Zimbabwe, the liberation army of the 1970s and the security forces were torturing very publicly. In the 1980s there was horrible public torture in large groups. This has continued up to 1990. There is still this impunity process, by way of the Presidential pardon. There are people who are convicted and immediately pardoned. Only recently there is a trend towards no trace torture and covering it up.

From the point of documentation, there should be a balance between working on current torture and historical torture. In Zimbabwe, historical torture has important current political issues. The genocide of the 1980s in Matabeleland seems to be laying the ground for future conflicts.

The Legal Resources Foundation and the Catholic Commission for Justice and Peace in Zimbabwe have documented this. We want a policy of reparation. We need to deal with historical torture in order to prevent current crises.

In the North East of Zimbabwe I am dealing with survivors from the 1970s. One person in ten reports a history of violence and torture. In the southern half of the country, we are getting figures of 5 in 10 in a primary care setting. It is important to do this kind of work so that you can lobby government for rehabilitation services.

With chronic injuries, it is quite an unrewarding process. We see a lot of people with back injuries from bad beatings. Others with joint damage from being tied up or hearing problems from blows to the head. Many people suffer from anxiety and depression, but there is a low incidence of post traumatic stress.

Concerning exhumations, these are often an organized NGO response. Legal expertise is combined with medical expertise. There is a forum of human rights organizations which has created an on-going mechanism for dealing with current torture.

It is important to think about the possibility of cross-border collaboration, perhaps through a network. It is difficult to get governments to act. Pressure from South Africa across the border to Zimbabwe might help the situation.

Discussion

Professor Pounder pointed out that there is also a tendency to use "presentationally acceptable" torture. It can be worded in such a way that it sounds quite minimal. For example, sitting people on kindergarten chairs for long periods of time.

A South African doctor pointed out the need for resources to help with documentation. How can you find people to help you? Another issue is the safeguarding of materials. Evidence is frequently stolen in South Africa. Another issue is accessibility. Torture often takes place outside urban areas, in places which are not easily accessible. How can this be dealt with?

Peter Jordi stated that if a case happens to be in a rural area, this can be an advantage since the police are not so sophisticated. However this is changing and in many places people are getting to know about the services his clinic can provide.

A lawyer said that in Zambia they handle cases of torture victims. There is a committee of

¹²*Clinical Director of Amani Trust, Harare.*

lawyers who use their own money to sue the State. Thirty percent of whatever is recovered from the state is put into a special fund. This fund is available to help other victims.

An ICD investigator said that if the torture is alleged to have been carried out by the police in South Africa then it is important to pass the information on to the ICD which is building up a database of cases of torture by the police. It is a problem that the police are not under an obligation to tell the ICD about complaints of torture that have been made against police officers. He also asked what is the difference between assault and torture - at what stage does an assault become torture?

Professor Thomsen said that torture is very difficult to define and is often a matter of judgement. However he clarified that torture constitutes cruel, inhuman or degrading treatment. Beating someone up in a police station is not torture until it becomes systematic.

Dr Faizel Randera suggested that it is easy to talk about torture in politically repressive regimes. But it happens even in democratic regimes. There is a culture of torture within the police that will continue unless people decide to tackle it.

Tony Reeler questioned what a reparation policy is all about. The issue of justice is very important. In most situations, we stop short of getting justice. In Zimbabwe, no one is held accountable.

Taking a Medical History: Technical, Ethical and Human Rights Aspects **Dr Ling Kituyi¹³**

It is often helpful to immediately get an idea of why a person has come to you for help: why did this person walk into my office?

Some reasons might be:

- *First aid* - for example, internal bleeding in a prisoner needing immediate care
- *Pursuit of justice*. In Kenya you have 365 days from the time of the incident to report it to the authorities. Frequently the authorities will keep you in prison for 367 days, thereby denying the victim access to justice.
- *Rehabilitation*.
- *Economic compensation*

Sometimes lawyers lead people on and do not tell them that the deadline for reporting has passed.

You need patience in gathering the person's story. It often takes them a long time to get to the point.

The setting

The person who has been tortured might be seen in different locations:

- A prison cell
- Your office
- In the field

¹³General practitioner, Nairobi

The setting will define what history you will take. Going to the prison is very difficult. In Kenya you have to get a court order and you are frequently kept waiting a long time. Very few doctors have time to do this kind of work.

You are not allowed to take photos at all. You are searched. It often helps to behave in as officious and bureaucratic manner as the prison officers themselves. They get very scared when you take notes. I always carry carbon paper in order to give officials copies of the notes I have taken.

When meeting the prisoner, take lots of time. You might be the first outsider to have contact with the prisoner. It takes time for the person to trust you. Prison officials have to be within sight, out of earshot. Sometimes they then put you in a very small room and this makes things impossible. Most people I see are alleged criminals, not activists.

In your own office you can take more control of the situation. Give people a sense of safety and tell them what you are going to do. In the field, I would advise the use of checklists. By the end of a few hours talking with many people, you can get very confused. Have ready drawings of the body so that you can note the sites of scars and injuries.

During court proceedings many lawyers want to see contemporaneous notes, so it is important to keep everything and file it carefully for possible later use.

Gathering information: 'tell me what happened to you'

In essence you seek to establish:

- who
- where
- what
- when
- with what (how)
- why?

It is important to note every small detail. You must also get the victim to be very specific. If they say they were beaten, ask with what; if with a stick, ask what kind of stick.

It is extremely important not to replicate the torture setting. These people are victims who have been interrogated already. Do not replicate their experience.

Note details that are not related to the medical condition. For example, car registration, details of clothing worn by the torturer. Also previous medical history is useful.

I try to use an open interviewing technique but often you end up having to ask for specific detail of torture methods. It can be dangerous if you find yourself putting words into people's mouths. In court you can be accused of giving the person ideas.

Incidences of sexual torture, rape and sodomy, usually have to be specifically asked about. You need to build up trust. An old man is not going to tell a young white woman very easily about these issues. Often it is easier for me to ask someone else more appropriate to carry out an examination in a case such as this.

When am I a documentalist? When am I involved in rehabilitation? The therapeutic relationship is often of more value to the victim. It is thus vital to adopt a sensitive approach. Documentation and related issues: In preparing documentation you will need to organize and pay attention to:

- rough notes

- blood tests
- x-rays / CT scan
- final report
- biopsies
- photos/drawings
- affidavits
- check lists
- security of information

It is important to find out how you can contact the person. In Kenya this is not always easy and you need to take practical steps to try to ensure continued access.

The response

Sometimes a prisoner might only want to receive antibiotics from you, fearing that if their case is made public they will be persecuted further. On the other hand you might be dealing with a politician who wants you to go to the press. In this case you must be very clear about your position. I rarely go direct to the press myself.

Some of the medical reports go to magistrates or, with the consent of the patient, to NGOs. In Kenya there is the Presidential Commission for Human Rights. I have never reported anything to them for security reasons but I would encourage my patients to do so and to tell me what happened.

Comments by Ms Nomfundo Walaza¹⁴

My comments are from the psychological perspective—I cannot comment on taking a medical history because I am not a doctor.

One of the central points is looking at the issue of confidentiality. It is central to taking a history and how one relates to a lawyer or medical practitioner. How do you begin to decide when and how to pass on this information.

The notion of trust when working with people who have been tortured is important. How do you balance the trust given to you as a practitioner with the trust given to a doctor? We have more time to see the person and document information. The primary purpose of someone coming to a psychologist is for healing. We need to give people the space to create trust.

We work with various disciplines—but do these other disciplines respect the work of the psychologists? Often I have been asked by lawyers who want to go to court to do assessments in a very short space of time. How do you balance what is needed from you and what you can provide?

Concerning the collection of information and keeping of files, we need to protect the information in our files very carefully. Another issue is how you negotiate with an individual concerning the information you are going to use and what you are not going to use.

When working with victims of sexual assault, you cannot just ask them to tell you the whole story. As a psychologist, you try to minimize the interrogative approach and to minimize the trauma. People often suffer guilt that they have done something that led to their being tortured.

¹⁴Director, Trauma Centre for Survivors of Violence and Torture, Cape Town.

Ms Walaza stressed the importance of understanding the multidisciplinary approach. Doctors and lawyers need to understand the work of psychologists. There is a need to see how each of these groups interlink as professionals.

Discussion

A participant from Zimbabwe referred to asking open or closed questions and the relationship between rehabilitation and documentation. People need to be supported through the process of documentation. The legal process in that sense can be therapeutic. You need to keep the interview quite structured with quite directive questions, rather than the open-ended testimony approach.

A South African lawyer commented that he tries to put people at ease by showing them photographs of other people who have been in a similar situation. They can see what has happened to another person and that their problem can be handled.

A South African nurse commented on the new approach to forensic nursing. New resources are being put into forensic nursing and they are creating a multidisciplinary team. Many nurses are confronted with cases which they do not have the skills to handle. Often it is nurses who are expected to spend time with the patients and hear their stories.

Ms Walaza responded that often we talk about the physical nature of the torture, but it is important to be aware that we also need to address the psychological aspects of torture.

If there is another agency where people can be referred to, this is important to note. People must recognize their limitations as a professional. A lawyer may say that he or she cannot help but they could refer you to someone else. Have some options available. It is also important to guard against secondary trauma and get assistance from people who are qualified.

Another participant highlighted the fact that the discussions centred on the role of professionals. They are a small resource and those among them that are committed to human rights is even smaller. It is important to create networks with other organizations and agencies who can help - for example, religious organizations, women's organizations. They can help with documentation and the therapeutic side. We must look more broadly and widen these networks.

In Zimbabwe the approach has been to train nurses how to do rehabilitation and assessment. There is a need to mainstream this training.

Sexual Assault: Rape as Torture Dr Lorna Martin¹⁵

Dr Martin spoke about rape and sexual assault as acts of torture. She used slides throughout her talk.

According to Amnesty International, in 93 countries in 1997 there was systematic torture. Torture is more common in areas affected by political unrest.

Rape as torture is used as a deliberate strategy to undermine community bonds.

According to South African law, rape is a common law crime. Rape is intentional.

In South Africa a man can now be charged with raping his wife.

The definition of intercourse - for legal purposes, the penis just has to be inserted as far as the vulva. Sodomy is defined as unlawful intentional relations *per anum* between two male persons.

¹⁵Registrar at Department of Forensic Medicine at UCT.

Relevant laws in South Africa are those relating to:

- public indecency
- indecent assault

Sexual Offences Act. This is a statutory law, primarily to protect young persons. Relevant sections are 9, 13 and 14. Of these section 14 is the most important. The age of consent for heterosexual acts is 16 and for homosexual acts is 19. Section 20A of the Sexual Offences Act covers acts committed between men at a party. This is now unconstitutional, but it still exists in the law.

Taking a history: what to do when examining someone who has been raped. There are certain requirements that doctors must abide by. It is very important to get consent in writing. You have to make very detailed notes and take pictures. There is document J88 (the police produce this document) which guides us in producing a report. Obviously someone who has been raped should be examined as soon as possible after the event.

The policeman should try to persuade the person to see a District Surgeon who has the correct experience to deal with rape cases. Sometimes injuries are very subtle and are not always violent.

Your attitude is very important when talking to the victim. Liaise with appropriate NGOs and get advice on how to handle these cases. Put aside thoughts of not believing the person. It is the doctors job to document, not to believe or not believe.

Your sympathy/empathy/attitude is important. But at the same time you must take a detailed history. If your lawyer does not want all that information, you should keep the notes somewhere else as contemporaneous evidence. Note the date and time of the examination and of the incident. Note any corroborating evidence. Cases are often won or lost as a result of what you have found as a doctor.

Basic information: Before examining try to get information on:

- past medical history
- obstetric/gynaecological history
- medication
- whether they had taken drugs/alcohol - in Johannesburg there have been many cases of women who have been drugged
- last normal sexual activity
- last menstrual period
- contraception

Information about what happened during the assault:

- the place (might cause injuries to the body - for example, if the victim is dragged across a road)
- was clothing removed
- did she remove it or was it the attacker
- the relative position of both the assailant and the complainant
- was there resistance - any injuries to the suspect
- threats
- injuries
- acts performed during the attack - if you do not ask then you will not be told. You must ask.
- loss of consciousness
- ejaculation by assailant, whether a condom was worn

Information about what happened after the assault:

- was there any bleeding, pain, discharges
- whether the victim changed clothing
- washed, bathed or douched

It is important to liaise with groups that are around you. Take a multidisciplinary approach.

Physical examination

Clothing

- is it damaged?
- is there trace evidence?

Injuries

- description and correlation
- cause and age
- defence wounds - to elbows, forearms, hands, fingers
- lips and mouth - blows to the face, attempted kissing, forcible closure of mouth
- contusions - ageing, finger imprint, bite marks

Re-examination of the rape survivor 24 hours later might reveal further bruises which have emerged. A lack of injuries does not preclude an aggressive, violent episode.

In rape survivors, the most common body areas that are injured are:

- facial (27%)
- upper limbs (29%)

Genital examination

- try to make the patient comfortable
- good light
- menstruation is not a contra indication
- general anaesthetic may be necessary
- injuries are often caused by foreign objects

In South Africa, crime kits are provided by SAPS forensic services to help in carrying out these examinations.

The treatment you give to the survivor is very important. Make a protocol - list what you will give in these cases and stick to it.

With sodomy survivors, take the same approach to the victim. In general men react far more badly than women who have been raped.

Discussion

Professor Thomsen referred to cases where false allegations have been made and said that he did not agree that this is not the business of the medical practitioner. You can help by telling the

police there are not grounds to prosecute. Professor Thomsen also raised the question of examination under anaesthesia. The victim might wake up not knowing what has happened to them. He would rather do an incomplete examination.

Dr Martin said that in South Africa there is not a very high level of false allegations, however a very experienced person needs to look out for this. Concerning anaesthesia, cases are referred to the hospital where they are more qualified to take the decision about whether or not to anaesthetize. Sometimes the person needs a general anaesthetic in order for their injuries to be dealt with.

In the Johannesburg Medico-Legal clinic, which is run by the Department of Health, there are district surgeons and nurses. Someone is available 24 hours a day. Each patient is given a booklet in her own language explaining what has happened. In Cape Town, the work is done from a District Surgeon's office; there is no crisis centre.

A participant from Zimbabwe asked whether Dr Martin sees any change in the pattern of rape victims. In Zimbabwe almost half are now under the age of 11 years because of the incidence of HIV. Dr Martin responded that in South Africa too the victims are becoming younger. There are gangs of young men who are HIV-positive who rape young women who are virgins, in the belief that this will cure them.

Another participant asked about facilities available for the rape victims after examination. Dr Martin responded that this was a problem in Johannesburg which is why the clinics were created. Another problem was that victims were having to wait to be examined. Appropriate facilities must be provided.

A question was raised about the legal system and the fact that women who have been raped are often re-victimized by the system. Dr Martin responded that a program has been developed for prosecutors. The NGO community are giving some input to this program in the hope that prosecutors will learn to be more sympathetic.

Physical Documentation and Testing Overview by Professor Peter Vanezis

First of all, what do we mean by documentation? You must be careful in using this phrase. You can get caught out when presenting evidence if you get the terminology wrong.

Documentation includes:

- handwritten notes of an autopsy/examination
- typed notes
- Dictaphone (some courts require you to keep tape recorded evidence for a long time.) It is still important to keep original tapes because of the possibility of editing.
- videotaping
- diagrams/sketches - done at the crime scene, post mortem room, or during clinical exam
- computer-aided documentation - it can be possible to reconstruct the scene

You have to be able to provide all the documentation in court. Problems can arise with all forms of documentation. There is the possibility of editing and interference. Integrity of the information is important.

Scenarios where we will use documentation:

Visit to the crime scene. This is where the documentation starts. A record of when you received the call to go the scene. When you arrived. What you actually did at the scene. What you saw - sketches or photos are required.

All of this documentation must be put together as a package in order to be put forward as evidence. A video of the crime scene might be important - particularly in circumstances where you cannot get to the crime scene yourself. The time you left the crime scene is also important because of injuries that might be produced artefactually.

When an autopsy is going to happen, the conditions the body is stored under and continuity of what happens to the body are both important. The autopsy is quite a complex process. It is not something that can be done in 10 minutes. Teamwork is important. The relative roles and functions of all people present should be noted in the autopsy report.

The autopsy report comprises:

- identification of the deceased
- consideration of the scene of crime
- findings of the examination of the deceased in the mortuary
- consideration of objects etc. relevant to injuries produced
- inclusion of relevant histology, toxicology and other findings

The first step is to identify the body. One has to bear in mind the possibility of mistakes. The identity of the body must be documented carefully. The integrity of the body must be maintained.

Start by taking full length photographs. Also photographs which show the distribution of injuries. It is important to show negative as well as positive things in case of later dispute. Good lighting and equipment is necessary. It is better to use specialist photographers in order to ensure the quality of the photographs. Photographs of internal examinations are not usually shown to juries. A series of photos will be taken and a pathologist will be asked which ones are suitable to be used in the court later on. It is often a good idea to look at the body again a few days later to take further photographs of bruising which may have emerged. Imprint injuries must be well documented - note the scale.

Radiography is used for firearm injuries.

It is important that samples are taken properly during the autopsy. They must be labelled, signed for and put in proper containers. Protect the continuity of evidence: note who you give the samples to.

Weapons should not be examined in the same room as the body.

Discussion

A Kenyan participant asked for more information about toxicology: where a checklist can be found and what to look for. Professor Vanezis replied that he would take blood samples and urine samples. He would ask for a full blood screen, including for alcohol. Generally speaking, a request for a full drug/alcohol screen is appropriate.

Professor Pounder commented that it is important to distinguish clinical from autopsy cases. Drugs are deposited in head hair. Head hair grows at about 1 cm per month. Black hair retains more drug than fair hair. If you have an indication of what the drug is you can look for it in the hair. You can also take nail samples to test for drugs.

One participant raised the question of a situation where a woman living in a rural area has been

raped but it takes five days before she seeks help. This causes problems for the medical practitioner because of the delay before any evidence is collected.

A South African participant responded that it helps if you can prove that it was physically impossible for a person to report the rape, or alternatively get a psychiatric opinion that the person was too traumatized to report the rape. To a certain extent there is a culture of not making a complaint - this is the case often within the Muslim community. Women are prevented by their family from reporting what has happened to them.

Court Testimony by Chris MacAdam¹⁶

There are legal requirements that a doctor must comply with before his testimony is accepted in court.

Admissibility:

The witness may only testify concerning facts which are observed. They may not give their opinion. An exception is where the person has specialist knowledge which enables him to give a view on the significance of certain facts. This is acceptable.

The nature and cause of injuries is always a matter of opinion. It is therefore essential that the doctor proves his qualifications and training to the court. It is open to the defence to object to the expert's right to testify.

The next issue is the weight given to the testimony.

Firstly the doctor's experience will be taken into account. Also the extent to which his or her evidence has previously been accepted. How well the doctor is able to defend his or her opinion. How well the examination was carried out.

The more experienced the court witness, the more likely their testimony will be relied upon. A clash of opinion is resolved depending on the extent of the experience of the different doctors.

In many cases a senior medical officer will advise the doctor preparing the report. He will then be asked to attend the trial.

It is also essential that the examination is as thorough as possible.

If two doctors have equal qualifications and both have done thorough examinations, the doctor who was at the scene of the crime would be in a better position.

The examination is the starting point of an on-going investigation. It is also important for the doctor to do medical research before compiling the report and testifying.

In the courtroom, the facts must be explained in basic terms so as to be understood by the lay person. If the jury or presiding officers do not understand the evidence, they will disregard it.

Cross-examination:

Many otherwise credible doctors are destroyed by cross-examination. The defence merely has to create reasonable doubt in minds of the jurors or presiding officers. The tactics of the defence lawyers are to discredit the evidence given by the doctor. The doctor may be subject to anger, confusion, tiredness, repetition. It is essential that he/she does not lose control.

The doctor should not regard his duty as discharged once he has given evidence. It may be

¹⁶Head of Witness Protection Program, TRC

necessary to stay while the accused is giving evidence. The doctor might be able to assist the lawyer doing the cross-examination.

A lawyer can continue to get opinions from doctors even after the post mortem report has been done. Pathologists can give complementary reports if required.

Experience in court is a learned skill. The court places a great value and has great respect for the testimony of medical experts.

Court Testimony - A Medical Viewpoint by Professor Shabbir Wadee¹⁷

Court Proceedings

The role of the medical witness unfolds in two broad contexts:

- A. Evidentiary - the doctor should be the advisor. Inquests are less adversarial than court hearings but can be contentious.
- B. Litigious
 - i) criminal
 - ii) civil

In both, proceedings may be conducted in an adversarial manner.

A. Evidentiary Proceedings (Inquest Act)

1. An inquest is an inquiry into the death of a person who has apparently died from other than natural causes.
2. An inquest is not a trial. No person stands accused.

The magistrate may appoint two people with experience in administration of justice who can guide the court. In South Africa the magistrate has to notify the family in advance of the inquest. This is to enable the family to arrange for legal representation if they want to.

B. Litigious Proceedings

Witnesses

- Ordinary witnesses - say only what they saw and heard
- Expert witness - someone entitled to draw conclusions. It does not necessarily have to be the most knowledgeable person on the subject. You are also entitled to have more than one expert witness. Unfortunately it often seems that quantity counts more than quality.

Criteria for selecting expert witnesses:

- their medical qualifications
- their reputation and standing

The aim of the expert witness is to assist the court in matters which the court itself is not able to judge adequately. The manner of the witness should be scientific, academic and persuasive - not

¹⁷Head of Department of Forensic Medicine at the University of Stellenbosch, Western Cape

arrogant. The witness should present him/herself as neutral.

The expert witness offers an opinion on the cause of death and on the manner of death. Opinions may be rendered in degrees of certainty/accuracy. In South Africa the manner of death is usually pronounced by the presiding judge/magistrate.

If the neutrality of the witness is compromised, the value and worth of the expert witness is lost with consequent loss of credibility.

Expertise

- the doctor should remain within his/her area of expertise
- 'I do not know' or 'I am not qualified to give an opinion' are statements accepted and respected
- request assistance of a more experienced specialist if unsure of a finding
- external ballistics are best dealt with by an expert
- remember that medicine is not an exact science

Conclusion

The courtroom experience should not be a fearful one for the doctor. Talk to the lawyers - meet the person beforehand. The more you go to court, the more confident you become.

In certain countries with a poor human rights culture, the expert medical witness may be the only objective person in court.

Expert witnesses in court

Expert witnesses must be:

- focussed
- accurate
- neutral
- informed
- composed
- professional
- honest

Expert witnesses must not

- exceed their competence
- lose their temper
- make jokes

Discussion

Professor Vanezis pointed out that no mention was made during the presentations of the category of professional witness. This category exists in the UK. This could refer to a doctor who stitched up a wound but did not do any more. For example, a casualty doctor who is asked to talk about the work he has actually done - but he is not asked to give an opinion because he is not expert enough.

Professor Dada clarified that in South Africa they do have this category of witness, but they do not recognize the differentiation.

A well-known British pathologist was quoted as saying the following about medical expert witnesses appearing in court. The witness should:

- dress up
- stand up
- speak up
- most importantly, shut up

You have to learn to close your mouth very quickly in the courtroom. People without

experience do not know when to stop talking.

One participant raised the issue of confidentiality. A doctor comes to court willingly. However there are cases where it is not proper for the doctor to appear in court. What are the rights concerning confidentiality when subpoenaed?

Professor Dada responded that a doctor who has been subpoenaed might break confidentiality when the patient has given permission. He might also be required to break confidentiality under statutory law - where the patients feelings are not taken into consideration. When you have to give evidence in a criminal or civil case, you have a choice. You can refuse to break confidentiality but you can be charged with contempt of court. In a criminal case you can even be sent to prison.

Professor Vanezis commented that he had difficulty with the idea of an expert witness as a neutral witness. It means that the doctor sits on the fence. In agreeing to carry out the autopsy, you focus yourself on the findings. You have to be clear about your opinion and you have to state it. The word 'objective' is preferable to 'neutral' - otherwise the doctor is in danger of losing credibility.

One participant responded that with regard to the Truth and Reconciliation Commission, it is important to move towards neutrality since doctors have been involved in the past in covering up torture and murder. Professor Pounder stated that one should adopt the view that the expert witness is a witness of the court. He or she has an obligation to be full, frank and fair. You can therefore avoid the use of the word "neutral" and similar words. The witness is not a witness for either the defence or the prosecution.

Another participant commented on the issue of ethics and objectivity. Requesting an expert opinion can be a double-edged sword. You might not get the opinion that you are looking for. It is important to first discuss with the doctor to find out what they intend to put in their report. A prosecutor commented that, in a prosecutorial role, you are obliged to give all information to the accused. If you asked for five opinions before getting the one that you wanted, you are obliged to say so.

A Kenyan doctor referred to medical mismanagement cases when a doctor is expected to give comments. It is particularly difficult when you are expected to give an opinion against your colleague. Professor Dada replied that one should give facts and let the court decide on negligence.

Another participant commented that in Zimbabwe doctors are required to make a comment on whether a surgeon acted in a reasonable manner. You are therefore required to state an opinion on the conduct of another doctor - for example if there is a death under anaesthetic.

Issues for the Future

During this section of the program workshop participants remained in plenary and chose to focus on continuing education issues and future networking. During discussion at the end of the previous day, the idea of creating a new consortium had been introduced. Professor Dada said that he had further thoughts about this and thought that it would be better to start by building up a database. He also suggested looking at the constitution of the previous association to see whether it could form the basis of a new society.

One participant referred to the launch of the new South African Medical Association (SAMA) two weeks earlier. Within that body there is a committee created on health and human rights which aims to put forward a human rights agenda. There is a need to mainstream human rights and medical issues. It is a possibility to create a SAMA sub-group for our purposes. However forming new bodies always creates problems of resources.

It was pointed out that participants had earlier been discussing the creation of a medico-legal

group. SAMA would only be able to accommodate the medical side. This meeting has brought together people from different disciplines and it would be important to include everyone.

A participant from Zimbabwe agreed that a network should not be built up on the basis of exclusivity. A lot of issues in the human rights field need teamwork. A more inclusive network should be created which will allow participation of countries other than South Africa. The agenda should be kept quite open - over time it will define itself.

James Welsh pointed out that there are already a number of networks in existence. The infrastructure is there. It might be that more effectiveness is needed rather than a completely new network. He asked about the needs of delegates from outside South Africa. In most other countries in the region there is not the same wide range of experts. There are just a few people operating in the field of health and human rights.

A Kenyan doctor agreed with the idea of an e-mail network. We can ask questions - for example, where one can get a particular test done. It would be a central place where we can get help. It would be so useful just to be able to call someone.

Several speakers made the point that the issue of support for colleagues who are under pressure is vital and that networking with others who were not able to attend the workshop would be important.

A short presentation was made about the work of the Health and Human Rights Project. This was established in April 1997. A submission has been made to the TRC about the role of health professionals in the previous abuses in South Africa. They also run an educational program. Two people work full time for the Project. The Health and Human Rights Project offered to coordinate between Amnesty International, SAMA and participants attending the workshop by setting up an e-mail discussion group. There is an already existing Health and Human Rights network that it would be appropriate for people to sign up to in order to share information. The contact e-mail address is: hhrp@trauma.org.za

Professor Dada raised the question of continuing education. His University can offer a centre for training, for example, of medical registrars, people taking sabbaticals, electives. They can provide some resources for doing research and can also visit other countries for the purposes of carrying out training. For further information contact by e-mail: dadam@med.und.ac.za. The only constraint is finance.

A South African lawyer suggested that Universities in South Africa should be assisting other Universities in the region. This could be funded by the South African government.

Professor Thomsen said that for many participants the meeting had been an eye-opening experience, particularly in terms of seeing that other people have needs and problems. It is important to keep in contact in future and to communicate. It is excellent that the Health and Human Rights Project have volunteered to assist. In Denmark there are also some possibilities of getting training. Programs lasting three months can be arranged through the Foreign Ministry.

Professor Pounder added that in the UK they have used funds from Physicians for Human Rights to develop a module for training. This is available on Internet and can be downloaded and used as much as people want. It is a ready-made training program - a 1 month module. The problem of getting training is always finding the funding. In the past, people have been able to get funding to work in Professor Pounder's department for a couple of months.

James Welsh ended the session by saying that there is a tremendous need for technical and moral support. There is also a need for continuing education, for pressure and for networking.

Final address

Mary Rayner introduced Dr Faizel Randera, Commissioner, Truth and Reconciliation

Commission, who gave the concluding address, emphasising the value of forensic skills in protecting human rights, particularly in the light of the evidence which emerged during TRC hearings concerning medical complicity in human rights violations.

Appendix 1: Program

FORENSIC MEDICINE AND ETHICS

A workshop on the application of forensic skills to the detection and documentation of human rights violations

Durban, South Africa, 3-5 July 1998

Friday 3 July 1998

Registration and opening

Throughout day: check-in and registration; materials to be available for collection on check-in

17.30 **Reception:** informal gathering/introductions/practical issues

18.30 **Dinner** with welcoming speech (Professor J R van Dellen, Dean of Faculty of Medicine, UND) and keynote address (Rev. Dr Barney Pityana, *Chair, South African Human Rights Commission*)

20.00 *Trial. Medical evidence in the prosecution of torture: a mock trial in which forensic medical evidence plays a central role. Devised by Prof. David McQuoid-Mason, Prof. Mahomed Dada and Dr Steve Naidoo. Participants will come from the Department of Law, UND.*

21.30 *End*

Saturday 4 July 1998

Investigations of deaths: in custody, in "confrontations", the buried body

09.00 SESSION 1: INTRODUCTORY OVERVIEW Chair: Dr Mary Rayner

09.05 1. Overview: 30 minutes (20+10)

Presenter: Advocate Neville Melville

Area covered: Systems of law and legal medicine: very basic explanation of how crime is investigated and tried, and how forensic medicine/science is used in different jurisdictions

End-objectives: Participants should have understanding of different approaches to law and

legal medicine in different jurisdictions as well as strengths and weaknesses of each

09.35 2. The “crime scene”: (i) the visible body: (ii) grave sites 60 min (25+10+25)

Presenters: Senior Superintendent Clifford Marion, plus comments from non-SA participants (plus discussion)

Areas covered: What is the crime scene? Collecting and preserving evidence; setting priorities; expertise required; tracking evidence; current weak points; role of the pathologist in different jurisdictions

End-objectives: Participants should understand the process of securing the crime scene, evaluating the *in situ* evidence, collecting material and how evidence is tracked from site to court. Participants should gain an essential framework on which to assess the state’s performance in scene of crime examination.

10.35

COFFEE/TEA

11.00 SESSION 2: DEATH INVESTIGATIONS Chair: Dr Laurel Baldwin

11.00. Legal, ethical and humanitarian aspects of autopsies

Presenter: Ms Jenny Powell

Areas covered: When an autopsy is required (under SA law and other jurisdictions); rights of the family; rights of third parties; consent; what meets minimum competence levels; contesting findings; support for families of the deceased; second autopsies; religious and community values and post-mortems

End-objectives: Participants should understand both the legal requirements and the ethical and humanitarian factors pertaining to autopsies and the circumstances in which they must be conducted

11.30 Understanding and documenting external signs of trauma on the body:

Presenter: Prof. Derrick Pounder

Areas covered: Sharp and blunt injuries, firearm wounds, burns, signs of asphyxia, signs of ill-treatment; pre- and post-mortem injuries

End-objectives: Awareness of the traces left on the body by trauma; what can be discovered visually; what requires further investigation; ability to make a basic critique of documentation and observations; gain insight into interpretation of reports

12.30 - 13.40

LUNCH

13.40 SESSION 3: THE AUTOPSY Chair: Prof. Jørgen Thomsen

13.40 The autopsy: overview

Presenter: Prof Mahomed Dada Comment: Prof. Peter Vanezis

Areas covered: Overview of the autopsy: Purpose; strategy; priority-setting, practicalities (dissection, specimen-taking, tests), determining cause of death and reporting.

GROUP discussion: the plenary will split (flexibly) into doctors/non-doctors groups: There will be opportunities in both groups to discuss real cases and participants will be encouraged to bring cases to the meeting.

Medical

For the doctors group there would be discussion of practical procedures and technical aspects. Autopsy strategy and priorities; dissection and other techniques; interpreting findings; preparing the report; case studies illustrating interpretation; determining cause of death

Presenters: UND team

Non-medical

This group would examine the role and strategy of the autopsy and how to interpret and critique the findings. Discussion will draw on (wherever possible) real cases provided by both presenters and participants.

Roundtable: Profs Pounder, Thomsen, Vanezis

End-objectives: Participants should gain an understanding of rationale and procedures involved in autopsies. Medically qualified participants should have some insight into specific technical aspects

16.10 - 16.40

COFFEE/TEA

SESSION 4: GRAVE SITES

Chair: Prof. Peter Vanezis

16.40: Grave sites and the buried body

Presenters: Prof. Jørgen Thomsen (overview); Dr Steve Naidoo (SA experiences)

Areas covered: Gaining access to areas containing grave sites; finding and exhuming the body, documentation, ethical and human rights aspects, forensic anthropology--what can be learned from the remains? What cannot be learned? Preserving, protecting and accounting for evidence; dealing with media interest

Objectives: All participants should have a good understanding of the importance of proper procedures for grave site investigation and measures to evaluate the performance of the investigating authorities; sources of expertise and advice

17.45

FINISH

- *Evening:* Dinner at hotel

Sunday 5 July 1998

Examination and documentation of injuries / other signs of ill-treatment or torture

08.45 Session 1: DOCUMENTING TORTURE

Chair: Dr Reggie Perumal

08.45 International and regional experiences of documenting torture/ill-treatment

Presenters: Prof. Jørgen Thomsen, Mr Peter Jordi, Dr Tony Reeler

Areas covered: Overview of the effects of different torture methods; *how* they cause damage; the psychological impact that they have; long-term effects; epidemiology; legal “proof” of torture; trend towards “trace-free” torture

End-objectives: Participants should appreciate the effects of different forms of ill-treatment on

the victim, importance of the precise documentation of injuries and psychological sequelae.

- 09.45 Taking a medical history: technical, ethical and human rights aspects
Presenter: Dr Ling Kituyi, Nairobi *Comment:* Ms Nomfundo Walaza
Areas covered: Taking a history in a primary health care setting; ensuring that material is recorded and documented in a way appropriate for later review by specialists; supporting victims
End-objectives: Participants should gain insights into interviewing and recording data in an effective way

10.15 *Coffee/tea*

10.45: SESSION 2: SEXUAL ASSAULT

Chair: Ms Nomfundo Walaza

- 10.45 Rape as torture
Presenters: Dr Lorna Martin
Areas: Legal aspects of rape; interviewing; examining; time-related evidence; psychological evidence; support for victims; cultural aspects
End-objectives: Clearer overview of what constitutes rape; the nature of evidence of sexual abuse; the effects on the victims (male and female), and for their emotional and medical needs.

11.45 Physical documentation: tests, photography

- Presenter:* Prof. Peter Vanezis
Areas covered: The what, how, when and where of applying tests additional to the basic procedures used when examining for signs of trauma; the role of photography; standards of proof
End-objectives: Participants should gain basic overview of available tests and their relevance for investigating/documenting complaints of torture.

12.15 - 13.30 Lunch

13.30 SESSION 3: COURT TESTIMONY + FUTURE

Chair: Dr Steve Naidoo

- 13.30 Testifying in court: role of the doctor as expert witness in both death investigation and torture cases
Presenter: Legal viewpoint (Adv. Chris MacAdam), Medical viewpoint: (Prof. Shabbir Wadee)
Areas covered: Determining the limits of testimony; keeping focussed; dealing with adversarial evidence; conveying what you want to say; review of mock trial and other case examples.
End-objectives: Participants should have a good understanding of how medical evidence is dealt with in court and what factors have to be taken into account in preparing to testify.

14.30 Issues for the future

Chair: Dr James Welsh

Meeting to break into working groups for 45 minute discussion of future issues with a 15 minute plenary to receive reports. [*]

- An international code of ethics for forensic practitioners? What are the ethics applicable to forensic examinations of living victims (as compared to the well-understood clinical or 'conventional' medical ethics)? Is there a need for a separate standards for forensic practitioners? Discussion led by Prof. Derrick Pounder.
- Continuing education issues. Needs for further training initiatives, continuing education and strengthening professional practice in Southern and east Africa. Linking universities and the NGO sector. (Role of Health Departments/ Ministries.) Discussion led by Prof. Mahomed Dada.
- Future networking, human rights promotion and support for colleagues under pressure. Discuss co-led by Prof Jørgen Thomsen and Dr Jeanelle de Gruchy.

15.30 Five minute reports to plenary

15.45 Concluding keynote address: Dr Faizel Randera, Commissioner, Truth and Reconciliation Commission

16.15: END OF MEETING

[*] In fact, the meeting continued in plenary to discuss education issues and networking.

*The workshop was dedicated to the memory of Prof. Isidor "Okki" Gordon (1913-1997),
Foundation Professor of Pathology and Forensic Medicine University of Natal, Durban*

Former foundation professor of pathology and forensic medicine University of Natal (b 1913; q Cape Town 1935), d 12 April 1997. His contributions to the struggle of underprivileged doctors, his strong stand against the injustices during the apartheid years, and his constant efforts to preserve the medical school at the University of Natal (at which the government wanted to prevent African students from studying) were outstanding and paid off: the medical school remains part of the University of Natal. As a pathologist he was involved in the Steve Biko investigation and acted as an assessor. Perhaps his greatest contribution to original research was his paper on a classification of deaths of medicolegal importance (BMJ 1944;2:337-9), while he wrote numerous books, most notably one on forensic medicine. He was a frequent visitor to Israel as a visiting professor and received many honours, including the silver award of the Medical Association of South Africa. He leaves a son, two daughters, and four grandchildren.

Y K Seedat, *British Medical Journal*, 1998;316:941 (21 March 1998)

Appendix 2: List of participants

Forensic Medicine and Ethics Workshop, Durban, South Africa, 3-5 July 1998 Participant list

- Mr H.O. Abuya, Nairobi, Kenya
Dr S.M. Aiyer, UND, Durban
Dr Shareen Akoojee, Director, Forensic Medical Services, KwaZulu Natal, South Africa
Dr Laurel Baldwin, Health and Human Rights Project, Cape Town, South Africa
Sr A Bonani, Asst Director, Nursing Services Correctional Services, E. Cape Province, E London, South Africa
Adv. H. Chanda, Convenor, Human Rights C'tee, Lusaka, Zambia
Dr L.R. Charles, District Surgeon, Durban, South Africa
Prof Mohamed Dada, Head, Dept of Forensic Medicine, UND, South Africa
Ms V. De Jager, Advocate, Office of the Attorney General, N. Cape Province, South Africa
Dr Jeanelle De Gruchy, Health and Human Rights Project, Cape Town, South Africa
Mr Peter Dunseith, Attorney, Mbabane, Swaziland
Dr J.F. Els, Forensic Medical Services, Kimberley, South Africa
Dr E. Erasmus, District Surgeon, East London, South Africa
Adv. S. Geraghty, Durban, South Africa
Dr J.G. Gunaselvam, Dept of Forensic Medicine, UND, South Africa
Ms Beverley Hargrove, Trustee, Legal Resources Foundation, Harare, Zimbabwe
Ms E. Hlatywayo, Psychiatric nurse, Amani Trust, Harare, Zimbabwe
Ms A. Jenneker, Regional Director, ICD, E Cape, South Africa
Dr John, District Surgeon, King Williams Town, South Africa
Mr Peter Jordi, Attorney, Wits Law Clinic, Johannesburg, South Africa
Dr D. Kalev, Chief, Section Forensic Medicine Dora Nginza Hospital, Port Elizabeth, South Africa
Dr X.G.M. Kanta, Dept of Forensic Medicine, UND, Durban, South Africa
Dr G.M. Kirk, Dept of Forensic Medicine, University of Natal Durban, South Africa
Dr S. Naidoo, Durban, South Africa
Mr J. Nesidoni, Director, Monitoring, ICD, South Africa
Ms D.D. Ngwane, Nurse, Sundumbili Clinic, Mandini, KwaZulu Natal, South Africa
Dr Barry Kistnasamy, Department of Health, Kimberley, South Africa
Dr Ling Merete Kituyi, Cactus Villa Health Clinic, Nairobi, Kenya
Adv. Chris Macadam, Head, Witness Protection Program, Truth and Reconciliation Commission, Cape Town, South Africa
Dr Victor Mafungo, Dept of Health Forensic Services, Kimberley, South Africa
Mr C Makhosane, Dept of Health, Kimberley, South Africa
Dr R. Makunike, Consultant Histopathologist, University of Zimbabwe, Harare, Zimbabwe
Mr A Manamela, Investigator, ICD, Pietersburg, South Africa
Sr Super. Clifford Marion, SAPS, Vereeniging, South Africa
Dr Lorna J Martin, Senior Registrar, Dept of Forensic Medicine, University of Cape Town, South Africa
Mrs M. Massunda, Health Educationist, Zimbabwe Human Rights Association, Harare, Zimbabwe
Professor Meel, Head, Department of Forensic Medicine, University of Transkei, Umtata, South Africa
Adv. Neville Melville, National Director, Independent Complaints Directorate, Pretoria, South Africa
Mr Q. Mfeka, Investigator, Network of Independent Monitors, Durban, South Africa
Dr M. Milupi, Senior Resident Medical Officer, Ndola Central Hospital, Zambia
Mr P. Mogothe, Investigator, ICD, Mafeking, South Africa
Adv K. Mohau, Secretary, Law Society of Lesotho Maseru, Lesotho
Mr S. Mokhine, Chair, AI-South Africa, Johannesburg, South Africa
Mr G. Moncho, Nurse, Dept of Health, Kimberley, South Africa
Dr Steve Naidoo, UND Department of Forensic Medicine, Durban, South Africa
Mr Simon Noge, President, Human Rights Association of Swaziland, Mbabane, Swaziland
Dr Alex O.K. Olumbe, Chief Government Pathologist, Nairobi, Kenya
Mr K. Patrick, Investigator, ICD, Cape Town,

South Africa

Dr Reggie Perumal, Forensic pathologist, Durban,
South Africa

Mr A. Pestana, Investigator, Network of
Independent Monitors, Durban, South Africa

Ms Bess Pillemer, Coordinator, Independent
Medico-Legal Unit, Durban, South Africa

Prof. Derrick Pounder, Dept of Forensic Medicine,
University of Dundee, Scotland

Ms Jenny Powell, c/- IMLU, Durban, South Africa

Mr M. Raburabu, Investigator, ICD, Johannesburg,
South Africa

Dr Faizel Randera, Commissioner, Truth and
Reconciliation Commission, Johannesburg, South
Africa

Dr Mary Rayner, Researcher, Southern Africa,
Amnesty International, London, UK

Mr Tony Reeler, Clinical Director, Amani Trust,
Harare, Zimbabwe

Mr Z Sibisi, Assistant Director: Investigation, ICD,
Durban, South Africa

Mr R. Simeza, Chair, Legal Resources Foundation,
Lusaka, Zambia

Mr F.W. Simwanza, Senior Investigator,
Permanent Human Rights Commission, Lusaka,
Zambia

Ms P. Singh, Dept of Forensic Medicine, UND,
South Africa

Mr J. Snitcher, Deputy Director, Special
Investigations, ICD, Pretoria, South Africa

Dr H. Speakman, General Practitioner, Mbabane,
Swaziland

Mrs G.E. Terblanche, Nursing Services,
Correctional Services, Port Elizabeth, South Africa

Ms Claire Thomas, Amnesty International Human
Rights Education Team, London, UK

Professor Jørgen Thomsen, Head, Dept of Forensic
Medicine, University of Odense, Denmark

Professor Peter Vanezis, Head, Dept Forensic
Medicine and Science, University of Glasgow,
Scotland

Dr L. van Schwalkwyk, Dept of Forensic
Medicine, UND, Congella, South Africa

Dr O Vawda, District Surgeon, Durban, South
Africa

Prof. Shabbir Wadee, Head, Dept of Forensic
Medicine, University of Stellenbosch, Cape Town,
South Africa

Ms Nomfundo Walaza, Trauma Centre, Cape
Town, South Africa

Ms G. Wannenburg, Investigator, TRC, Durban,
South Africa

Dr James Welsh, Coordinator, Medical Program,
Amnesty International, London, UK

Appendix 3: Forensic Medicine and Ethics, Durban, South Africa, 3-5 July 1998

Evaluation of workshop

Overall evaluation:

Your general evaluation of the workshop as a whole:

- ☉ Very worthwhile Comments:.....
- Worthwhile
- Satisfactory
- Not particularly useful
- ☹ Not at all useful

Organization

How do you rate the following aspects of the workshop from the point of view of organization:

	Excellent	good	average	tolerable	poor
Invitation and early information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flight and accomodation arrangements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conference room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conference materials/papers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conference subject matter/program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you were a chair, presenter, or commentator how well did you feel briefed for your role:

Very well	Well	OK	Not well	Poorly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Workshop content

The overall range of subjects covered was:

- Too extensive and too thin Comments:.....
- Extensive but at the right level of detail
- Lacking important subject matter
which should have been included
- About right in terms of breadth and depth

Overall, the workshop structure, flow and clarity of information were:

- Excellent Comments:.....
- Good
- Average
- Tolerable
- Poor

Balance between presentation and discussion

About right

Overall, not enough presentation time compared to discussion time

Overall, not enough discussion time relative to presentation time

Comments.....

What was best about the workshop?

What was least effective about the workshop?

What was missing from the workshop?

What improvements would you suggest for a future workshop of this type?

Evaluation of meeting: Forensic Medicine and Ethics, 3-5 July 1998: Results

Fifty participants completed the form as set out above. The following is a brief summary of the results and some representative comments follow the summary.

- *On a “general evaluation” scale ranging from “very worthwhile” to “not at all useful”, 33 participants found the workshop “very worthwhile”, 15 “worthwhile” and two “satisfactory”.*
- *In answer to the question on the overall range of subjects covered, 8 participants found the content “too extensive and too thin”, 25 found it “extensive but at the right level of detail”, 3 found it “lacking important subject matter which should have been included”, and 13 found it “about right in terms of breadth and depth”.*
- *The workshop “structure, flow and clarity of information” overall was judged by 20 participants as “excellent”, by 27 as “good” and by two as “average”.*
- *On the balance between presentation and discussion, 25 found that it was “about right”, nine that there was “not enough presentation time compared to discussion time”, and 16 that there was “not enough discussion time relative to presentation time”.*
- *On practical arrangements and overall organization, between 84 and 96 percent of the 50 participants who completed the forms thought that the preconference information, the flight and accommodation arrangements, the conference room, the materials and the conference program were either “excellent” or “good”. Some presenters and chairs felt that there was need for more pre-session briefing and coordination.*

The extracts below are taken from the completed forms. The comments cited are only a fraction of those given but have been chosen as reflecting typical opinion or the most succinct overview.

Your general evaluation of the workshop as a whole:

General

- “[Has] come at very opportune time in the region...”

Networking

- “It has opened way for professionals from different walks to work together”

Time constraints

- “Period was too short for discussion and input”

Workshop content (the overall range of subjects covered):

Time constraints

- “Extensive but time too short”

Content

- “Cross-pollination between various fields NB - perhaps more medical detail needed”

Workshop structure, flow and clarity of information:

Time constraints

- “There was just not enough time allocated”

Structure

- “In retrospect, might have reconsidered scheduling day 2 first, then day 1 second. Easier to deal with the living subjects first, then concentrate on victims/death in presentation”

Other

- “Resource persons highly qualified”

Balance between presentation and discussion:

Time constraints

- “Time too short to deal properly with both aspects of presentation and discussion”

Other

- “More discussion panels should be encourage especially to highlight the problems encountered”

Pre-briefing of chairs/presenters/commentators:

- “Okay. I think that I’d have liked a little more time”

What was best about the workshop ?

Networking

- “Opportunities for networking. Exposure to wide range of medico-legal topics” and "regional flavour"

Information

- “High calibre of speakers with great experience and slide material. Networking and chatting informally - not enough time allowed for this though (... often much more useful in fact than the formal question time discussions).

Presentation

- “The multi-disciplinary approach”

Organization

- “Well organized. Educated experienced presenters. Good spirit in open discussions"
- “Exchanging of opinions of experts from different countries and non-medical practitioners”
- “The opportunity to share in the diverse and very rich professional and regional experiences of the participants” and "the importance of a multi-disciplinary approach..."

What was least effective about the workshop ?

Time

- “Not enough time. No prior information about institutions/systems in participating countries. Could have been done by distributing list of participants with brief description of their organization/profession” and “Time keeping”.

Other issues

- “Minimal use of other professionals i.e. psychology, [social workers] and nurses to add value to some of the inputs particularly on Sunday sessions”; “Documentation of presented material for later reference i.e. handouts of lecture material. [Better] time management” and "greater contact between African delegates".

What was missing from the workshop ?

Time issues

- “Time for informal meetings”

Representation

- “Wider representation from other provinces in SA (where problems are rife!)”, “[More] experiences from the region”; inclusion of "social workers especially in cases involving families and communities”

Other

- “Final goals to be achieved for the future”, “[More] on psychological factors, which are very important in torture.”; more "small group work (about 6-10 people) and more time for discussion at practical level”

What improvements would you suggest for a future workshop of this type ?

- “More discussion”, “further address[ing] of forensic medicine in relation to human rights abuses”
- “(1) greater time (3-4 days). (2) practical skills workshops: giving medical evidence in court; dissections; role-playing of disclosure of torture (leading to) documentation; how to take photos/specimens; where to send material/resources internationally. (3) more focus on continued networking + problem-solving at international level”
- “Small group discussions. Sessions dealing with countries with limited resources (personnel, technical aids, supportive government or private sector funds) and how to intervene to support a human rights/forensic science agenda”
- “(1) Time management (2) Reproduction of lecture material (3) More flexibility in terms of inputs from the floor (4) Involvement of all related fields in medicolegal issues, i.e. social welfare, nursing, psychiatric services (5) Time allocation be appropriate with content and nature of presentation and the discussion to ensue.”