The 2022-revised version of the Istanbul Protocol: orientation kit for people in rush

Pau Pérez-Sales[1]

At last, after a seemingly endless wait, the second revision of the Istanbul Protocol (IP) has seen the light of day. Conceived in 1999, and revised 5 years later in 2004, it has taken another 15 years for there to be a much-needed updating and revision process (Haar et al., 2019).

Reference manuals in medical science need constant updating to stay alive, and this was the case with the IP. Yet, paradoxically, the main updates in this new version have not altered the medical or psychological science chapters (which remain essentially the same in their vast majority), but expanded the legal contents. While interdisciplinarity enrichens these processes, it entails complexity and need for clarification. The new protocol is not brief: 220 pages as compared to the 78 pages of the 2004 version. It is important that this extended version does not daze and dissuade health professionals who have been referring to the older version.

We summarise for those who frequently use the IP what they will find and where to invest their reading time.

The revised English version can be downloaded from the internet[2]. Although it is announced that it has already been translated into six languages, the official versions in other languages are not yet available.

The debate behind the scenes: shorter or longer, simpler or more complex.

There has always been a debate in the IP revision process between two doctrinal approaches. On the one hand, the position of those who, from their daily work on the front line and from the sometimes-complex training processes in environments where it is difficult to get qualified personnel, asked for a simpler, more agile instrument that would be less frightening in primary health care or in a hospital setting. This position was mainly represented by countries from the Global South and especially by practitioners from centres in Africa and Asia (Kelly et al., 2016). On the other hand, there was the position – mostly coming from forensic experts from the Global North - that the revision should point to a more comprehensive and highly specialised protocol, that would further develop, expand or clarify aspects of the 2004 version.

1) MD, PhD, Psychiatrist, Clinical Director at SiRa Center (Madrid), Editor in Chief. Correspondence to: pauperez@runbox.com

2 https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf

https://doi.org/10.7146/torture.v32i3.133931

The new version of the IP triples its length. Quite a statement on what to expect when you unpack it for the first time. Without the new version of the IP being an exhaustive manual of forensic science (the medical and psychological parts include scarce changes), the final result is closer to the second model than to the first.

For those of you who live in a rush, let's not panic and, as Monty Phyton said in *Life of Brian*, look on the Bright Side of Life[3]: There is a lot of material in these pages that will be of great help to you.

The Handbook becomes a reference tool.

A good tip for integrating this revision of the IP into daily practice if you are a rushed worker is to change the way you understand and use the text. Whereas previously it was a text that could be read easily and quickly in a weekend or during a training workshop, today what we have is closer to a reference manual. All chapters have increased, not only in length, but also in density and complexity. The work of the dozens of experts who have collaborated in groups has entailed a process of addition and redundancies. The same ideas are offered to readers from multiple angles and each chapter now has its own entity and presents an all-encompassing perspective, as if it were a small independent piece. As always, this has advantages and disadvantages.

Therefore, a preliminary advice is that, from now on, carefully select what interests you and focus on an in-depth reading of that part, depending on your professional profile. The rest shall remain in your desk as excellent reference material.

And if you have very little time or you do not use the IP on a daily basis, wait until brief training guides are available for different professional profiles, something that surely will happen. The basics have not changed and you can continue working with your familiar version while progressively incorporating the changes. There is full compatibility of the core elements of the 2022 version with the 2004 version one, as it could not be any other way.

The advantages of this text.

A broader and more complex text also has unquestionable advantages and can make your life easier. Notably, it reduces the risk of erroneous and sometimes fraudulent interpretations of the text, as it has sometimes been the case with the 2004 version in certain jurisdictions (Moreno & Iacopino, 2008; Pérez-Sales et al., 2022). The revised version resolves and thoroughly anticipates most possible forms of manipulation or distortion of the IP, leaving a solid body of doctrine. The new version has incorporated clarifications and a shared normativity that leaves very narrow room for perverse interpretations that go against the victims.

It is also worth remembering that the Istanbul Protocol is not a closed formulary (in the worst sense of the word *formulary*) that must be completed point by point, but rather a set of guidelines and rules, some as a body of minimum standards of obligatory observance, and others as suggestions and indications of good practice. Those who erroneously untouchable claim that the IP should be followed as an ancient cooking recipe, overlook that what is important is to strictly apply the *principles and philosophy* underlying the protocol. Once these principles and philosophies are fulfilled, the margin of discretion and simplification or complexification that each evaluator wants to use is entirely up to him or her

3 https://www.youtube.com/watch?v=jHPOzQzk9Qo
https://www.youtube.com/watch?v=X_-q9xeOgG4

Table 1. Changes between the 2004 version and the current version

Chapter	2004 Version		2022 Version			
	Name	Length	Name	Length	Changes	Main audience
I	Relevant International Legal Standard	8	Relevant international legal norms and standards	24	Updated, more systematic and comprehensive	Legal experts
II	Relevant ethical codes	4	Relevant ethical codes	14	Reworked and expanded including new areas and professional profiles	Legal and Medical experts
III	Legal Investigation of Torture	9	Legal investigation of torture and illtreatment	21	Reworked. Clarified concepts and solved and addressed challenges.	Legal experts Policy makers
IV	General considerations for interviews	7	General considerations for interviews	24	Re-organised. Expanded by gathering parts that were distributed in chapter V and VI before.	Health professionals Some useful guidelines for other professions
V	Physical evidence of torture	12	Physical evidence of torture and illtreatment	21	Core elements unchanged. Expanded in specific new areas, specially sexual torture, gender and children	Health professionals
VI	Psychological evidence of torture	13	Psychological evidence of torture and illtreatment	26	Expanded, clarified concepts, more detailed descriptions and updated diagnostic categories	(Mental) Health Professionals
VII	Non-existent		Role of health professionals in documenting torture and ill-treatment	8	NEW chapter – Gathers medical duties in non-custodial settings	Health professionals in everyday work or facing ethical dilemmas
VII	Non-existent		Implementation of the Istanbul protocol	9	NEW chapter – Recommendations for the implementation of the IP at a global nationwide level.	Legal experts. NGO and HR groups. Policy Makers
Annex 1	Principles on the Effective Investigation and Documentation of Torture and OCIDTP	2	Principles on the Effective Investigation and Documentation of Torture and OCIDTP	2	UNCHANGED	All professionals
Annex 2	Diagnostic tests	Disappears	Guidelines for documenting torture and ill-treatment of children	6	NEW Annex – Summarises info related to children developed in chapters IV and VI	
Annex 3	Anatomical drawings for the documentation of torture and ill-treatment	8	Anatomical drawings for the documentation of torture and ill-treatment	27	Completely reworked and Expanded with a special focus on gender issues and sexual torture.	Health Professionals
Annex 4	Guidelines for the medical evaluation of torture and ill-treatment	3	Guidelines for the clinical evaluation of torture and ill-treatment	3	UNCHANGED	All professionals

to decide according to the purposes and the framework of application of each case being evaluated. An IP should not be considered invalid because it does not comply with one or more of the sections in the suggested schema for the final report, as detailed in Annex IV of the 2004 (and 2022) versions, but rather because it violates any of the principles for this application.

In any case, if you are used to follow the Annex IV scheme step by step, here are the good news: The annex remains exactly the same as it was. In this, the coordination team wanted to give legal continuity to the previous version and did not want to jeopardise ongoing litigation by an erroneous or distorted interpretation that could challenge an IP based on the 2004 version on the grounds that the expertise provided no longer conformed to *contemporary* IP guidelines.

Table 1 summarises in a snapshot the changes between the 2004 version and the current version with reference to the number, name and content of the chapters, the differences in length and type of changes introduced, and the profile of the professional to whom the chapter is primarily addressed. In the remainder of this Editorial, we will go through the main changes section by section.

Principle of loyalty and good faith.

The first introductory pages provide some relevant preliminary notes to prevent the misuse of the Protocol. It is established that the IP should serve to document evidence of torture, but, in any case, to:

a. Exonerate perpetrators on the basis of the absence of physical or psychological findings of torture. Torture must be investigated by law enforcement authorities and expert forensic reports are a key supporting element, but not a substitute for investigation.
b. To arbitrarily disqualify or overrule independent expert opinions that conform to the principles of the IP by appealing to formalisms of structure or wording that are in no way in the spirit of the Protocol.

These have been historical frequent perverse practices in some countries while the Istanbul Protocol clearly states that principles of loyalty to the truth and good faith must prevail.

Chapter I. Legal norms and international standards.

The new Chapter I constitutes a comprehensive legal review of the concept of torture. Under the guidance and expert hand of Juan Méndez, we now have 25 pages that constitute a synthesis of international jurisprudence on the concept of torture, the interpretation of the main monitoring bodies and the mechanisms of international enforceability. If you need a brief yet comprehensive, authoritative and documented guide to conduct a training process with legal operators not used to the torture field, Chapter I of the IP may be a good place to start. It begins with the Convention's definition of torture (and admits no other) and then discusses its critical elements: direct and delegated State responsibility and how this should be understood in the expert process, the criteria of suffering, intentionality, purpose and application of sanctions in light of the doctrine of the Committee against Torture (CAT), as well as States' obligations for prevention, including the Optional Protocol (OPCAT) and visiting and monitoring mechanisms. It reviews the UN mechanisms that have jurisdiction in the field of torture, clarifying a map that may not always be easy for interpretation. It provides a brief doctrinal analysis of the specificities of the Inter-

American system and the jurisprudence of the Inter-American Court, the doctrine of the European and African Court of Human Rights and other regional instruments. Finally, it points out the most important aspects related to asylum and refugee law, international humanitarian law and the framework, and jurisdiction of international criminal tribunals in relation to torture.

Chapter II. Ethical standards.
The 2004 IP version established in its Chapter II the ethical principles that should govern the investigation of torture, and summarised in Annex 1 its most relevant elements. While the latter has not changed, Chapter II has been expanded to include ethical principles affecting judges, prosecutors and lawyers (see Table 2), especially in relation to the right to a fair trial. In addition, the principles of medical ethics are developed in greater depth (see Table 3). The dilemmas and conflicts of physicians, especially working under conditions of dual loyalty[4], are moved to a new specific chapter (Chapter VII) in which they are discussed in detail, besides other ethical conflicts in applied practice (Table 4).

Chapter III. Investigation of torture.
The new Chapter III explores how the investigation of torture should be conducted, and it is the chapter of the IP in which the reader will find more novelties. This new revised version does a thorough job of clarifying and expanding on the minimum conditions required for a proper investigation. Perhaps, for a reader coming from the medical and psychological forensic field, it may be perceived as an unnecessary chapter, too far away from the reality of the field worker. To understand its logic, one should have in mind that in the international - and especially the European - arena, there are more convictions of state parties for failing to investigate allegations of torture than for committing them. In an international environment of widespread impunity for torture cases, it is useful that the IP establishes what are the minimum conditions for a torture investigation to be considered acceptable. Besides that, some recommendations for monitoring visits on places of detention are also relevant to torture cases. This is the focus of this chapter.

It is a chapter with a legal structure. It establishes the framework of obligations and rights of States and victims, delimits the legal and procedural framework of a commission of enquiry, as well as the role of prosecutors, judges and other actors in the investigation of torture allegations. In the previous 2004 version, these elements were cited and briefly reviewed. However, in the current 2022 version, there is an in-depth legal work that seeks to expand and clarify the mandate and obligations of each party in the light of its current jurisprudence.

Among the preliminary observations, the chapter highlights the obligation of states to

4 A conflict of dual loyalties is a situation in which the physician or mental health professional is faced with two legitimate and conflicting interests: the primary, which is the duty to the best interests of the patient, and the secondary, derived from obligations to the institution for which he or she works. There are many situations that are considered to be dual loyalties conflicts. For example, working for a religious institution whose principles of practice conflict with best medical practice; working as a prison physician being assigned by contract to tasks that collude with the principles of medical ethics described in the EP; facilities where the professional is required to provide access to confidential patient information on the basis of security concerns or other criteria; having to document situations of alleged mistreatment perpetrated by staff of the same institution that pays the health professional, and so on.

investigate allegations in all cases. The fact that there is a small number of criminal convictions of torture cases in the country should not be an excuse for not investigating, alleging that torture is "unlikely to happen". This small number of cases may be due to elements linked to the actual capacity of victims to disclose or complain or the lack of guarantees of a due process. The investigation may be conducted in the form of a criminal investigation, or a commission of enquiry, or a fact-finding visit. Governments are reminded of the obligation to include ill-treatment and torture in their national criminal code, as well as the need to have independent bodies monitoring the situation in places of detention.

There are seven aspects that a proper legal investigation of allegations of torture should fulfill (see table 5).

Chapter IV. General considerations for the interview.

The updated edition of the Istanbul Protocol has reorganised the recommendations for conducting the expert interview by centralising information which appeared in chapters V and VI in the previous version and providing a time-based structure that follows the steps of a traditional interview.

Unlike the previous version, now this chapter is addressed not only to health professionals but also to lawyers, prosecutors or members from human rights organisations who exercise monitoring functions or who are in direct contact with the victims. Therefore, the aim of the chapter is not only to support the medical-psychological evaluation, but also to give some general indications for the legal and juridical interview.

In the previous edition, the purpose of the IP was to collect a full account of the facts, to assess physical and psychological signs and symptoms, and to determine the degree of consistency between the findings and the victim's allegations. The current edition adds two new purposes: (a) to make a clinical interpretation of the findings and give an expert opinion on the possibility of ill-treatment or torture taking into account the psychosocial history, examinations, secondary evidence and knowledge of regional torture practices; (b) to make an assessment of the validity or reliability of these clinical findings.

Most experts already made both assessments, even if they were not explicitly included in the IP, but now, in the new formulation, they have become obligations.

The first part of Chapter IV is devoted to general recommendations, reiterating once again the need to comply with the ethical standards of the IP, as well as insisting on recommendations of good practice to create a trusting relationship between victim and interviewer and to minimise the risk of re-traumatisation. These aspects have already been developed in previous chapters. Some specific recommendations for interviewing victims of sexual and gender-related torture are now added in this chapter. The reader will also find recommendations for interviewing children and other vulnerable populations, especially those with severe post-traumatic stress disorder (PTSD) symptoms. In this regard, there is an analysis of transference and counter-transference reactions, as well as recommendations for the use of interpreters.

It is stressed in the text (as well as in other parts of the Protocol) that interviews with victims of torture should be conducted by trained and supervised personnel and, in the case of sexual torture and child sexual abuse, by persons with specific training in the field. In this sense, for example, it is strongly recommended that judicial authorities should not assume that every forensic expert is qualified to evaluate victims of torture, and a specific

analysis of the curriculum vitae as related to the assessment of torture victims is recommended. Regarding this, it is again reiterated that no greater value should be given to the reports of official forensic experts before independent examiners, without evaluating the level of qualification and merits of each of the different experts.

The 2022-IP insists, as in the previous version, on the need to integrate the assessments of the different professionals in a single report that includes the physical and psychological elements. In this version, another element is added: in the event that either the physical or psychological evidence strongly supports the allegations of torture, the report as a whole must reflect that there is strong evidence without erroneously contemplating that the physical evidence carries more weight than the psychological evidence, or that both types of evidence must be "positive", as had been observed on some occasions in the past.

Table 2. New ethical codes relevant to legal actors.

Common Principles	• Duty to conduct themselves professionally and independently • Duty to ensure equal treatment to all persons, including minimizing the risk of re-victimisation or trauma.
Judges	• Duty to promote and protect human rights – not concealing violations perpetrated by military, para-military or law-enforcement agents • Duty to decide matters impartially in accordance with law according to the Basic Principles of the Independence of the Judiciary. Judges should have sufficient knowledge of the Istanbul Protocol and its Principles and ensure that they are applied by relevant parties. • Promote protection from torture by (a) demanding that a suspect be brought before them at the earliest opportunity and check whether he or she is being properly treated (b) balancing acceptability of proof when there are allegations of torture, including suspension of the trial. No conviction should be done based solely on a confession obtained by means of duress or torture.
Prosecutors	• Duty to investigate and prosecute torture • Duty to refuse evidence obtained through torture – exclusionary rule. The investigations of the allegations of torture should be performed by a prosecutor other than the one in charge of the initial criminal investigation. • Duty of impartiality and objectivity, without pressures and with Independence from the State authorities • Duty to ensure that State authorities respect the right to be free from torture, including guaranteeing that no illegal or improper method of obtaining evidence is used, monitoring places of detention requiring that interrogations are done before a judge, and prosecuting officials who are suspected of abuses.
Lawyers	• Duty to promote and protect human rights. • Duty to treat their client's interests as paramount according to the Basic Principles of the Role of Lawyers • Duty of Confidentiality

Table 3. Review of ethical standards for health professionals.

2004	2022
Global	
1. Duty to act with independence. 2. Prioritise the interest of the patient above any other interest 3. Notify the authorities of all cases of abuse observed	1. Not participate or collaborate actively or passively in acts of ill-treatment or torture, including participation in the interrogation of detainees or certification of the health status (fitness for interrogation). 2. Guarantee that people in detention centers are in conditions that do not deteriorate their physical or psychological health, including absolute respect for the Nelson Mandela Rules 3. Do not participate in situations of abuse that can be considered ill-treatment or torture specifically linked to the medical profession: forced-feeding of people on hunger strike, not providing analgesic treatment for coercive or punitive purposes, involuntary internment in medical or psychiatric institutions for unjustified reasons, medical or psychiatric interventions against the will of the patient, among others. 4. Obligation to report the observed abuses and to support fellow professionals (including subordinates) who carry out this reporting action.
During the exam	
1. Informed Consent adequate in form and content and adapted to the capacity of understanding of the person, including mental capacity, age and culture. 2. Privacy – The right to examine and be examined in private, without limitations or restrictions. 3. Confidentiality – Report not delivered to detention or custody authorities. Obligation to notify the victim of restrictions on the duty of confidentiality when there are legal mandatory obligations. 4. Security assessment and prevention of the risk of retaliation	The same, plus: 5. Beneficence – In all the decisions that the health professional must make, act at all times in the best interest of the patient 6. Non-maleficence – Act following the criteria of above all, do no harm, especially in reference to the elements of relationship of trust, bond and minimizing the risk of re-traumatisation

Table 4. Ethical dilemmas in situations of dual loyalty.

2004	2022
Dual obligations	
	1. Inform the patient of dual obligations 2. Maintain the primary obligation of the best interests of the victim and waive the assessment when this is not possible, providing alternatives. 3. Occasional exceptions to the duty of confidentiality when there is a risk to the life of the person being assessed or to third parties. 4. Document patterns of abuse anonymously and report such patterns to international or national human rights bodies

New Chapter VII: Clarifying the role, duties and rights of doctors in primary care and hospitals (emergency room and others). Steps to follow:

1. Health professionals should seek to obtain the necessary training on the IP. Lack of necessary training is not an excuse to diminish ethical obligations. Lack of time, heavy workload or inadequate number of professionals is also not an excuse.
2. In non-legal contexts:
   c. Exclude any third parties from the evaluation room to ensure privacy, including any law-enforcement officer.
   d. Collect the account of events. Document the medical and psychological consequences.
   e. If previously trained, make a judgement of consistency and an opinion on the possibility of ill-treatment and torture.
   f. Provide a copy to the appropriate legal authorities and the patient, if requested. Do not provide a copy to law enforcement officials. Keep a copy in secure medical files.
   g. Make appropriate referrals and notify the authorities. If necessary, refer for new assessment with more experienced clinicians and specially when suspected sexual torture.

Chapter IV then establishes the necessary requirements regarding interview conditions: physical space, environmental conditions, position of the interviewer with regard to the victim and other elements relevant to building rapport. It also establishes the safeguard conditions in cases of assessment of persons in detention: the evaluation cannot be accepted by medical personnel who are attached to the same institution that carried out the detention unless there is a specific requirement from a judge. The transport and custody to the assessment room must not be conducted by the same persons who carried out the detention to avoid eventual intimidation and a lawyer must be present. The examination must be conducted in private and without the presence of third parties and the detainee shall be entitled to an independent assessment by a trusted medical or psychological personnel. The result of the assessment shall be given to the detainee or to the detainee's legal representative and a copy shall be kept by the clinician. Under no circumstances

Table 5. The seven principles of a proper investigation of torture allegations

1. Review the facts in detail to see if the criteria of the UN definition of torture are met, including severity of suffering, intentionality, alleged purpose and level of involvement of agents acting on behalf of the State. Special consideration should be given to facts that are based on a discriminatory motivation.
2. Timely, prompt, independent and effective investigation, even in the absence of an explicit complaint of the victim where there is sufficient grounds to suspect ill-treatment.
3. In the case of commissions of enquiry, having access to all sources of documentary information and having the legal capacity to interview witnesses and persons who may be implicated as perpetrators.
4. Ensuring measures of protection for the victims and witnesses.
5. Respecting victims' rights of complaint, information and hearing.
6. Acting with institutional independence from the alleged perpetrators.
7. Producing a proper forensic report in accordance with the principles of the Istanbul Protocol, including an opinion on the compatibility of the physical and psychological findings with a hypothetical situation of ill-treatment by torture.

shall it be given to custodial staff or to the institution where the person is detained in as far as they might be involved in the ill-treatment. The new Chapter IV also provides a detailed analysis of how security conditions and the risk of reprisals should be considered, with relevant guidance.

In short, the first part of the new Chapter IV is a practical and detailed translation of the ethical requirements set out in Chapter II.

The second part of this chapter deals with strategies for preparing the interview and building trust. It discusses the need to find a balance between a detailed account of allegations and the potential risk of re-traumatisation and, describes in more detail than in the previous version, the reasons why there may be inconsistencies. It also highlights the need for the clinician to make an analysis of the reasons for these inconsistencies based on the interview and the examination.

Finally, the structure of the interview is addressed in detail, following the same outline as detailed in the previous version of the Protocol. There are no substantial changes here, except for the list of potential methods of torture. The list has been updated to include in greater detail methods of torture with a mainly psychological component that were not previously covered in such detail.

The chapter ends with recommendations for the interpretation of findings. It retains the same five levels of consistency and states that consistency should be made on the basis of an overall consideration of all physical and psychological evidence, as well as other evidentiary elements. Furthermore, it states that a protocol that does not include an opinion on the possibility of ill-treatment or torture should be considered deficient. In this regard, it recommends including a causality analysis that attempts to link the evidence, the symptoms and the conclusions.

Two additional recommendations are made here: one concerning the suspicion of simulation or self-harm, in which case the new version of the Protocol indicates that the opinion of a second clinician, independent of the first, should be sought and demands that both give a concurrent judgement. The second one, regarding the analysis of reliability and credibility, establishes that it must stick to the clinical elements. It is not the purpose of the Istanbul Protocol to establish the credibility

of the victim, but only the reliability of the account of events and the evidence. Finally, the chapter reiterates, once more, that the absence of physical or psychological evidence does not rule out torture. In this regard, the chapter notes that a deliberate misinterpretation of the absence of evidence as an indication of the absence of torture may constitute a form of collusion with the perpetrators.

Chapter V. Physical evidence.

The following chapters, the most relevant from a forensic point of view, are the ones that have changed the least. Chapter V, on physical evidence, remains substantially the same. It maintains the structure of the examination, emphasising that the anamnesis and medical examination of torture does not consist merely of the observation of external injuries, but of a complete and detailed medical examination by apparatus. The chapter indicates - in the same way as in the previous version - which elements should be searched for systematically and in depth, extending the indications with regard to some situations that were not well covered before, such as the detection of signs of dry and wet asphyxia and, in particular, signs of sexual torture. Within this part, a special section - not existing in the previous version - is dedicated to the forensic analysis of female genital mutilation and the examination of signs of sexual abuse in men.

In the rest, all the considerations of the previous version are maintained, including the five levels of consistency and, as we will see later, the anatomical drawings and graphs are substantially improved and continue to be included in the annexes.

Chapter VI. Psychological evidence.

This chapter also retains the same structure as the previous version. It emphasises the central role of a psychological assessment. On the one hand, because it is key to document the psychological suffering of the victims and, on the other hand, because psychological damage often lasts longer over time as opposed to physical injuries that may not exist or may disappear quickly. This is why - the IP emphasises- psychological examinations should never be excluded in the assessment of a torture victim. Exclusively, medical examinations would not be considered complete or adequate.

The text details how the ultimate aim of torture is the destruction of the personality, reducing the person to a position of helplessness and dehumanisation. It stresses that not every victim of torture has to present a clinical psychiatric diagnosis, but that the damage can be expressed in other non-clinical ways, and warns - as it did in the previous version - about the uncritical use of the concept of PTSD and the need to understand suffering from a perspective that integrates cultural and religious beliefs.

The text then reviews the main psychological symptoms and signs that can be expected.

Finally, there is a review of the most frequent psychiatric diagnoses, without this being interpreted as meaning that the absence of at least one of these diagnoses, or the absence of PTSD, is incompatible with the existence of torture.

The chapter significantly expands the indications for neuropsychological examination and gives specific indications for the assessment of children. The judgement of consistency in five levels remains also unchanged.

In short, it is a chapter that updates the previous version without substantial conceptual changes.

The new Chapters VII and VIII.

The Protocol includes two new chapters. We have already discussed Chapter VII on the role of health professionals in contexts beyond de-

tention (see Table 4). Issues that have already been addressed in chapters II, IV and V are regrouped here and reiterated once more.

The new Chapter VIII is a set of recommendations for the development of public policies and civil society actions for the implementation of the IP in a given country. It is a roadmap of aspects to be taken into account by each of the actors involved in the prevention and documentation of torture and is therefore addressed to a very specific audience.

The new (and old) annexes.

There are no changes to the two annexes that constitute the heart of the IP: Annex I on the principles of effective investigation and documentation and Annex IV containing the model of report. Here, the revision has opted not to take risks and introduced changes that could eventually question past or ongoing legal proceedings. Annex II on diagnostic tests disappears and is integrated into chapters V and VI on physical and psychological examination, and Annex III, which includes anatomical drawings, is expanded to include new areas and outlines specific to the documentation of sexual torture (see table 1).

So, what are the headlines for a hurried reader?

We could summarise the headlines as follows:

1. The new text is three times the length of the previous one. This does not necessarily mean new elements, but that each chapter is seen as a unit in itself which, on one hand, increases its potential but, on the other hand, makes the text at times somewhat redundant and a difficult read.
2. The minimum ethical and legal conditions are basically maintained, although some details are expanded:
   - The basic principles and minimum standards to conduct proper research are clarified and further developed.
   - Deontological and good practice requirements and duties for the physician are slightly expanded with two new requirements; and clarified, especially in contexts other than detention.
   - Ethical and deontological requirements for the legal professions are now included.
3. The clinical and forensic part is the least changed.
   - Annex IV remains the same and the guidelines for medical and psychological examination keep the conceptual core and structure.
   - The elements that were scattered in terms of interview recommendations are extracted and grouped together in a reinforced Chapter IV, which becomes essential for reading and may be the most important chapter for professionals who will use the Protocol in direct contact with victims.
   - The forensic expert in this new version must go further in his or her conclusions and must now (a) give an expert opinion on the possibility of the existence of ill-treatment or torture and (b) make, when required, an assessment of the validity or reliability of the clinical findings.

   In addition
   - Specifically included are guidelines for sexual and gender-based violence and for the assessment of children.
   - Diagnostic tests are updated, including recommendations for taking photographs, and forensic anatomical drawings are improved.

Some final comments.

As explained at the beginning, a first impression when confronted with the new Protocol can be overwhelming, but a closer examination shows that if the parts that each professional profile requires in their work are well selected, the update can be integrated with relatively easy for those accustomed to using the previous version of the Protocol. If you are a lawyer, you can focus on the initial two chapters and have a look at Chapter IV. If you are a medical doctor, keep Chapter IV and Chapter V on your desk for detailed reference, and if you work in primary care or a hospital practice, add Chapter VII. If you are a mental health professional, focus on reading Chapter IV and Chapter VI.

The text has undeniable redundancies. For example, the doctor's duty to report suspicions of ill-treatment or torture is explained or reminded on up to twelve occasions along the text[5]. And these redundancies can sometimes lead to minor dysfunctions: for example, we are informed in Chapter II (pg. 38) that it is better to interview minors alone so that they can speak freely, in Chapter IV (pg. 72), that it is better for the interviewer to decide on a case-by-case basis and in Annex II (pg. 133) that it is better for parents or guardians to be present if there are no solid reasons to the contrary. These, are in any case, small and detailed elements of minor relevance, and do not compromise the soundness of the new and long-awaited IP.

The potential of this new version is enormous. It is now up to us to take advantage of this huge effort of so many hundreds of people in work groups, and to spend hours squeezing it in and making the most of its 220 pages.

In conclusion, the field of torture documentation and prevention is in for a treat. With the publication of the new version of the IP, a giant step forward has been taken by capitalising on the experience of fifteen years of using it in a solid, strong and impressive text, destined to be the guiding light of work in the fight against torture for decades to come.

References

Haar, R. J., Lin, J., Modvig, J., Nee, J., & Iacopino, V. (2019). The Istanbul Protocol: A global stakeholder survey on past experiences, current practices and additional norm setting. *Torture Journal*, *28*(1), 70–84. https://doi.org/10.7146/torture.v29i1.111428

Kelly, T., Jensen, S., Koch Andersen, M., Christiansen, C., & Sharma, J. R. (2016). A comparative study of the use of the Istanbul Protocol amongst civil society organizations in low-income countries. *Torture Journal*, *26*(3), 60–73. https://doi.org/10.7146/torture.v26i3.109501

Moreno, A., & Iacopino, V. (2008). Forensic investigations of torture and ill-treatment in Mexico. A follow-up study after the implementation of the Istanbul Protocol. In *The Journal of legal medicine* (Vol. 29, Issue 4). https://doi.org/10.1080/01947640802494820

Pérez-Sales, P., Galán-Santamarina, A., Aguirre-Luna, D., Moscoso-Urzúa, V., Luna-Muñoz, D., Castilla-Calderas, M., & Escareño-Granados, E. (2022). Uso inadecuado del Protocolo de Estambul en la evaluación de víctimas de tortura por profesionales forenses en México. / Inadequate use of the Istanbul Protocol in the assessment of torture victims by forensic professionals in Mexico. *Gaceta Sanitaria*, *36*(3), 240–245. https://doi.org/10.1016/j.gaceta.2021.01.007

Other languages

On-line versions available in French (*La version 2022-révisée du Protocole d'Istanbul: kit d'orientation pour les personnes en situation d'urgence*) and Spanish (*La versión revisada de 2022 del Protocolo de Estambul: kit de orientación para personas con prisa*).

5 Points 148, 149, 155, 162, 173, 177-182, 273, 603, 611, 622, 631 y 665.