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CONTENTS

MÉXICO PRESENTS THE UNIVERSAL PERIODICAL TEST BEFORE THE HUMAN RIGHTS COUNCIL OF THE UNITED NATIONS

The United Nations Human Rights Council passed Resolution 5/1, labeled "Human Rights Council: Institutional Construction" on June, 2007, establishing a new mechanism called the Universal Periodical Test. EPU seeks to revise the situation of human rights within all States attached to the organization, regardless of whether said States are members of the aforementioned Council or not. Tests are based on information provided by: each State; the Office of the United Nations High Commissioner for Human Rights, and the contribution of other interested parties, such as Non-Government Organizations that have been acknowledged by the United Nations and National Human Rights Institutions. Supported by its status as a type "A" Human Rights institution, the México National Commission of Human Rights (Spanish initials CNDH) elaborated its contribution and sent it to the Human Rights Council on September 2008.

Information on the current situation of Human Rights in México was analyzed during Session IV of the Universal Periodical Test, held from the 9th to the 13th of February in Geneva, Switzerland. Dr. Javier Moctezuma, Executive Secretary of the CNDH, attended Session IV on behalf of Dr. José Luis Soberanes Fernández, President of the National Commission.

40 countries participated in the interactive dialogue, out of which, Canada, Spain, Belarus, Tunisia, India and Colombia spoke of the work being done by the CNDH. The Canadian Government recommended its Mexican counterpart that Recommendations issued by the CNDH should be implemented.

91 Conclusions and/or Recommendations had been delivered to the Mexican Government by the end of Session IV on February 13th, 83 of which were immediately accepted, whereas the remaining 8 will undergo further examination, but should be included within the results report that is to be adopted by the Human Rights Council during the upcoming Session IX, to be held on June of this year.

RECOMMENDATIONS

The following is a recap of recommendations issued by the CNDH during the month of February. A complete version can be found on the Commission's official website.

Recommendation 4/2009
February 12th 2009
Case: Child M1
Responsible Authority: National Rehabilitation Institute

On November 27th 2007, Messrs. SSL and MMA filed a complaint before the National Commission, reporting alleged violations to the Human Rights of their 8 year old son, attributable to personnel attached to the National Rehabilitation Institute of Mexico City. The reported violation is based on the fact that, on June 7th 2007, the alleged victim suffered severe trauma as the result of injuries sustained to the frontal part of the face and neck. The child was taken to Hospital del Niño in the State of Tabasco and later, transferred to "Los Angeles" Hospital in the same federal entity. It was added that, due to the fact that the aforementioned hospital had neither the proper technical nor medical elements to provide the victim with proper attention, the hospital in question assigned the case to the Sub-managing office of Otolaryngology attached to the National Rehabilitation Institute, located in the Federal District. Since October 16th 2007, further studies were conducted and finally, the child was diagnosed with "pathologic reduction of respiratory conduct and scar tissue in throat region, with paramedic bilateral chord paralysis and reduced capacity of proper respiratory space to twenty percent".

The complaint points out that the aforementioned diagnosis led to a tracheotomy, performed on the boy on November 8th 2007. A tube was inserted, but seven days after the surgical procedure, the patient presented difficulty to breathe. In addition, insufficient oxygen flow and mucus discharge turned his skin pale. Suction and cleansing procedures to clear the area complicated gradually and, on November 16th, the symptoms previously mentioned led to cardiac arrest, cardio-respiratory complications and low heart frequency. After spending seven minutes without oxygen, the patient was transferred to the aforementioned hospital's intensive care unit, where he remained in a coma that led to irreversible neurological damage.

Because of all of the above, the affected parties demanded the intervention of the National Commission so that an investigation of their stated facts could be conducted and the proper responsible parties be singled out. At the same time, the parents of the victim asked for their son to receive proper medical attention and adequate treatment for his ailments.

The evidence provided and deemed necessary for the opening of a file motivated by the complaint formulated by Messrs. SSL and MMA, led the National Commission to conduct a legal-logical analysis that yielded enough evidence to charge public officials attached to the National Rehabilitation Institute of Mexico City of violations to the right to protection of health against the victim.

Evidence has exposed that the occlusion of the respiratory tract suffered by the victim on November 16th 2007, can be attributed to inadequate vigilance and to inopportune and incorrect suction of secretions. The procedures were conducted by nurses attached to the National Rehabilitation Institute of Mexico City while the patient was under their care on November 15th and 16th 2007. Medical records found within the victim's clinical file, indicate that medical instructions were precise, but that supervision was lacking, since constant reminders that secretions in the respiratory tract had to be sucked out frequently and gently were issued. Instructions went as far as indicating that, "should secretions become thick or breathing turn difficult, 2 cc of physiologic solution must be introduced through tracheotomy for cleansing and suction purposes". Vigilance and secretion suction had to be thorough, since a similar action meant to prevent the formation of another blockage of mucus, such as the one that occurred on November 16th, had already taken place on November 14th 2007. Nonetheless, the situation led to the occlusion of the victim's respiratory track, cardiac and respiratory arrest. On that occasion, it was seven minutes before the patient finally responded to the cardiopulmonary resuscitation procedures applied by the medical staff responsible for his care.

It should be noted that in this case, the cardiopulmonary arrest suffered by the victim on November 16th 2008 could have been avoided, had the proper care been taken by the nurses in charge of the patient and attached to the National Rehabilitation Institute of Mexico City on November 15th and 16th 2008. Nurses should have made certain that the breathing tube inserted through tracheotomy was kept properly clean. However, neglect on their part led to obstruction of the tube, due to a mucus blockage that produced cardiopulmonary arrest, leading in turn to anoxoisichemical encephalopathy (brain damage created by the death of nerve cells due to insufficient oxygen and/or severe and irreversible neurological damage due to lack of oxygen).

The Commission believes that deficient medical attention seriously compromised the physical integrity of the victim. As a consequence, the National Commission of Human Rights issued Recommendation 4/2009, addressed to the General Manager of the National Institute of Rehabilitating, recommending the following:

FIRST Any and all responsible authorities must be ordered to conduct all pertaining administrative procedures, so that the victim's immediate family receives proper compensation for all damages suffered, in accordance to the law and in virtue of considerations proposed in the observations chapter contained within this document. In addition, the Commission must be presented with thorough proof that the victim's immediate family demands are being met.

SECOND Instructions must be issued to the pertaining authorities, so that the National Rehabilitation Institute of Mexico City can provide child M1 with all of the medical services and attention he may require on a permanent basis. The victim must be provided with an optimal quality of life, based on the considerations proposed within the contents of this recommendation and all expenses produced by this chapter must be assumed accordingly.

THIRD Any and all administrative instructions deemed necessary must be issued to all personnel members in charge of providing professional nursing services to tracheotomy patients in the care of the National Rehabilitation Institute of Mexico City. Patients must

be placed directly under the strictest and most proper supervision of the nurse in charge of the current shift, so that actions such as the one that led to this recommendation may be avoided in the future.

FOURTH Instructions must be issued to whom it may concern, so that the Internal Control Body can initiate and determine the pertaining administrative investigation procedure against the nursing personnel attached to the National Rehabilitation Institute of Mexico City that was in charge of child M1 on November 15th and 16th 2008, in accordance to the law and based on considerations proposed within the contents of this recommendation.

FIFTH Instructions must be issued to whom it may concern, so that the Internal Control Body may begin and determine an administrative investigative procedure against the medical staff attached to the National Rehabilitation Institute of Mexico City, responsible for the medical file of child M1, in accordance to the law and based on the grounds of being in breach with the Official Mexican Norm NOM-168-SSA1-1998 of the Clinical File, while keeping the Commission properly informed of the procedure from the beginning to its final resolution.

SIXTH Administrative instructions deemed necessary must be issued so that the medical, nursing and administrative staffs attached to the National Rehabilitation Institute may be properly informed of all applicable Official Mexican Norms for the Health Sector, particularly Official Mexican Norm NOM-168-SSA1-1998 of the Clinical File.

Recommendation 5/2009
February 12th 2009
Case: Mrs. María del Carmen González Mitre
Responsible Authority: Secretary of Health

On May 9th 2008, Mr. Amado Azueta González, filed a written complain before the National Commission, stating that on April 2007, his 63 year old mother, Mrs. María del Carmen González Mitre, experienced some pain on her left shoulder, for which she received medical attention at the Pulmonary Department of Hospital General de México; a medical facility attached to the Secretary of Health. The patient was transferred to the Orthopedic Department at Hospital General where she underwent through several rapid tests, finally being diagnosed with a bone infection, for which shoulder infiltrations were issued as treatment and later, the patient underwent 10 rehabilitation therapy sessions with the use of local heat and infrared rays. However, symptoms and pain increased and, during the months of June and July, inflammation of the patient's shoulder grew due to the presence of an abscess. It was not until November 20th, that the patient underwent a study labeled as free liquid clavicle cytology. The study revealed metastasis tissue carcinoma that was treated only with antibiotics and pain killers. Mr. Azueta added that, since his mother was still in pain, she finally underwent surgery on December, although her condition did not improve and the carcinoma kept growing in a most painful manner, this time, accompanied by bleeding. Treatment was limited to cleansing procedures and bandage changes meant to absorb the blood only, although on December 20th, the medical staff in charge of the patient diagnosed her with a pus-infected left clavicle vs. massive bone infection. The situation continued until January, when the patient was transferred to the National Cancer Institute, where lung tissue cancer was immediately detected. At that point the victim was told that, due to the significant advance of her illness, she only had four months to live. Mrs. María del Carmen González Mitre finally passed away on May 4th 2008.

It is possible to ascertain that the manner in which Medic SP5, the medic responsible for orthopedics at Hospital General de México and attached to the Secretary of Health, handled the case was inadequate. It has been concluded that, despite being aware of the fact that the victim had suffered from metastasis tissue carcinoma since the 24th of December and even though the victim did receive medical attention during January, the medic in charge failed to ask for an immediate evaluation. Had the patient been properly evaluated, she would have been transferred to the patient to the Oncology Department for studies, such as: cult; pulmonary tomography; magnetic resonance; bone gama-graphics; serial bone metastases; laboratory analyses, and positron emission tomography. None of the above was conducted, despite the fact that the patient was in a general hospital which has the proper infrastructure and human resources and as a result, the lung cancer was allowed to evolve and metastasis extended to other places; a foreseeable situation that was not prevented.

Likewise, Medic SP5 failed to conduct a trans-surgical biopsy that could have helped obtain an immediate diagnosis during the surgical procedure conducted on December 19th 2007. It is to be understood that a specialized medic must be experienced enough in order to detect suspicious bone or bland tissue injuries; a fact that would have helped discard the diagnosed bone infection and confirm the cancer diagnosis. However, since no such studies were conducted, focusing on surgical cleansing procedures only helped spread the cancer to other organs.

All of the above has led the Commission to confirm that, in this case, Mrs. María del Carmen González Mitre was not provided with adequate, opportune, professional and high quality medical attention, in order to treat the lung tissue carcinoma that she suffered, thus being denied of the opportunity for better prognostication and quality of life. Therefore Medics SP3, SP4, y SP5, all medics attached to the Pulmonary and Orthopedics departments of Hospital General de México, should be held accountable for the violation of the victim's rights to life and health protection.

As a consequence, the National Commission of Human Rights issued Recommendation 5/2009, addressed to the Health Minister, which recommended the following:

FIRST Any and all involved parties must be ordered to conduct the pertaining administrative procedures so that the closest party ruled as most entitled can be properly compensated, in direct consequence of the death of Mrs. María del Carmen González Mitre, according to all applicable laws on the matter and also, in accordance to the considerations proposed in the observations chapter of this recommendation. In addition, the National Commission must be presented with proof that all of the demands are being met.

SECOND Instructions must be issued to the pertaining Internal Control Body, so that the proper investigative procedure may be conducted against Medics SP3, SP4 and SP5; all accountable for providing Mrs. María del Carmen González Mitre with medical services within the Pulmonary and Orthopedics Departments of Hospital General de México; a hospital attached to the Secretary of Health, based on the grounds that the victim was not provided with efficient attention. In addition, the National Commission must be kept properly informed of said procedure from the very beginning and until a final resolution has been reached.

THIRD Obligatory and regularly scheduled training sessions must be organized, in order to assure the adequate handling of records and annotations in the clinical file, in accordance to guidelines featured within the Official Mexican Norm of the Clinical File 168 SSA-1-1998, so that any and all recurring omissions highlighted within the observations chapter contained in this recommendation can be avoided in the future.

Recommendation 6/2009
February 12th 2009
Case: Contestation Appeal filed by Mrs. María Olga Olea Zamudio
Responsible Authority: The Honorable Congress of the State of Sinaloa and the Honorable Constitutional Municipality of Culiacán, Sinaloa

On August 15th 2006, Mrs. María Olga Olea Zamudio filed a complaint before the Human Rights Commission of the State of Sinaloa. The complaint was filed against public officials attached to the Management Office of Urban Development and Ecology, as well as members of the Unit of Inspection and Vigilance attached to the Honorable Municipal Office of Culiacán, Sinaloa, based on the grounds that an irregular construction that obstructed the sidewalk and affected her commercial spot had motivated Mrs. María Olga Olea Zamudio to file a complaint on August 4th 2006. However, the procedure motivated by the filed complaint had not been resolved. In response, the Human Rights Commission of the State of Sinaloa credited violations to the human rights of Mrs. Olea Zamudio on April 2nd 2007, and issued Recommendation 11/07, addressed to the Head of the Honorable Constitutional Municipality of Culiacán, Sinaloa.

On December 10th 2007, the National Commission received file CEDH/P/DF/001247, dated December 4th 2007, presented by the General Visitor of the Human Rights Commission of the State of Sinaloa, acting as President of the Institution. The file included a contestation appeal filed by Mrs. María Olga Olea Zamudio, where she expressed her inconformity with the fact that the Municipality of Culiacán, Sinaloa had rejected recommendation 11/07. The aforementioned recommendation asked for the following:

FIRST Instructions must be issued to the pertaining authorities within the Internal Control Body of the Honorable Municipality of Culiacán. The heads of the Management for Urban Development and Ecology and of the Unit of Inspection and Vigilance of the Municipal Office must take any and all corrective and remunerating actions on the grounds of actions and omissions committed against the principles of legality, honor, loyalty, impartiality and efficiency in their work, position or commission, as public officials attached to the Municipality of Culiacán. All actions conducted by said public officials must adhere strictly to the Internal Administrative Rulebook and to the law.

SECOND Having taken care of all of the above and with a view to repairing the human rights of the victim, the heads of the Management of Urban Development and Ecology and of the Unit of Inspection and Vigilance, or any other pertaining unit, must immediately fulfill their positions and adhere strictly to all pertaining laws, in order to issue the proper sanction against Mr. Raúl Domínguez Moreno, based on the grounds that the analysis of the facts that motivated this recommendation has lent credit to the fact that he is accountable of committing a violation of municipal laws.

Appeal 2007/421/1/RI has been ratified by the National Commission. Therefore, the Constitutional Head of the Municipal Office of Culiacán, Sinaloa was presented with the following report:

Based on the logical-legal analysis conducted on the evidence found within file 2007/421/1/RI, the National Commission has established a violation against the fundamental rights to legal safety, legality and due process. The report presented by the Head of Deliverance and Legal Analysis of the Honorable Municipality of Culiacán, Sinaloa states that Recommendation 11/07, addressed to the Head of the Municipal Office of Culiacán, Sinaloa, was not accepted because “the case made by the Recommendation issued by the local human rights body is poor and not exhaustive enough. Mainly, concerning the establishment of Municipal and State laws, which allegedly point out the performance of municipal public officials, since the violated legal precepts are not specified. In addition, reference is even made to legal ordainments that were not in effect by the time the resolution was reached”.

Nonetheless, the fact that the local human rights body may have been imprecise on its interpretation of the aforementioned legal precept does not justify rejection of the Recommendation, since the National Commission has observed the existence of violations of the human rights of legality, legal safety and due process committed against Mrs. María Olga Olea Zamudio. All of the above is attributable to unlawful performance in public service, since up to date, no complaint or charges presented by the victim before municipal authorities have been addressed. The latter constitutes an omission on behalf of public officials attached to the Honorable Constitutional Municipality of Culiacán, Sinaloa, since to this day the victim has not received notice of any resolution reached in the referred administrative procedure.

Following this line of thought, the National Commission has credited violations to the human rights of Mrs. María Olga Olea Zamudio. Irregularities such as these cannot be ignored or go unpunished. For this reason and based on Article 66, incise b) of the Law of the National Commission of Human Rights, Recommendation 11/07, issued by the Human Rights Commission of the State of Sinaloa and addressed to the former Head of the Municipal Office of Culiacán, has been modified. As a result the National Commission has issued Recommendation 6/2009, addressed to the Chairman of the Honorable Congress of the State of Sinaloa, attaching a copy addressed to the Honorable Constitutional Municipality of Culiacán Sinaloa:

FIRST. The pertaining Internal Control Body must be notified, so that it may initiate and determine an administrative investigation process that establishes any and all involved public officials accountable for the facts that motivated this recommendation, in accordance to the law and as established in the observations chapter contained within the Recommendation.

SECOND. The administrative process initiated on the complaint presented by Mrs. María Olga Olea Zamudio must find an immediate resolution. In addition, all interested parties must receive notice of said resolution.

Recommendation 7/2009
February 13th 2009
Case: Messrs. Edmundo Reyes Amaya or Andrés Reyes
Amaya and Gabriel Alberto Cruz Sánchez or Raymundo Rivera Bravo
Responsible Authority: Ministry of the Interior, Constitutional Government of the State of Oaxaca, Municipal Office of Oaxaca de Juárez, Oaxaca

The National Commission of Human Rights issued Recommendation 7/2009, addressed to: Fernando Gómez Mont, Secretary of the Government of Oaxaca as representative of the Federal Government; Ulises Ruíz Ortíz, Governor of the State of Oaxaca, and José Antonio Hernández Fraguas, Head of the Municipal Office of Oaxaca de Juárez, with regards to the case of Messrs. Edmundo Reyes Amaya or Andrés Reyes Amaya and Gabriel Alberto Cruz Sánchez or Raymundo Rivera Bravo, whose disappearance –on the 24th of May 2007— was reported to the CNDH by non-government institutions. In addition, the self-denominated Popular Revolutionary Army (Spanish initials EPR) has demanded the reappearance of their colleagues to the Mexican Government.

Based on dispositions stated in Article 102, Section “B”, of the Political Constitution of the Mexican United States and Article 44 of the Law of the CNDH, the National Commission demands that the victims are presented alive. In addition, the CNDH considers that, since violations of the human rights of the victims have been established. The Mexican State –represented by the Federal Government, the Government of the State of Oaxaca and the Municipal Office of Oaxaca de Juárez— must fully restitute the violated human rights of the victims, as well as offer full compensation, to the victims or their immediate families, to repair any damage they may have suffered.

Investigations conducted by the CNDH presented enough proof to help establish that public officials attached to the now defunct Secretary of Citizens Protection (currently known as the Secretary of Public Safety), the General Attorney’s Office (both attached to the State of Oaxaca), and the General Management for Public Safety in the municipality of Oaxaca de Juárez, omitted taking adequate action in order to find the location of the alleged missing persons.

In addition, through the Sub Attorney’s Office for the Specialized Investigation of Organized Delinquency, the General Attorney’s Office of the Republic is currently investigating the case, although after 18 months of ongoing investigation, authorities have failed to obtain any results.

Research and valuation based on the complaint file, which contains results obtained through the ongoing investigation thus far, reports provided by the aforementioned and allegedly responsible authorities, and the logical analysis – legal analysis based on the evidence — have allowed the CNDH to document that public officials attached to several government dependencies, who took part in an operation conducted on May 24th 2007, presented reports before the National Commission. Also, law enforcing agents involved on the actions conducted during the operation told different versions, made several omissions and grave contradictions, allowing for the Commission to determine that the end results differed greatly in each version.

In that sense, it seems safe to ascertain that, sometime during 24th and 25th of May 2007, both victims were detained during the operation and discreetly transported to the facilities of the State’s Attorney’s Office later on. From that point on, their whereabouts are

unknown, just as non-government bodies reported. The group demands that the victims are presented alive, claiming that authorities involved with the operation have done nothing to prove their accusations wrong, despite having plenty of time and information to do so.

The unwillingness to adhere to the truth and contradictions found within the reports produced by the authorities responsible for the case, in addition to their unwillingness to collaborate with the CNDH's investigation, translate to acts of obstruction of truth, concerning the facts that led to the detention and eventual disappearance of both victims, who have been linked to the evidence gathered by the Commission; evidence thoroughly described in the recommendation, which is enough to determine the responsibility hereby attributable to the State.

By failing to provide results in the case, the General Attorney's Office of the Republic is accountable for unlawful practice in its public function of upholding justice. In addition, the General Attorney's Office is also accountable of having refused to cooperate with the investigation conducted by the CNDH, having obstructed the Commission, thus impeding the CNHD to become aware of any progress made in all actions taken by this social representative of the Federation.

All of the above serves to confirm that the State has failed to fulfill its commitments with regards to human rights both on the national scene as well as abroad. Because of this, the National Commission demands that the true facts that led to the detention and disappearance of the victims and their fate become publicly known. In addition, the victims must be set free or placed under the charge of pertaining authorities, assuming that they may have incurred in delinquent behavior of some kind, not to mention that the results of any and all investigations conducted by the Public Attorney's Office with regards to this case must be reported to society at large in an open and transparent manner.

Standing out among the many actions taken by the CNDH with regards to this Recommendation are: the formulation of 295 files addressed to diverse authorities; 281 on-field actions, including inspections and several other tasks; 215 interviews held with relatives of the missing victims, federal public officials, both at state and municipal levels, as well as non-government institutions, employees of commercial establishments, religious authorities, witnesses and neighbors; 35 visual inspections held at the Military Prison on Military Field Number One, located in Military Zone 28/a, including detention areas under the charge of the State's Attorney's Office in the states of México, Chiapas and Oaxaca, in addition to the Federal District and the townships of Ixcotel, Mihuatlán de Porfirio Díaz, San Antonio de la Cal, La Experimental, San Bartolo Coyotepec, San Pablo Huixtepec, Zimatlán, San Pedro Totolapan, Santa Cruz Xoxotlán and Oaxaca de Juárez, all of them located in the State of Oaxaca. As a result, 10,089 files were compiled in 17 volumes and one journalistic graphic folder.

The National Commission believes that public officials attached to the aforementioned entities violated the victims' rights to: freedom; personal safety; legality; legal safety; access to justice; defense, and due process as stated by the Political Constitution of the Mexican United States; as well as the International Pact of Civil and Political Rights; the American Convention on Human Rights; the Declaration on the Protection of All Persons Against Forceful Disappearances; the Universal Declaration of Human Rights; the Declaration on Fundamental Rights of Justice for Crime Victims and Against the Abuse of Power; the Conduct Code for Public Officials in Charge of Upholding the Law; and the Inter-American Convention on Forceful Disappearances.

Based on the evidence and reasoning that was thoroughly distributed within the recommendation, the National Commission observed that the public officials who participated in the operation are very likely to have updated allegations found in Article II of the Inter-American Convention of Forceful Disappearances, in the part that reads, "the term Forceful Disappearance must be applied when one or more individuals are deprived from their liberty in any way, shape or form and whenever the act is committed by agents of the State or by individuals or groups that act with previous authorization and support or acquiescence of the State. In addition, a Forceful Disappearance is followed by lack of information or denial to recognize said deprivation of liberty or failure to report the missing person's whereabouts. The situation obstructs the use of legal resources and any pertaining guaranties for due process". The statement casts a shadow of doubt on the aforementioned authorities denial of having participated in the detention and following disappearance of Messrs. Edmundo Reyes Amaya or Andrés Reyes Amaya and Gabriel Alberto Cruz Sánchez or Raymundo Rivera Bravo, especially since no convicting elements contained within the complaint to help discredit the accusation were presented and even though the National Commission provided the pertaining authorities with clear and punctual information on the manner in which the norms that regulate their performance work.

Through its Recommendation, the CNDH asks for authorities to present the victims alive at once and, should said authorities be held accountable for incurring in unlawful activities, they must be placed in the hands of the proper authority. Otherwise, the National Commission must be informed of the fate suffered by the victims.

In addition, the National Commission asks for authorities to assume their responsibilities in order to repair the damage and to guarantee that the victims' immediate families receive the benefits, should the victims no longer be alive. Also, public officials in charge of law enforcement must receive proper training, so that they become aware of and respect human rights. Periodical evaluations of the profiles of law-enforcing personnel must be conducted and an Inter-disciplinary work force must be formed in order to guarantee that acts such as these never occur again. Also, the government of the State of Oaxaca must work with its federal counterpart so that the Public Attorney's Office can adjust its performance in accordance to the lines established by the penal legislation that regulates

Mexican Law and Order. Finally, instructions must be issued to public officials so that they provide legally responsible institutions with the vigilance and defense of human rights that they need in order to provide all of the demanded information.

Through its representation, the Federal Government must ask that the General Attorney's Office determines the pertaining investigation, in accordance to the law. An inter-disciplinary work force must evaluate all actions conducted by the social representative of the Federation with regards to this case, as well as any and all detected irregularities found within said social representation's investigations. In addition, the Public Attorney's Office and the Internal Control Body must be allowed to take proper action against responsible public officials, so that they may initiate an administrative investigation of any and all public officials attached to the General Attorney's Office that may be accountable for obstructing the CNDH from fulfilling its full and constitutionally granted functions.

The Government of the State of Oaxaca has been asked to conduct an investigation of any and all public servants attached to the current Secretary of Public Safety that may be involved in the facts, along with the person in charge of the Police Force attached the State's Attorney's Office at the time. In addition, the Public Attorney's Office must be granted enough authority to conduct an investigation of all of the above, as well as investigate all actions and omissions conducted by personnel attached to the Management of Emergency Services 066 for the State of Oaxaca.

The Municipal Office of Oaxaca de Juárez has been asked to conduct an administrative investigation of public officials attached to the General Management Office of Public Safety involved in the case, who have been accused of sidetracking and obstructing the CNDH from fulfilling its fully, constitutionally granted functions.

Recommendation 8/2009
February 15th 2009
Case: On the case of Mrs. Felícita Enríquez Saavedra
Responsible Authority: National Secretary of Defense

On August 6th 2008, Mrs. María del Rosario Rosado Enríquez filed a complaint before the National Commission, reporting violations to the human rights of Mrs. Felicita Enríquez Saavedra, her mother and a beneficiary of National Security for the Mexican Armed Forces, which were allegedly committed by public officials attached to the National Secretary of Defense. The complaint states that on March 26th 2008, the victim went to the medical urgencies department of the Military Infirmary of Ixtepec, Oaxaca, complaining about stomach aches and diarrhea. The victim was checked into the infirmary and given medical attention by an anesthetist and First Captain, finally being released on March 28th. However, since the victim's ailments persisted, she checked into the facility's urgency department once again on April 5th, 10th and 26th 2008, and was seen by the same public officer and was checked in and released later due to improvement. Nonetheless, the responsible doctor did not inform her of the reason for her ailment and told both women that the victim had to be transferred to the Central Military Hospital, located in Mexico City.

On April 26th 2008, the victim traveled to the Central Military Hospital in Mexico City by her own means. The doctor in charge at the medical facility attended the victim on April 27th and informed her and her daughter that the patient was in a grave and delicate state; that she had been fortunate not to die on their way. While in the Central Military Hospital, the victim was given the medical attention that she required. However, due to the time it took for her to receive proper medical attention, the victim passed away at Ixtepec, on May 11th 2008.

The issuing of this Recommendation is based on the grounds of violations to the human rights to life and health protection, as well as for the fact that Mrs. Felicita Enríquez Saavedra failed to receive adequate medical attention. Evidence gathered by the National Commission ascertains that Mrs. Felícita Enríquez Saavedra was not evaluated in adequate fashion by the medical unit in Ixtepec, due to the fact that the symptoms she presented were minimized and studies such as: hematic biometry; complete blood quemicals; renal and hephatic functions; general urine analysis; electrocardiograms, and chest telemetry, were not conducted.

The fact that the patient was not provided with the proper studies that her illness demanded, clearly indicates that a precise diagnosis was not established. In addition, it is quite clear that the patient was not provided with opportune medical treatment nor transferred in time to a third level hospital. The situation derived in a complication of the basic illness (chronic renal insufficiency), thus leading the patient to an early death, since the series of complications, such as cardiac and pulmonary problems, came as the direct consequence of the inadequate attention of the illness and its complications.

The National Commission has observed that several omissions and delays in the medical attention provided to Mrs. Felicita Enríquez Saavedra at the Military Infirmary of Ixtepec are mainly responsible her death. The fact that her symptoms were minimized was the leading factor in failure to provide a timely diagnostic and as a consequence, proper medical attention was not provided to the patient either. In addition, the fact that the patient was not transferred in time led to complications in her basic illness, thus leading to her death on May 11th 2008, at the Central Military Hospital.

In virtue of all of the above, the National Commission has determined that the medial staff attached to the Military Infirmary at Ixtepec, Oaxaca, responsible for the care of Mrs. Felicita Enríquez Saavedra failed to comply with the dispositions found in Article 8, sections I and XXIV of the Federal Law of Administrative Responsibilities for Public Officials, therefore failing to fulfill their duties. This behavior

led to the violation of the victim's fundamental human rights to health protection and adequate medical attention as established by Article 4, third paragraph, of the Political Constitution of the Mexican United States, which indicates that the State must provide quality medical services, adopting any measures deemed necessary in order to fully comply with the right to quality in health services.

Therefore, the National Secretary of Defense has been recommended to repair damages to the immediate family of the deceased victim. In addition, the Unit of Inspection and Controllership of the Mexican Army and Air Force must be investigated, so that the pertaining administrative investigation process may be initiated, against the personnel attached to the Military Infirmary of Ixtepec, Oaxaca. Also, an administrative investigation procedure must be initiated against First Captain M.C. as the first medic in charge of the victim at Ixtepec, due to his participation in the facts included within this Recommendation.

Recommendation 9/2009
February 15th 2009
Case: Contestation appeal filed by Mr. Juan Rodríguez Mancilla
Responsible Authority: LVIII Legislation of the Honorable Congress of the State of Guerrero, Honorable Constitutional Municipality of Olinalá in the State of Guerrero

On July 18th 2008, the Commission for the Defense of Human Rights of the State of Guerrero issued Recommendation 22/2008, addressed to personnel attached to the Municipal Office of Olinalá. The recommendation asked for instructions to be issued in order to conduct an administrative procedure against the Head of the Municipal Office of Olinalá, Guerrero, based on the grounds of improper performance in public functions and an attack conducted against private property owned by Mr. Juan Rodríguez Mancilla. Likewise, the State Commission asked for the victim to receive proper compensation for the damages suffered, as well economic retribution for compensation purposes. Nonetheless, the recommendation was not accepted. In response, Mr. Juan Rodríguez Mancilla filed a Contestation Appeal against the denial, which was recorded under number 2008/312/2/RI.

The facts recorded in the complaint state that the Head of the Municipal Office of Olinalá informed the victim that the construction of a new road would go through his land. In exchange for his acceptance, Mr. Rodríguez was offered the construction of a new road that would be closer and help connect Ocotitlán with the small town called, "Las Dos Cruces". Mr. Rodríguez accepted the proposal, asking in return that the old path or road that went across his land would be closed. The Municipal Head agreed to close the aforementioned road, offering instead to build the new road that would lead to Ocotitlán. However, the municipal authority failed to keep his promise and the victim's land was instead divided into three parts.

Evidence gathered by the National Commission has led the institution to believe that the offenses alleged by the victim are valid and can be processed. In addition, it has been established that the State Commission was correct in the production of Recommendation 22/2008, since the Head of the Olinalá Municipal Office violated the fundamental rights of legal safety and legality, as well as the rights to property ownership of Mr. Juan Rodríguez Mancilla, by performing an improper action within his public functions.

The performance of the Head of the Olinalá Municipal Office has led the National Commission to consider that the LVIII Legislature of the Honorable Congress of Guerrero should act on the actions and omissions committed by this public official. The Legislature must make full use of its powers and attributions and determine any and all legal actions that must be taken against the acts attributable to the Head of the Olinalá Municipal Office.

Due to the situation, the National Commission issued Recommendation 9/2009 on February 15th 2009, addressed to the Chairman of the Board of the LVII Legislature of the Honorable Congress of the State of Guerrero, as well as to personnel attached to the Honorable Constitutional Municipality of Olinalá, Guerrero, stating the following points:

To the Chairman of the Board of the LVIII Legislature of the Honorable Congress of the State of Guerrero: The necessary instructions must be issued to whom it may concern in order to determine the charges attributable to the Head of the Olinalá Municipal Office, who is responsible of the violation of the rights to legal safety and legality, as well as to the right to property of Mr. Juan Rodríguez Mancilla. If necessary, any and all agreements must be reached in order to establish the proper sanctions and proof of complete fulfillment must be produced and presented.

To the personnel attached to the Honorable Constitutional Municipality of Olinalá: Instructions must be issued to whom it may concern, so that Recommendation 22/2008, issued on July 18th 2008 by the Commission for the Defense of Human Rights in the State of Guerrero, is fulfilled in its entirety. In addition, the National Commission must receive proof of the latter and instructions must be issued to whom it may concern, so that from now on, the personnel attached to the Olinalá Municipal Office may punctually meet any and all requirements made by the National Commission.

Recommendation 10/2009
February 16th 2009
Case: The Case of A1, female applicant for position as firefighter
Responsible Authority: Head of the Municipal Office of Morelia, Michoacán

Several reports published by different national journals on July 8th and 9th 2008 informed of the physical and psychological humiliation that A1, a female applicant for a position as a firefighter at the time, was subjected to by personnel attached to the Management for Civil Protection and the Municipal Fire Department of Morelia, Michoacán. Based on dispositions established by Article 14 of its Internal Rulebook, the reports motivated the National Commission to follow the case which was originally initiated by the Human Rights Commission of the State of Michoacán on July 8th. The National Commission considered that these actions transcend the interests of the State of Michoacán, since they have made a mark on public opinion at a national scale. Therefore, file CNDH/1/2008/3608/Q was created with the purpose of demanding that any and all involved authorities render their respective reports.

The contents of the journalistic reports responsible for the facts that have motivated this pronouncement told the story of a female who was subjected to physical and psychological humiliations by the heads of the Municipal Fire Department of Morelia, Michoacán, while participating in a training course for new applicants. It should be noted that, ever since the first formalities were conducted and, as soon the first reports reached the National Commission, the young female mentioned in the journalistic reports also appears on a video provided to other media outlets by the Quadratín Mexican Agency of Information and Analysis, helping to identify her as Miss A1. On July 9th 2008, Miss A1 went to the facilities of the Human Rights Commission of the State of Michoacán in order to report the facts made publicly known by the media that involve public officials attached to the Management of Civil Protection and to the Municipal Fire Department of Morelia. The identity of the perpetrators was also confirmed by personnel attached to the State's Human Rights Commission, during an interview held with the victim on July 11th 2008, in addition to reports rendered by the Head of the Honorable Municipality of Morelia and the Manager of Civil Protection and the Municipal Fire Department. Statements have served to confirm that the female the media referred to as "an applicant for a position as a firefighter", also shown in the video, is indeed Miss A1.

The victim's statements made on July 9th 2008 before personnel attached to the Human Rights Commission of the State of Michoacán, in addition to information provided by the Manager and Sub-manager of Civil Protection and the Municipal Fire Department indicates that the Management of Civil Protection and the Municipal Fire Department of Morelia conducted periodical basic training sessions meant to increase the number of base firefighters, as well as volunteers. Sessions include assistance to indoor theory, on-field training, service and camp hours.

It is necessary to stress just how important the news and articles published in different media outlets are. Media reports become facts in the public eye and, since these reports were directly related to the results obtained during the National Commission's investigations and to the evidence gathered for this case, there is no need for further proof, as the situation falls into the jurisdiction of human rights, domestically as well as abroad. The facts have become public but moreover, they can be corroborated through official documentation or, concretely for this case, facts have been proven through audiovisual material, which has corroborated proof of the actions attributable to public officials attached to the Municipal Office of Morelia, Michoacán.

Therefore, the National Commission has determined that the behavior of SP1, Head of the Morelia Fire Department, and Lieutenant SP2, was a violation of the right to legal safety of the victim, as established by Article 14, second paragraph of the Political Constitution of the Mexican United States. The aforementioned Article states that all human beings have the right to live in a democracy, under the vigilance of a coherent and permanent regulating legal system that must be provided with certainty and stability, so that the limits of public power can be defined before the heads of subjective rights, thus guaranteeing the Power of the State in all of its different functions.

In addition and in accordance to Article 44, Sections I V and VI of the Law of Responsibilities for Public Servants in the State of Michoacán, the two heads of the Management Office of the Municipal Fire Department of Morelia that participated in the facts overstepped their authority, since the Article in question establishes conduct codes that must be observed by public officials while performing their duties in order to safeguard legality, honor, loyalty, neutrality and efficiency.

As a result, the National Commission of Human Rights issued Recommendation 10/2009, addressed to the Head of the Municipal Office of Morelia, recommending the following:

FIRST Instructions must be issued to whom it may concern, so that the Municipal Controllership of Morelia Michoacán may initiate and determine the proper administrative procedure to be held against the two heads of the Management Office of the Municipal Fire Department of Morelia that were involved in the facts. The procedure must be based on considerations established by the observations chapter contained within the Recommendation. In addition, the National Commission must be kept fully informed of said procedure from beginning to end.

SECOND Clear and precise instructions must be issued to the Head of the Management Office of Civil Protection and Municipal Fire Department, so that the training required by the members of the Fire Department may be implemented, under the Management Office's direct supervision and authorization. Courses must strictly adhere to the human rights of all participants in order to avoid that actions such as the ones that led to this Recommendation occur ever again.

THIRD Instructions must be issued to whom it may concern for any and all actions deemed necessary so that the entire staff attached to the Municipal Office of Morelia, Michoacán receives adequate training in human rights in order to prevent that irregularities such as the ones that originated this recommendations may occur ever again.

Recommendation 11/2009
February 16th 2009
Case: On the case of journalist Rafael Villafuerte Aguilar, Head of the Weekly Journal "La Razón"
Responsibel Authority: The Constitutional Government of the State of Guerrero

On June 10th 207, Mrs. Sonia Gama García filed a complaint before the National Commission, reporting that on December 13th 2003, her husband, journalist and head of the weekly journal "La Razón" Rafael Villafuerte Aguilar, was killed while driving his car on the outskirts of Coyuca de Catalán, Guerrero. The facts led the General Attorney's Office of the State of Guerrero to open investigation file MIN/SC/02/302/2003. Still, the investigation remained unresolved by the time the complaint was filed and no persons had been detained for the crime, even though there were enough testimonies, in addition to a report produced by the Ministerial Police where the perpetrators had been identified.

On September 2003, a certain person told Mr. Rafael Villafuerte Aguilar that the current Head of the Municipal Office of Altamirano, Guerrero, had asked for his journal to be less critical. Mrs. Sonia Gama García claimed that, one week before her husband's murder, Mr. Villafuerte Aguilar had told her that he had run into the same person and that this individual had insisted on repeating the words of the Municipal Head. According to the testimony, the person that worked as Manager of Social Communications for the Municipal Office of Pungarabato, Guerrero at the time had filed a lawsuit against Mr. Villafuerte Aguilar based on the grounds that the journalist was supposed to have been using this person's name as an alias for his work. In addition, shortly after the facts, this person kept making suspicious and frequent questions about the perpetrators of the assassination and the reason for such crime.

Taking into consideration that the facts included within the complaint are especially grave and have influence on national public opinion, in addition to their nature, they must be considered to go beyond the interests of the State of Guerrero, therefore, the use power of attraction for this case was deemed necessary on October 8th 2007.

Complaint file 2007/4167/5/Q was opened, asking the General Attorney's Office of the State of Guerrero for the pertaining information several times. The information was delivered and shall be evaluated within this document.

Logical-legal analysis of the facts, in addition to the evidence that comprises complaint file 2007/4167/5/Q, which shall be described in the following sections, makes it possible to observe the following: ministerial, legal and law enforcing personnel attached to the General Attorney's Office of the State of Guerrero responsible for the production of initial investigation MIN/SC/02/302/2003, which was started on the grounds of the murder of Mr. Rafael Villafuerte Aguilar, have violated the human rights of legality, legal safety, and opportune and immediate access to justice of Mrs. Sonia Gama García and her daughters.

While the intention is not to interfere with the investigation of the crimes or the persecution of the potential perpetrators, it must be said that several irregularities, delays and irresponsible practice of functions were found during the evaluation of evidence yielded by the aforementioned initial investigation. Such diligences are the exclusive responsibility of the agent of the Public Attorney's Office, as established by Article 21 of the Political Constitution of the Mexican United States and Article 77 of the Political Constitution of the State of Guerrero. Therefore, the National Commission wishes to express its deepest respect for the functions of the Public Attorney's Office.

In accordance to the current Penal Code of the State of Guerrero, it should be noted that the omissions and delays that ministerial personnel incurred in during the investigation of the facts that led to the murder of Mr. Rafael Villafuerte Aguilar should be considered as typical criminal behavior. Likewise, delays or obstruction of the administration of justice and incurring in omissions that may produce some damage can be considered as crimes against the administration of justice. Therefore, in this case, penal responsibilities of public officials that were aware of investigation MIN/SC/02/302/2003 must be investigated by the pertaining ministerial authority.

Reactivation of the investigation on the facts that led to the death of Mr. Rafael Villafuerte Aguilar must not and cannot put the safety and physical integrity of Mrs. Sonia Gama García and her daughters at risk, just because said investigation could compromise certain interests in the city of Coyuca de Catalán, Guerrero. Therefore, for this case at least, it would be most convenient if ministerial authorities were to take any and all preventive measures deemed necessary to help prevent actions that may affect the personal safety and legal scope meant to provide Mrs. Gama García and her immediate family with proper protection.

Taking all of the above into consideration, Recommendation 11/2009 was issued, addressed to the Constitutional Governor of the State of Guerrero, recommending the following:

FIRST The General Attorney of the State of Guerrero must be instructed properly, so that initial investigation MIN/SC/02/302/2003 can proceed as swiftly and efficiently as possible. In addition all pending investigation lines must be followed until they have been spent, as well as any further lines of investigation that may result from the initial procedure, until a final determination is reached, in accordance with the law.

SECOND Instructions must be issued to whom it may concern, so that the Internal Controllership of the General Attorney's Office of the State of Guerrero can initiate an administrative procedure to determine any and all actions that may have been committed by agents

attached to the Jurisdictional Public Attorney's Office. Inspectors responsible for the elaboration of initial investigation MIN/SC/02/302/2003, based on the grounds of omissions and delays in said investigation, must also work on the procedure, all in accordance to the law and to the observations contained within the Observations chapter included in this Recommendation.

THIRD The General Attorney of the State of Guerrero must be properly instructed in order to grant the pertaining agent of the Public Attorney's Office with the power needed to initiate an investigation of any and all public officials responsible for the elaboration of initial investigation MIN/SC/02/302/2003, so that any and all parties accountable for the omissions and delays contained within the Observations chapter included in this Recommendation can be processed.

FOURTH The General Attorney of the State of Guerrero must be properly instructed, so that he may take any and all preventive measures deemed necessary in order to protect the safety and physical integrity of Mrs. Sonia Gama García and her daughters, thus avoiding any and all kinds of retaliation against them that may result from the initial investigation of the murder of Rafael Villafuerte Aguilar.

Recommendation 12/2009
February 17th 2009
Case: On the case of members of the Human Rights Center "Fray Bartolomé de las Casas"
Responsible Authority: Constitutional Government of the State of Chiapas

On October 24th 2006, a note published by the journal "La Jornada" informed of a break-in that took place in the facilities of the Human Rights Center "Fray Bartolomé de las Casas" without any apparent signs of a possible robbery. Motivated by the report, the CNDH established contact with Mr. Diego Cadenas Gordillo, Sub-manager of the aforementioned human rights center, on October 25th 2006. Mr. Cadenas Gordillo ratified the published facts and asked for the intervention of the National Commission so that follow up procedures on initial investigation 001086/AL40/2006, motivated by the break-in, could be initiated before Courtroom Number 1, located in San Cristobal de las Casas, attached to the former General Attorney's Office of the State of Chiapas at the time.

Following the terms established in Article 3, third paragraph of the Law of the National Commission of Human Rights, as well as in the last part of Articles 14 and 157 of the Commission's Internal Rulebook, 157, power of attraction was deemed as the right procedure for this in this particular case.

On November 17th 2006, personnel attached to the National Commission traveled to San Cristóbal de las Casas, in order to hold an interview with personnel attached to the Human Rights Center "Fray Bartolomé de las Casas". Interviewees said that on March 2006, several acts of aggression, surveillance and intimidation were committed against members of the board and personnel attached to this human rights center in particular, involving Mr. David Méndez Moreno, when persons unknown to the center's staff broke into his home, taking possession of a laptop computer, some earrings and a golden chain. For this reason, initial investigation 000249/AL40/2006 was initiated before Courtroom Number 4, in San Cristóbal de las Casas, attached to the former General Attorney's Office of the State of Oaxaca at the time. Mr. Manuel Gómez Hernández said that on July 2006, he received a threat on his cell phone. For this reason, administrative act 000399/IA01/2006 was initiated before Courtroom Number 3, in San Cristóbal de las Casas, attached to the former General Attorney's Office of the State of Chiapas at the time.

In order to initiate complaint file 2006/4844/5/Q, the National Commission asked the former General Attorney's Office of the State of Chiapas for the pertaining information on several occasions.

As the complaint file was initiated, personnel attached to the National Commission learned about several other offenses committed against members of the Human Rights Center "Fray Bartolomé de las Casas", very similar in nature to the crime suffered by Mr. David Méndez Moreno, who lost a laptop computer, some earrings and a gold chain when his home was robbed.

In this regard and from statements that integrate investigation 000249/AL40/2006 which was initiated before Courtroom Number 4, in San Cristóbal de las Casas, attached to the former General Attorney's Office of the State of Chiapas and motivated by referred facts, it can be delivered that ministerial authorities incurred in irregularities and delays in the elaboration of said investigation, including experts in fingerprints and on-field criminal inspectors who failed to gather fingerprints at the victim's home.

Therefore the National Commission issued Recommendation 12/2009, addressed to the Constitutional Governor of the State of Chiapas, recommending the following:

FIRST The General Attorney of the State of Chiapas must be properly instructed, so that any and all instructions deemed necessary may be issued in order to conduct the pertaining diligencies that help determine initial investigations 001086/AL40/2006 and 000249/AL40/2006, in addition to administrative act 000399/IA01/2006, all filed before the Jurisdictional Public Attorney's Office at San Cristóbal de las Casas, Chiapas.

SECOND Instructions must be issued to whom it may concern, so that the Internal Controllership attached to the General Attorney's Office of the State of Chiapas may initiate an administrative procedure to determine the responsibilities that agents attached to the

Public Attorney's Office, in addition to personnel from the Investigation Agency of the State may have incurred in, with regards to initial investigations 001086/AL40/2006 and 000249/AL40/2006, as well as administrative act 000399/IA01/2006. All of the above must follow all considerations contained within the Observations chapter included in this Recommendation. In case that the General Attorney's Office is involved and a process is deemed necessary, the Office of the State of Chiapas must appoint a social representative to determine the extent of their involvement with the case.

THIRD Instructions must be issued to whom it may concern, so that a culture of respect of human rights is promoted through training sessions provided for public officials attached to the General Attorney's Office of the State of Chiapas, in order to assure that the rights of organizations for the defense of civil rights are guaranteed and that any and all actions similar to the ones described in this recommendation can be avoided in the future.

Recommendation 13/2009
February 19th 2009
Case: On the cases of Ausencio González Gómez, Felipe Nery Marmolejo Muñoz, Erika Yazmín Pérez Martínez and Karen Esperanza Pérez Martínez
Responsible Authority: National Secretary of Defense

On February 15th 2008, the CNDH recived a complaint from The Human Rights Commission of the State of Chihuahua which had been filed by Mrs. María de Lourdes Gómez de González, for offenses committed against Messrs. Ausencio González Gómez and Felipe Nery Marmolejo Muñoz. The complaint stated that on January 31st 2008, at approximately 23.30 hours, personnel attached to the Mexican Armed Forces detained both victims, as well as Mrs. Erik Erika Yazmín Pérez Martínez and Karen Esperanza Pérez Martínez, at the Municipality of Lerdo, Durango. After being subjected to physical and oral violence, the victims were transferred to military facilities, where both males suffered serious offenses, so that they would declare against each other. Approximately 36 hours later, the victims were placed at the disposition of the head of the Agency of the Public Attorney's Office of the Federation in Torreón, Coahuila. Among the first duties conducted by the aforementioned holder of the Agency on February 2nd 2008, was an investigation of the injuries sustained by Felipe Nery Marmolejo Muñoz and Ausencio González Gómez.

The National Commission opened complaint file CNDH/2/2008/887/Q. Evidence gathered thus far by the Commission, establishes violations to the human rights of personal safety, legality and legal safety, in the form of torture, illegal detainment and illegal performance of public functions, all motivated by the facts that occurred between January 31st and February 2nd 2008 at the municipalities of Lerdo, Durango, and Torreón, Coahuila, against the victims on behalf of personnel attached to the Mexican Armed Forces.

The offenses became evident in the report of the victims' physical integrity, which was presented by an official medical inspector attached to the Forensics Department of the State Delegation of Coahuila attached to the General Attorney's Office of the Republic, as well as in the application of specialized evaluations and interviews conducted with the victims by inspectors of the National Commission. Questionnaires required by the Manual for the Efficient Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol) were utilized, since their results strengthen the notion of torture as an act of violation. Therefore, it could be established that the injuries suffered by the two offended men were sustained at the time of their detention and are the result of abusive force employed in an intentional manner and seeking to inflict serious pain and suffering, in addition to psychological alterations. Symptoms of the latter became evident when the two male victims narrated the facts, stating that they were beaten and received electroshocks to the back and feet. Additionally, both victims were submerged in cold water and had their heads covered with bags meant to keep them from breathing, among other things.

As far as the female victims are concerned, results indicate that their physical integrity was threatened. Both women were the objects of humiliations, threats and intimidation, and were subjected to oral violence and threatened with firearms. The stress they were under produced psychological alterations such as anxiety and severe depression; symptoms that point to Post-traumatic Stress Syndrome, according to the manner in which such psychological alterations are classified in the Manual for the Diagnosis and Statistics of Mental Illnesses.

Therefore, the National Commission has observed that the victims were subjected to torture and illegal detainment; actions that constitute violations against human kind that imply an attempt against the rights that all human beings are entitled to in order to protect their physical and psychological integrity. In direct consequence, the National Commission issued Recommendation 13/2009 on February 19th, addressed to the Secretary of Defense, which fundamentally states the following:

Instructions must be issued in order to repair the damages suffered by Ausencio González Gómez, Felipe Nery Marmolejo Muñoz, Erika Yazmín Pérez Martínez and Karen Esperanza Pérez Martínez, by means of psychological and medical support, in addition to all the rehabilitation deemed necessary that may allow the victims' physical and psychological condition to be reestablished and back in the state they were before the violation to their human rights occurred. In addition, the National Commission must be kept informed of the results obtained by the treatment.

The Unit of Inspection and the General Controllership of the Mexican Army and Air Force must be granted with the authority to initiate the pertaining administrative investigation procedure, against any and all military personnel involved in the facts that led to this Recommendation, including the military medical personnel responsible for the elaboration of the victim's medical certificates. The investigation must be based on the actions and omissions expressed within the observations chapter included in the Recommendation. In addition, the National Commission must be kept properly informed of the results yielded by the investigation from the moment the procedure begins until a final conclusion is reached, along with the final resolution.

As established within the Observations chapter included in this Recommendation, the General Attorney for Military Justice must be granted with the necessary authority, so that such considerations may be taken into account by the agent of the Military Public Attorney's Office in charge of investigation 6ZM/29/2008 initiated against military personnel attached to the 33rd Infantry Batallion. The investigation, based on offenses committed against Ausencio González Gómez, Felipe Nery Marmolejo Muñoz, Erika Yazmín Pérez Martínez and Karen Esperanza Pérez Martínez. The National Commission must be kept properly informed on the results of the investigation, during the time it takes for the procedure to be initiated and legally perfected and until a determination is reached, in addition to receiving proper information with regards to any and all measures to be taken in order to avoid the repetition of such actions in the future.

Instructions must be issued to whom it may concern, so that military elements attached to the IX Military Region of the Mexican Armed Forces, including military medical personnel, receive proper training in order to assure that all actions are preformed with strict adherence to legality and the utmost respect to human rights. The rights to life, personal integrity and safety must be guaranteed and torture, cruel and/or degrading treatment must never occur. The National Commission must be informed, once all of the above has been accomplished.

Recommendation 14/2009
February 19th 2009
Case: On the case of the PEMEX Usumacinta Platform, located on Sonda of Campeche
Responsible Authority: The General Manager of Petróleos Mexicanos and the General Attorney's Office of the Republic (Spanish initials PGR)

The National Commission of Human Rights issued Recommendation 14/2009, addressed to Petróleos Mexicanos and to the General Attorney's Office of the Republic, motivated by a case where 22 persons were killed and 68 more were seriously injured, while on board the marine platform "Usumacinta", on October 23rd 2007, due to insufficient security measures that failed to guarantee the physical safety and lives of workers.

According to investigations that lend support to Recommendation 14/2009, public officials attached to PEMEX allowed for the platform to operate disregarding security norms and regulations required for this type of facilities. Likewise, training and equipment provided for employees who worked in the facilities were deficient and, in addition, there were no emergency escape boats located anywhere near the platform. These actions constitute failures and omissions that –in accordance to the norms that rule PEMEX—can be attributed to the oil company itself.

The logical-legal analysis conducted on the evidence that comprises complaint file 2007/3755/1/Q has helped to establish the existence of violations to the human rights to life, legality, legal and physical safety of persons, as established by the Political Constitution of the Mexican United States, the International Pact of Economic, Social and Cultural Rights, and the Additional Protocol of the American Convention on Human Rights with regards to Economic, Social and Cultural Rights.

Lack of collaboration on the part of the Campeche Delegation of The General Attorney's Office of the Republic was evident, since access to the pertaining initial investigation AP/PGR/CAMP/CARM-II/142/2007 was obstructed. In addition the following evidence was found missing: photographs of the platform where the accident occurred; the logs of the superintendents attached to PEMEX and to the drilling company; the hard discs of computers, and about 70 statements issued by workers who were onboard the platform the day of the accidents, as well as an inspection report elaborated by experts attached to the Mexican National Autonomous University (Spanish initials UNAM). Also missing, was data that would have helped to enhance all the evidence yielded by the investigation on violations to human rights that the National Commission conducted.

The National Commission regrets this lack of institutional collaboration on the part of the PGR, for it goes against the Democracy that rules over our country. The behavior of these public officials was made known to the General Attorney of the Republic, because, as head of the PGR, he has enough authority to order that these actions are thoroughly investigated, not to mention that he holds the power necessary to impose any pertaining sanctions.

Testimonies which were obtained from survivors consistently points out that on the day of the accident, they heard superintendents in charge of the platform call for the aid of towing boats, since the position of the marine platform was wrong. At the same time, witnesses recalled that superintendents had commented earlier that the areas for fire containment presented a high index of sulfuric hydrants, thus making maneuvers more perilous.

Based on the above, it becomes evident that the personnel in charge of the platform, both those attached to PEMEX as well as those working for the drilling company, were well aware of the fact that the marine platform was in the wrong position and that the weather was terrible during those days. Therefore, the personnel in charge should have foreseen that any maneuvers meant to reposition the platform would prove extremely risky, not too mention that such maneuvers would put the lives of all workers who were onboard the platform in danger. Because of this, workers had to be transferred to a safe security zone before the platform could be repositioned.

The CNDH did not overlook signs found within the report produced by the "Battelle Memorial Institute" company, which states that there are no rescue ships in the Gulf of México. In addition, the report also establishes that PEMEX has overlooked several different safety requirements, which are necessary for the operation of its marine oiling facilities, since the oil company allowed for workers onboard the "Usumacinta" platform to conduct their functions in insecure conditions, thus risking their physical safety and lives at all times. The latter was due to the fact that measures needed to correct any and all structural deficiencies were not taken, despite having previous and direct knowledge of all the security failures that all platforms, their own as well as those they subcontract, present… In addition, PEMEX and its subcontractors do not comply with the Emergency Safety, Health and Environmental Program. All of the above has allowed for the CNDH to hold Petróleos Mexicanos accountable, based on the grounds that the oil company continues to allow work to be conducted under unsafe conditions, in addition to the fact that PEMEX has disregarded multiple complaints presented against them by people who work at oiling facilities.

The case file was opened on August 16th 2007, motivated by a complaint filed before the National Commission by Federal Congressman Cuauhtémoc Velasco Oliva, which warns that PEMEX has overlooked several different safety requirements in its oiling facilities, allowing its workers to continue to do their jobs onboard marine platforms that present unsafe conditions. In addition, PEMEX has not been able to correct any detected deficiencies, despite being aware of those cases where failure has compromised safety onboard its platforms. On September 14th 2007, Velasco Oliva presented new elements to his complaint and extended it.

The Recommendation issued by the CNDH asks for the General Manager of Petróleos Mexicanos to produce proof that the oiling company is fulfilling its obligations and that the victims' direct families have been properly compensated, just as demanded. In addition, proof that surviving victims have received the proper medical and psychological aid is demanded. Likewise, the General Manager of PEMEX has been asked to provide personnel with proper training and make the use of safety equipment permanent for all of the personnel members that work on PEMEX facilities. The Internal Control Body must investigate the public officials in charge of the "Usumacinta" platform at the time of the facts, and that the oil company does not grant any contracts to subcontractors that do not apply the necessary measures necessary to guarantee and improve safety conditions for all workers of marine oiling facilities or structures.

The General Attorney of the Republic has been asked to grant the Internal Control Body of the PGR with the sufficient authority, in order to initiate an investigation against the public officials who inhibited and obstructed the investigation conducted by the CNDH. An investigation must be initiated against the personnel who refused to provide the CNDH with information related to the initial investigation of this case. As established by the Constitution and several other federal and local entities, public officials attached to the CNHD must be properly instructed, so that they may observe that visitors attached to the Commission are granted with powers that allow for them to gather information and conduct their duties in accordance to the powers and attributions granted to them.

According to Article 102, Section B, of the Political Constitution of the Mexican United States, this is a public Recommendation, issued with the fundamental purpose of making a statement with regards to the irregularities committed by public officials while conducting their duties, as conferred to them by the law, as well as seeking to obtain that any investigation that results from the Recommendation is conducted by any and all pertaining administrative bodies or any other kind of pertaining authorities, so that, within their powers and attributions, they may apply the pertaining sanctions, thus solving any irregularities that may need to be addressed.

In accordance to Article 46, second paragraph, of the Law of the National Commission of Human Rights, public officials addressed in the Recommendation have been asked to confirm that the document has been accepted within 15 working days from the notification date. In addition, they must provide proof that the Recommendation has been fulfilled.

NATIONAL ISSUES

The National Commission of Human Rights issued Report 10/2008 of the National Mechanism for the Prevention of Torture in Detention Areas Attached to the State of Durango and established that all seven municipal penitentiaries in the state lack the proper features, related to preventive prisons and to the penitentiary system. In other words, activities related to this matter are not supported by any applicable norm –and all existing lines of procedure contradict the Mexican Constitution—, since it is a prerogative for both, the Federation and all States.

The Report, addressed to 13 of the 39 heads of Municipal Offices in the State of Durango (who preside over municipalities that feature detention centers) indicates that, from the 5th to the 8th of August, said detention centers were visited by personnel attached to the Third General Visitation of the CNDH. Visits were conducted to examine the treatment and detention conditions, as well as actions meant to prevent torture or other cruel, inhuman or degrading treatment or punishment that inmates are subjected to, from the moment they arrive and while under detention.

According to the investigation conducted by the CNDH in its role as the National Mechanism for the Prevention of Torture –based on dispositions established by: Constitutional Article 102; Article 6, Section VIII, of the CNDH's law; Article 61 of the Commission's Internal Rulebook; Articles 19 and 21 of the Optional Protocol of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment—, proper security is lacking inside the facilities of detention centers under the responsibility of Municipal authorities and the actions that must be conducted inside a penitentiary are equally lacking. In addition, the investigation established that detention centers are not equipped with adequate personnel nor do they have the economic resources necessary to cover the basic needs of the penitentiaries' population.

The National Mechanism seeks to conduct periodical visits in detention centers in order to prevent torture, as well as other cruel, inhumane or degrading kinds of treatments or sentences. For that effect, the Mechanism is promoting measures that seek to improve treatment and provide proper detention conditions for persons who have been deprived of their liberty, through dialogue with the pertaining authorities.

According to dispositions established in Article 22 of the Optional Protocol of the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, the CNDH has asked the for the heads of the pertaining Municipal Offices to produce a report that must be delivered within 30 natural days from the notification date found within said reports. Also, municipal heads must designate a representative from their respective municipality and grant them sufficient decision power, so that they can initiate dialogue with public officials attached to the Third General Visitation of the National Commission. Dialogue will allow for evaluation of measures that may be taken in order to prevent any action committed by an authority that is considered to put the safety of detainees at risk, as well as to dignify treatment and conditions in those detention centers under their care.

The general picture presents detention centers and security cells that have no electricity. Also, record keeping of inmates and visitors is very poor. Cells are filled with trash and feces, while facilities are in poor shape and currently used as archives and warehouses. One detention center presented a hole in the roof, made by inmates who managed to escape and the roof has still not been repaired. Sanitary facilities have no water, bathroom furniture, doors or walls. As far as personnel is concerned, the investigation found administrative judges that deliver sentences via telephone, or that are completely unaware of norms and their respective functions. In one case, the Head of Public Safety in San Juan del Río has been in charge of delivering sentences and issuing sanctions for the last 12 years, even though he is not qualified for such functions.

In addition to the fact that municipalities are not qualified to investigate crimes, it was found during the investigation that the use of handcuffs is not regulated. Inmates in penitentiaries under Municipal Jurisdiction are doing time for administrative sanctions, as initiated and processed or sentenced. Areas for females are notably lacking, along with medical services, instruments and healing materials. Since facilities and preventive programs are so inadequate, discrimination becomes commonplace. Regulation for the application of penalties for workers, masons, or other employees, goes as far as one week's worth of the current minimum wage, whereas the Constitution establishes that such penalties should be the equivalent of just one day of minimum wage. Admission, permanence and release of detainees are all but non-existent. Motivation is also lacking and abusive acts of authority are frequently committed by public officials that should be responsible for surveillance and custody of inmates instead.

There are cases where overpopulation is 283%. Since there are no public telephones, authorities justify the use of cell phones. Food is deficient or, in some cases, completely missing for inmates and detainees, whose direct families must provide them with food and water. In order to receive medical attention, inmates must wait between two and three days or pay in order to be transferred to a clinic or hospital, while remaining handcuffed and transported in Pick Up trucks that pass as police cars for there are no ambulances.

Inspection visits occurred in 15 different detention centers located in the heads of the municipalities of Canatlán, Cuencamé, Durango, Gómez Palacio, Guadalupe Victoria, Lerdo, Nazas, Nombre de Dios, El Oro, Pueblo Nuevo, San Juan del Río, Santiago Papasquiaro and Vicente Guerrero. The Guide for Supervising Detaining Centers, designed by the National Mechanism for the case of Municipal Penitentiaries was used in the latter. Also, interviews were conducted with: administrative judges; wardens, public safety managers and commanders; medics attached to public health institutions, and persons deprived of their liberty.

The report is divided into five subjects: I. Dignified and Human Treatment, where the conditions of jailing facilities, spaces for the placement of inmates, the use of handcuffs, tap water and food are analyzed; II. The Right to Legality and Legal Safety, that deals with processed and sentenced inmates and irregularities on the imposition of administrative sanctions; III. The Right to the Protection of Health; IV. Human Rights for Special Groups, and V. Problems that Affect Institutional Safety. Finally, the report concludes with two sections: VI. Observations for the Improvement of Attention of Detainees, and VII. Observations Concerning Norms.

The Report seeks to fulfill all obligations acquired by our country in the Optional Protocol of the Convention Against Torture and Cruel, Inhuman or Degrading Treatment or Punishment.

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