



Freedom from Torture

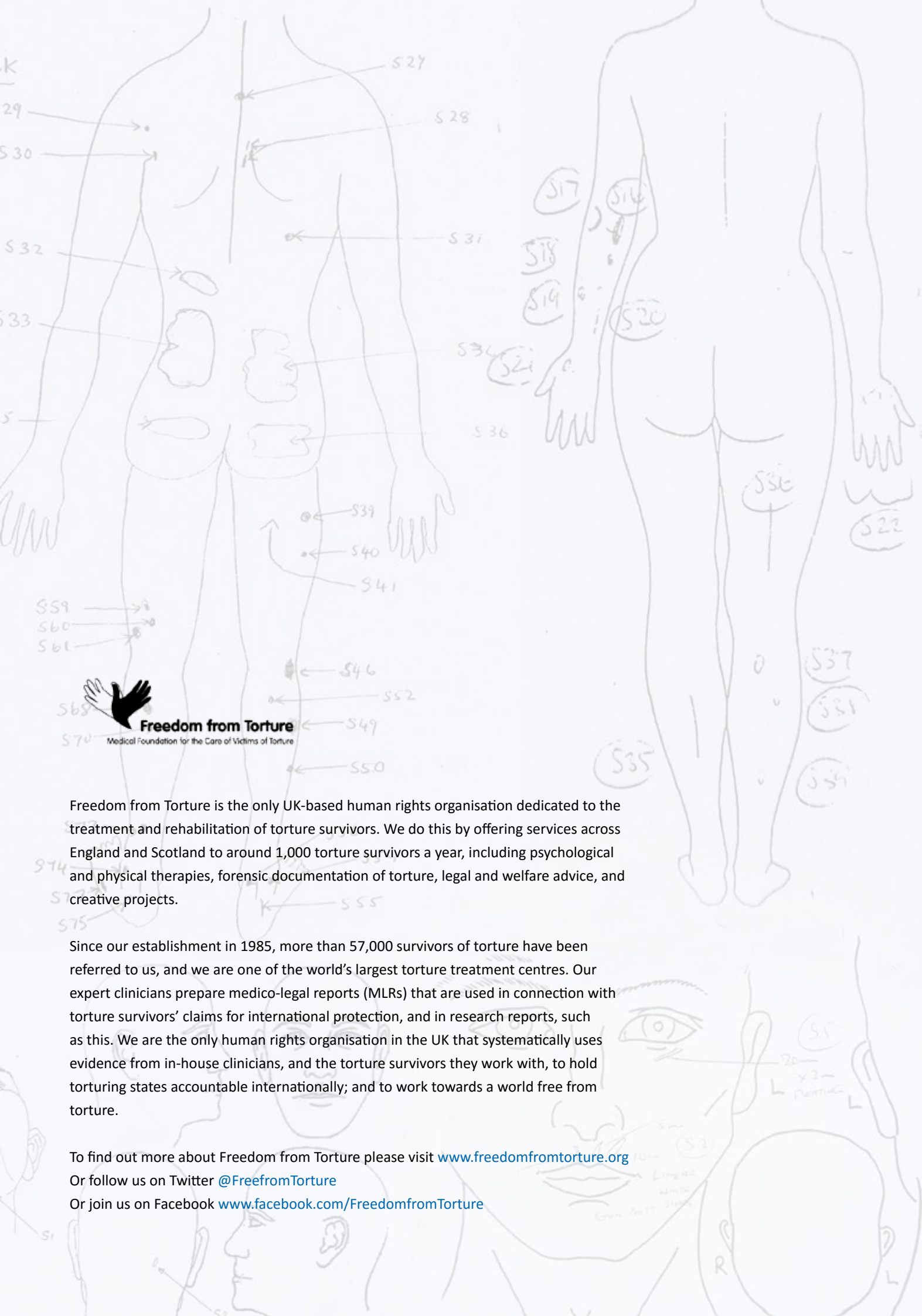
Medical Foundation for the Care of Victims of Torture

Proving Torture

Demanding the impossible

Home Office mistreatment
of expert medical evidence

November 2016



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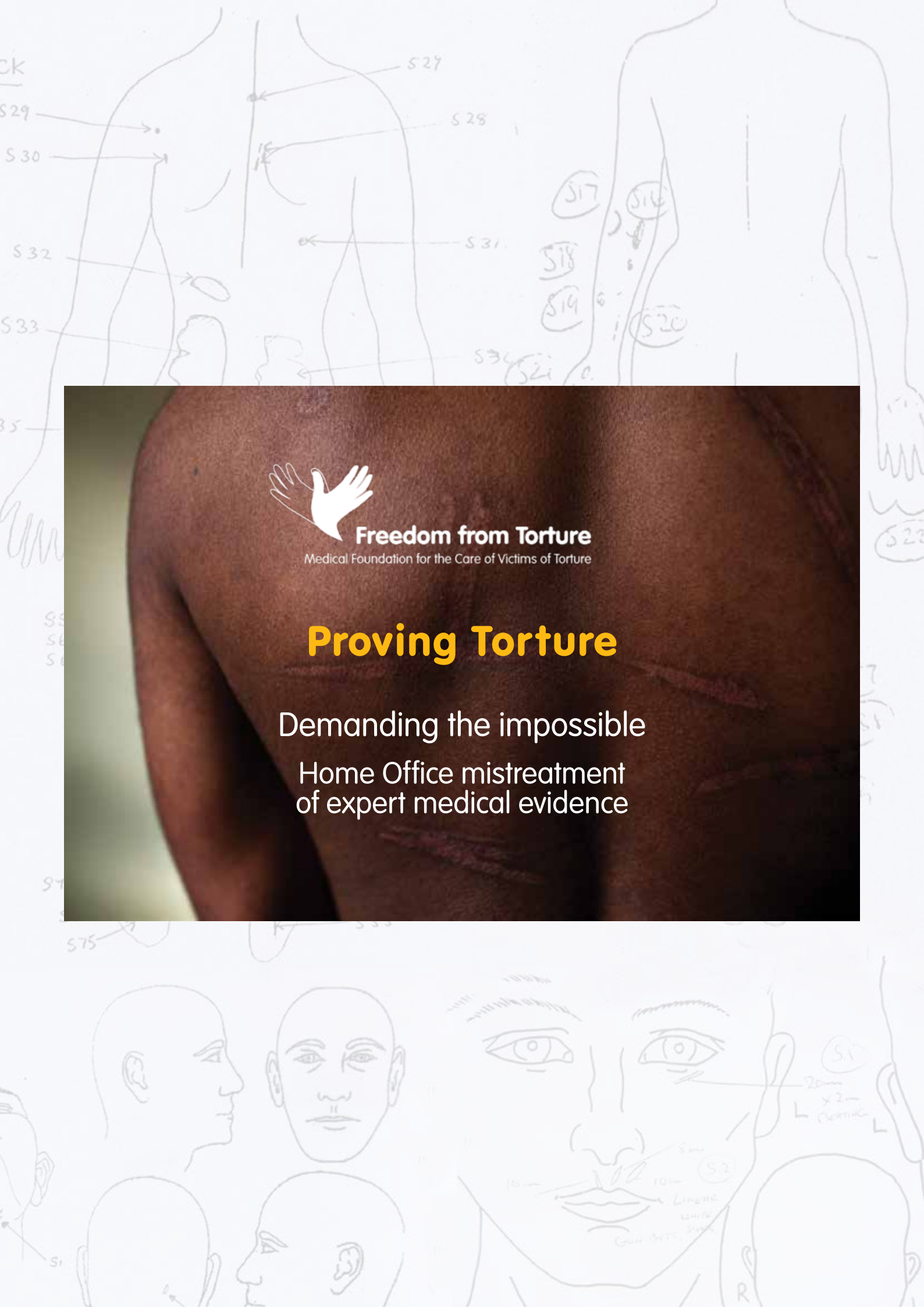
Freedom from Torture

Medical Foundation for the Care of Victims of Torture

Freedom from Torture is the only UK-based human rights organisation dedicated to the treatment and rehabilitation of torture survivors. We do this by offering services across England and Scotland to around 1,000 torture survivors a year, including psychological and physical therapies, forensic documentation of torture, legal and welfare advice, and creative projects.

Since our establishment in 1985, more than 57,000 survivors of torture have been referred to us, and we are one of the world's largest torture treatment centres. Our expert clinicians prepare medico-legal reports (MLRs) that are used in connection with torture survivors' claims for international protection, and in research reports, such as this. We are the only human rights organisation in the UK that systematically uses evidence from in-house clinicians, and the torture survivors they work with, to hold torturing states accountable internationally; and to work towards a world free from torture.

To find out more about Freedom from Torture please visit www.freedomfromtorture.org
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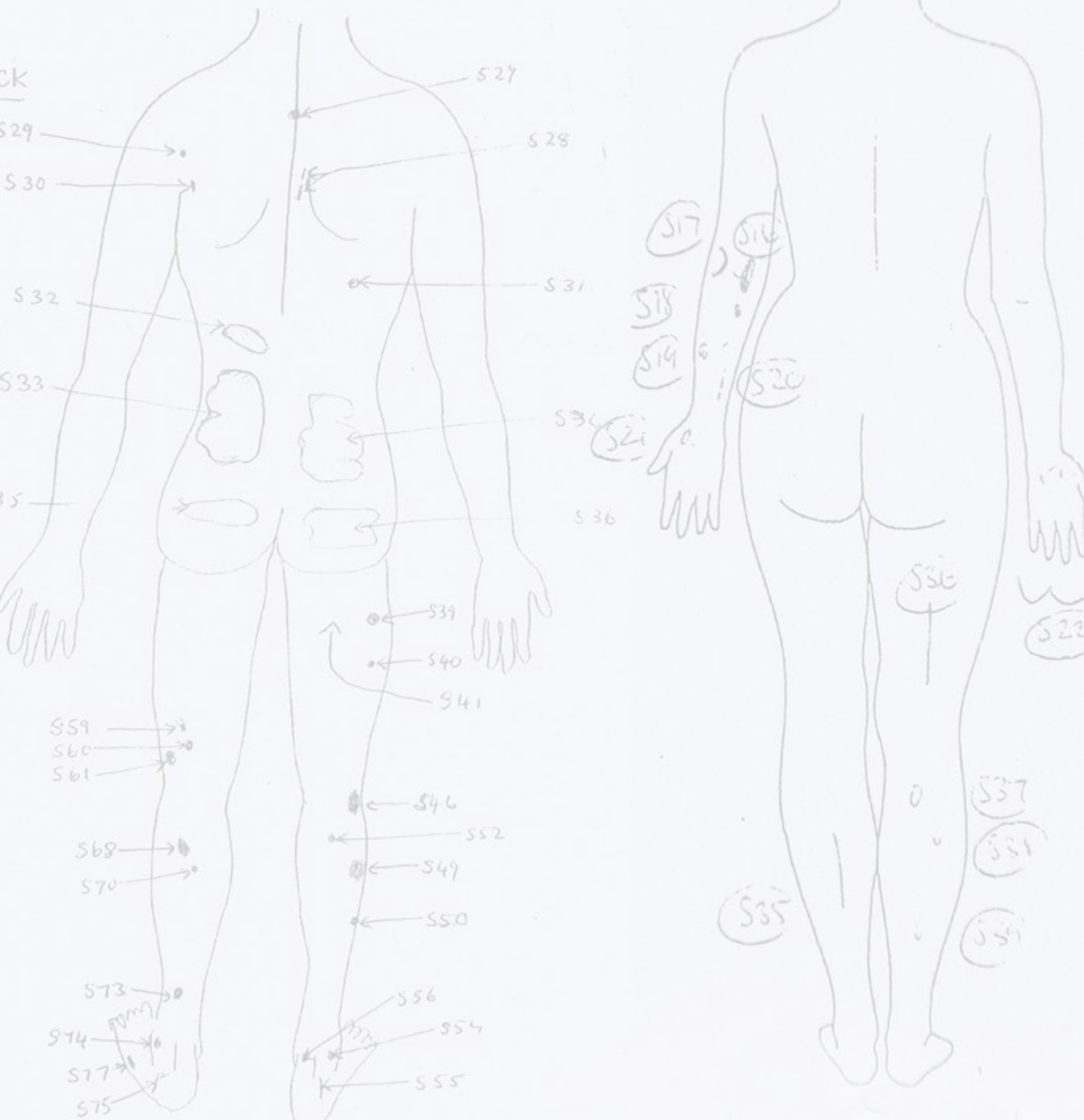


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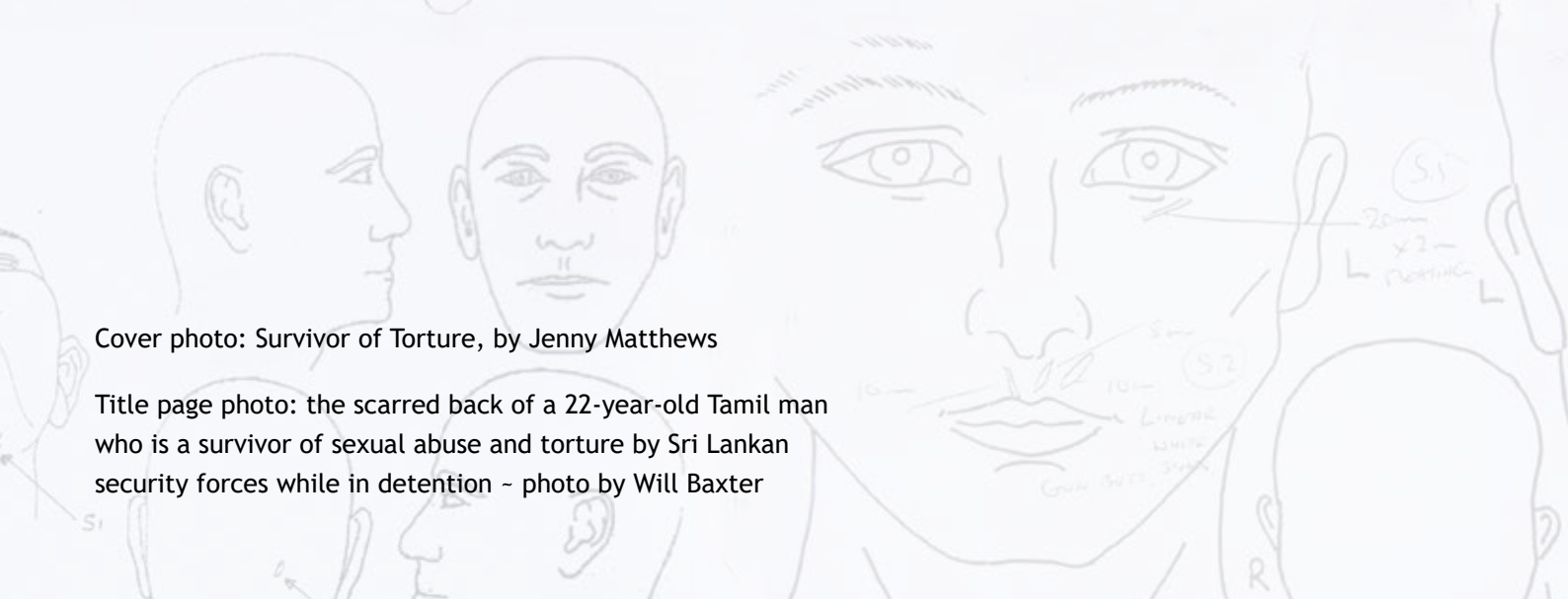
Demanding the impossible

Home Office mistreatment
of expert medical evidence



Cover photo: Survivor of Torture, by Jenny Matthews

Title page photo: the scarred back of a 22-year-old Tamil man who is a survivor of sexual abuse and torture by Sri Lankan security forces while in detention - photo by Will Baxter



Freedom from Torture must be congratulated for this excellent report. It clearly sheds light on what many of us working within the complex field of assessment of torture have been perturbed by for years - seemingly bizarre Home Office decisions in some asylum claims. These are decisions which appear to fly in the face of medical and psychological evidence which has been properly identified, documented and interpreted by those with specific expertise working to internationally accepted standards.

The UN endorsed Istanbul Protocol is a model of multi-professional, robust international consensus providing clear guidelines as to how physical and psychological evidence of torture should be gathered and the findings put in a readily accessible form for any justice system. The clinician's role when undertaking such an assessment is to be 'objective and unbiased', meaning that far from believing everything they are told, in some cases, a clinician may come to the conclusion that a claimant's account is not consistent with the medical findings (in which case the legal representative must decide whether to use the evidence). The role of this assessment is to assist the judicial system to come to the correct decision. In order for that to happen, an appropriate physical or psychological assessment by a trained clinician with appropriate expertise is crucial.

Worryingly, this research finds that in some instances asylum caseworkers in the UK appear to apply the incorrect standard of proof to the claimant's account, not at the 'reasonably likely' level as the law requires, but closer to the criminal standard - 'beyond reasonable doubt'. In part this appears to be due to a lack of understanding that in a medical and psychological setting it is not possible to work in absolutes.

The research additionally shows that some caseworkers are making their own 'clinical' interpretations on matters completely outwith their training or expertise. In any other court or tribunal setting, a similar pattern of such practices would be scandalous. Any professional crossing these sorts of lines would be open to serious sanction from their

professional body. A doctor or other healthcare professional acting in this way could risk having their professional registration withdrawn.

These mistakes can have dangerous end results including, in the worst case scenario, wrongful return of a torture survivor to further torture. Even if an appeal is made, and is successful, these individuals may be further traumatised by the prolonged and stressful appeal process.

The absence of appropriate training by the Home Office for asylum caseworkers may be the cause of this poor decision-making. The training module exists, but has never been rolled out. The obvious question is why not? The answer is not easily forthcoming. Such a training programme would allow asylum caseworkers to understand the reasons why a trained clinician is required to interpret evidence; to understand how the clinician relates their findings to the claimant's account; to understand the evidence levels incorporated within the Istanbul Protocol, and how and why they are applied.

Getting the right decision at an early stage is beneficial not only to those who have suffered torture, but also to a legal process that is substantially compromised by lack of funding. I hope that the Home Secretary will take full account of the findings of the research and the solutions clearly laid out and act on them. If implemented, justice will be better served for those vulnerable individuals who have been subject to torture, with the added benefit of reducing the demands on the taxpayer. This is an opportunity that must not be missed.

Dr Jason Payne-James

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President - Faculty of Forensic & Legal Medicine of the Royal College of Physicians

ACKNOWLEDGEMENTS

This report was researched and written by Jo Pettitt, with research assistance from Emily Wilbourn and Hannah Piggott.

We would first like to acknowledge the 50 survivors of torture who gave consent for us to use their case for the purpose of this research. We thank them for their contribution, without which this work would not have been possible.

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included in the research. Their tireless work has provided the source material for this research.

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Asylum: If someone is at risk of persecution in their own country, they may go abroad and ask for asylum in another country. Granting ‘asylum’ means giving someone permission to remain in another country because of that risk of persecution.

Asylum claimant (asylum seeker): An asylum claimant is someone who has made an application for protection on the basis of the Refugee Convention or other treaties including the European Convention on Human Rights. A person who has applied for asylum in the UK will have their claim processed by the Home Office. While they are waiting for a decision they are known as an asylum claimant or asylum seeker. Someone who has received a positive decision on his or her asylum claim is officially recognised as a refugee.

Asylum caseworker: UK Home Office asylum caseworkers decide whether to grant or refuse an asylum claim. They conduct interviews with asylum claimants and consider the applicant’s account of the risk of persecution they face and any supporting evidence they offer, including medical evidence, in order to decide whether it meets the criteria for granting asylum.

Asylum Policy Instruction: Decisions taken by asylum caseworkers must be compatible with the guidance in the Home Office’s Asylum Policy Instructions, which are published and available online.

Clinical response letter: A letter provided by Freedom from Torture’s Head of Doctors at the request of an asylum claimant’s legal representative when a medico-legal report has been provided by Freedom from Torture and the asylum claim has been refused. The letter responds to the mistreatment of the medical evidence in the asylum decision.

Credibility: The assessment of credibility forms the core of the asylum decision-making process. The caseworker evaluates the truthfulness of the history given by the asylum applicant and their reason for seeking asylum. Given that corroborative evidence is very often lacking in asylum claims, the assessment of credibility based on the internal coherence of the person’s testimony, its external consistency with country of origin information or other forms of objective evidence, and its inherent plausibility, are

at the centre of the asylum decision-making process.

Fresh claim: Further submissions including new evidence can be given to the Home Office at any point after an asylum claim is refused, but a “fresh claim” can only be made when there are no pending appeals in the case. The asylum claimant or their legal representative gives the Home Office further submissions (new evidence or documentation) and the Home Office decides if it qualifies as a fresh claim, using the legal test set out in the Immigration Rules.

Immigration and Asylum Chambers of the Tribunal: In 2010, Immigration and Asylum Chambers were established in both tiers of the Unified Tribunals framework. The chambers replace the Asylum and Immigration Tribunal. The Immigration and Asylum Chambers hear appeals against decisions made by the Home Office in immigration and asylum claims. The Upper Tribunal (Immigration and Asylum Chamber) deals with appeals against determinations made by the First-tier Tribunal (Immigration and Asylum Chamber).

Immigration Judge: Immigration Judges hear cases in the Immigration and Asylum Chambers of the Tribunal. Tribunal judges are responsible for ensuring the individual tribunal hearings they chair reach the correct decision in law.

Istanbul Protocol: The Istanbul Protocol, endorsed by the United Nations, contains the first set of internationally recognised standards for the effective examination, investigation and reporting of allegations of torture and ill treatment. It was primarily developed to support torture prevention by providing states with a tool to document torture in order to hold perpetrators to account through a legal process. However, the use of the Protocol in other contexts, such as asylum procedures, was also envisaged. The UK Home Office has endorsed the use of the Istanbul Protocol in the asylum context, as have the UK courts.

Istanbul Protocol consistency schema: According to the Istanbul Protocol methodology, the clinician documenting evidence of torture should assess the consistency of lesions or other injuries with the attributed cause given by the person, and then describe the level of consistency using the schema

set out at paragraph 187: “(a) Not consistent: the lesion could not have been caused by the trauma described; (b) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes; (c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes; (d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes; (e) Diagnostic of: this appearance could not have been caused in any way other than that described.” At paragraph 188, the Istanbul Protocol states: “Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.”

Medical Foundation: In 2011 the charity Medical Foundation for the Care of Victims of Torture changed its name to Freedom from Torture, but our Medico-Legal Report Service retained “Medical Foundation” in its title due to the high level of recognition of this name among specialist legal service providers and decision-makers at the Home Office and the Tribunal.

Medico-legal Report/Medico-Legal Report

Service: The Medico-Legal Report service at Freedom from Torture produces detailed forensic reports documenting and evaluating physical and psychological injuries attributed to torture. The purpose of the medico-legal report is to assist decision-makers in individual asylum applications, and for these purposes Freedom from Torture report writers act strictly as independent experts. Legal representatives refer people to Freedom from Torture if they consider there may be evidence of torture that can be documented in a medico-legal report as part of an asylum application. The Medico-Legal Report Service at Freedom from Torture has been accepted by the UK Home Office in an Asylum Policy Instruction as “having recognised expertise in the assessment of the physical, psychological, psychiatric and social effects of torture.”

Post-traumatic stress disorder: An anxiety disorder precipitated by an experience of intense fear or horror while exposed to a traumatic (especially life-threatening) event. The disorder is characterised by intrusive recurring thoughts or images of the

traumatic event; avoidance of anything associated with the event; a state of hyperarousal and diminished emotional responsiveness. These symptoms are present for at least one month and the disorder is usually long-term.

Reasons for Refusal letter (RFRL, refusal letter): If a decision is taken to refuse asylum after substantive consideration of the claim, the Home Office caseworker drafts a reasons for refusal letter. This should clearly set out the reasons why the asylum application is refused.

Self-infliction by proxy: In recent years, it has become more common for asylum caseworkers to allege that scarring could have been inflicted by the asylum claimant, or at their behest by a third party, as a means of fabricating torture evidence for the purpose of bolstering an asylum claim.

Standard of proof: A low standard of proof (“reasonable degree of likelihood”) applies to asylum claims, since the implications for the person of a wrong decision are potentially so serious - a real risk of torture, other types of persecution or even death if they are forced to return to the country they fled from. This contrasts with criminal cases, where the far higher standard of proof (“beyond reasonable doubt”) is intended to minimise the risk of innocent people being deprived of their liberty due to a wrong decision.

TABLE OF CONTENTS

KEY POINTS	9
INTRODUCTION	11
2.1. About Freedom from Torture’s Medico-Legal Report Service	16
2.2. The Istanbul Protocol	16
2.3. Home Office policy on the treatment of medical evidence of torture	18
RESEARCH FINDINGS	19
3.1. Standard of proof and weight of expert medical evidence	19
Role of the decision-maker and standard of proof	19
Findings: standard of proof and weight of expert medical evidence	20
Case examples: standard of proof and weight of evidence	21
3.2. Substitution of opinion or a clinical judgment	22
Asylum Policy Instruction	22
Findings: Substitution of opinion or a clinical judgment	23
Case examples: Substitution of subjective opinion and clinical judgment by the asylum caseworker	26
3.3. Qualifications and expertise to document physical and psychological consequences of torture	28
Qualifications and expertise of medico-legal report authors at Freedom from Torture	28
Asylum Policy Instruction	29
Findings: Qualifications and expertise to document physical and psychological consequences of torture	30
Case examples: Qualifications and expertise to document the consequences of torture	31
3.4. The assessment of credibility and use of the expert medical evidence	32
Assessment of credibility	32
Role of the medical expert	33
Assessment of credibility in practice	33
Findings: Assessment of credibility and use of the expert medical evidence	34
Case examples: Assessment of credibility and use of the expert medical evidence	36
3.5. Medico-legal report methodology and interpretation of the findings	38
Findings: Medico-legal report methodology and interpretation of the findings	38
Case Examples: Medico-legal report methodology and interpretation of findings	43
CONCLUSION	47
RECOMMENDATIONS	51
ANNEX 1: RESEARCH METHOD	53
Context and aim of the research	53
Case set	53
Research method	54
Data analysis	54

ANNEX 2: DESCRIPTION OF THE CASE SET

55

Demographic profile

55

Stage of the asylum claim

56

Type of medico-legal report, author and issuing centre

56

Home Office decision-makers and legal representatives

56

Outcome of asylum claim

57

Findings for sub-groups of cases

58

Case study 1: Case number 22

61

Ravi's case

61

Case study 2: Case number 35

65

Ali's case

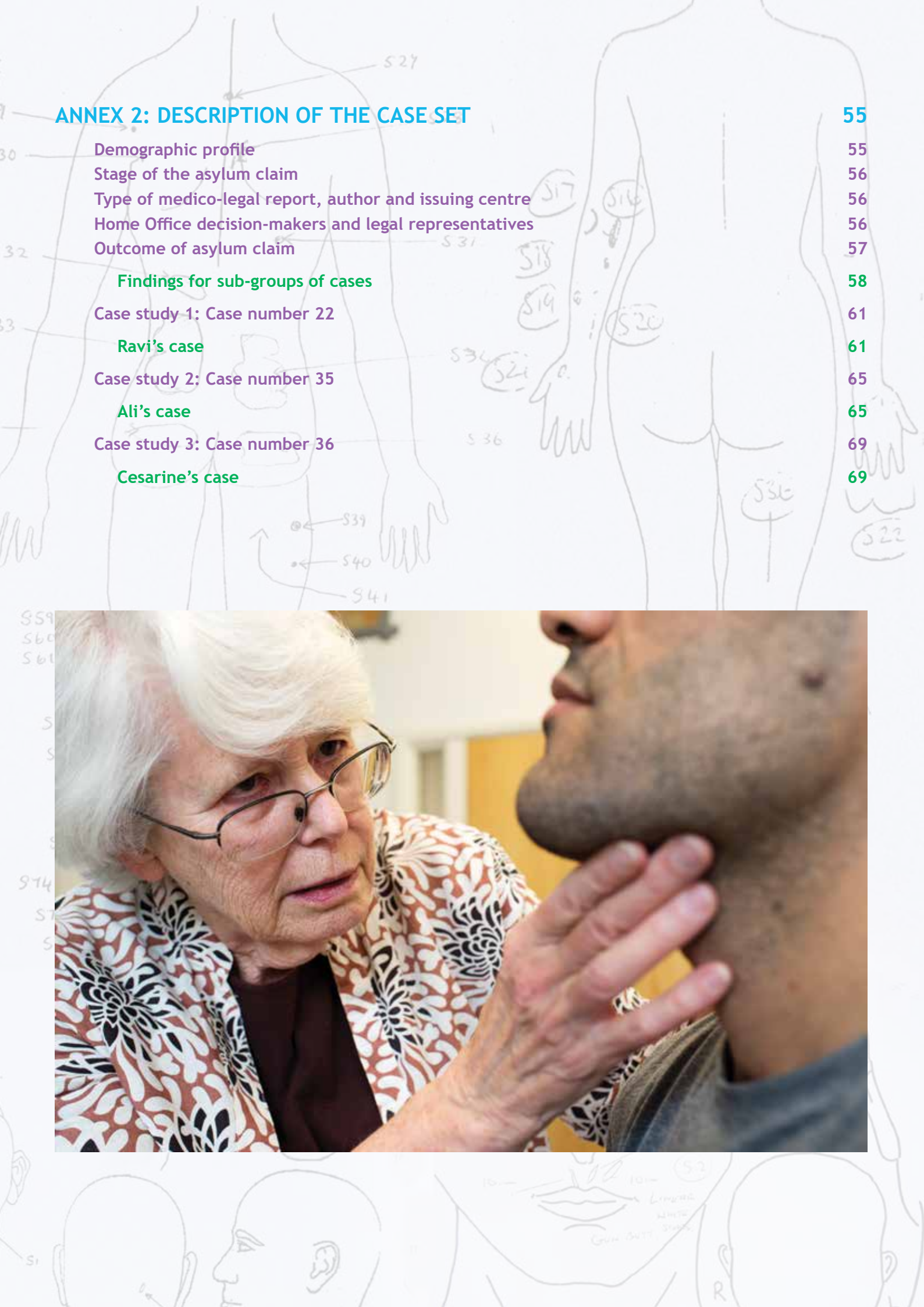
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Case study 3: Case number 36

69

Cesarine's case

69



KEY POINTS

Survivors seeking asylum in the UK can find it almost impossible to prove to the Home Office that they were tortured

This happens even when they present extensive expert medical evidence, which is often disregarded or mistreated

The Home Office frequently demands a level of certainty in this evidence that is unattainable, going far beyond the legal standard of proof that applies to asylum claims

Being disbelieved and having their medical evidence mishandled can be catastrophic for torture survivors

They know that when the wrong decision is made, they could be forced to return to further torture

Harrowing legal appeals also prolong their psychological trauma which impedes their chances of rehabilitation and social integration

Too many Home Office decisions with medical evidence of torture are poor and have to be corrected by judges - at considerable cost to tax payers

In 76% of cases in our research for which the final outcome is known, the person was granted asylum following a successful legal appeal

The average success rate for asylum appeals is 30%

This indicates a serious problem with Home Office handling of asylum claims by torture survivors

Asylum caseworkers without any clinical qualifications often replace the expert opinion of a medical doctor with their own speculation about clinical matters

Our research suggests that many asylum caseworkers see medical evidence as an obstacle to be "got around" in justifying why the asylum claim should be refused

This undermines basic principles of British justice

This bad practice contravenes a clear Home Office policy on how to handle expert medical evidence of torture

The problem is that this policy is poorly implemented

The Home Office has an excellent training programme to help caseworkers implement it correctly but has never rolled this out

“ My concern for safety was very real. Any more delay and the window of opportunity would close. I couldn't stop to collect evidence to prove my age, to prove that I am fleeing from torture to save my life, to prove that I was coming from this particular country, to prove that I was who I said I was

Member of the Survivors Speak OUT network¹

“ It is so hard, waiting for the medico-legal report, knowing that it is the only way you can prove what has happened to you, and at the end, if it is not believed, it adds so much stress to your mental state; you lose all hope. You know that there is nothing more you can do about your case because there is no other way for you to prove that you have been tortured

Member of the Survivors Speak OUT network

INTRODUCTION

It is a significant challenge for asylum claimants to provide evidence to support their application for international protection and to demonstrate that their stated fear of persecution in their home country is well-founded.

People rarely have access to documentation that proves they have been detained and ill-treated by state authorities, and flight from their home country may have been chaotic and unplanned. The journey to the country where they seek refuge may have been in the hands of people smugglers who routinely confiscate and retain documents that could prove identity, nationality or other aspects of the person's claim.

In refugee status determination the burden of proof falls on the asylum claimant to establish why they need protection.² However, given the grave implications of getting a decision wrong - torture, other types of persecution or even death if they are forced to return to the country they fled from - the standard of proof is relatively low, compared with criminal or even civil proceedings. The standard is described as "a reasonable likelihood" and, according to UK case law, applies to all factual aspects of an asylum claim, in which both past persecution and future risk of persecution need to be demonstrated.³

Home Office Asylum Policy Instruction on assessing credibility

"The level of proof needed to establish the material facts is a relatively low one - a reasonable degree of likelihood - and must be borne in mind throughout the process. It is low because of what is potentially at stake - the individual's life or liberty - and because asylum seekers are unlikely to be able to compile and carry dossiers of evidence out of the country of persecution" (5.2)

In the UK, asylum claimants give oral testimony in an interview with a Home Office asylum caseworker, in which they must explain in detail how they have been treated in the past and substantiate their fear of further persecution in the future, if returned to their

home country. This primary evidence is considered in light of what is known about their country of origin. Asylum caseworkers refer to country of origin information and guidance produced by the Home Office concerning the human rights record of the country and the treatment of people with a similar profile to the claimant to assess the plausibility of their claim, the credibility of their testimony and whether they might be at risk in the future. However, this information is rarely specific to the person.

For those who claim to have been tortured in the past there is an additional form of evidence that may be submitted to the Home Office - a medico-legal report. These expert reports document for the individual claimant any physical and psychological evidence of torture, in accordance with internationally accepted guidelines and standards set out in the United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment known as the Istanbul Protocol⁴, and give an expert opinion on the consistency between this clinical evidence and the person's account of torture.

For these purposes, the clinician who produces the medico-legal report must comply with the duties of an independent expert. This means, among other things, that they must not simply accept the account given to them by the claimant and must thoroughly and objectively assess this account in line with their clinical experience and these international guidelines and standards.

In the UK an applicant's legal representative may submit a medico-legal report to the Home Office at the initial stage of the asylum decision-making process or as part of further submissions for a new asylum application (known as a "fresh claim"). A report may also be submitted for an appeal, should the asylum claim be refused at the initial stage, and will be considered by an Immigration Judge in the Immigration and Asylum Chamber of the Tribunal.

It is for decision-makers to decide how much weight to give this evidence in accordance with policy guidance (see section 3.1 below), but a medico-legal report may be very helpful where there is little else available to substantiate the factual elements of a

claim, and given that the effects of torture may make it particularly difficult for survivors to give evidence that is coherent and comprehensive within the setting of an interview with a Home Office caseworker.

Freedom from Torture operates one of the largest and most well-respected forensic torture documentation services in the world, known as the Medical Foundation Medico-Legal Report Service.⁵ Each year, our specialist clinicians (mainly doctors) produce medico-legal reports for hundreds of torture survivors for consideration as part of their asylum claim.

In recognition of our expertise and in response to evidence of the poor treatment of medico-legal reports by asylum caseworkers, demonstrated by a very high overturn rate of 69% on appeal⁶, the Home Office issued an Asylum Policy Instruction in January 2014 setting out how medical evidence from the Medico-Legal Report Service at Freedom from

Torture (and the Helen Bamber Foundation) should be treated.⁷ An excellent training programme was designed to help caseworkers implement this policy correctly, but unfortunately it was not rolled out⁸, and there has been no systematic monitoring of compliance with the Asylum Policy Instruction over the intervening years.

Evidence from this research shows that poor treatment of expert medical evidence by asylum caseworkers persists, signified by an even higher decision overturn rate of 76% on appeal for cases included in the research, involving asylum claims for which we prepared a medico-legal report that were refused by the Home Office between January 2014 and December 2015 (see Annex 2, Outcome of Asylum claim).

CONTEXT

Europe is in the midst of the largest refugee crisis in history. Many of those on the move as part of these flows are survivors of torture, although there are many reasons why they may be reluctant to disclose this during their journey.⁹ Some eventually arrive in the UK and seek protection via our national asylum system.

The precise number of torture survivors seeking protection in the UK is unknown. The Home Office does not collect statistics on the number of asylum claims involving torture allegations. A recent study suggests that 27% of adult forced migrants living in high-income countries like the UK are survivors of torture.¹⁰

Survivors of torture require specialist care and support upon arrival in the UK. Many have complex physical, psychological, social and legal needs arising from their torture and their often prolonged and dangerous journey to safety.

According to the National Audit Office, 55% of the Syrian refugees who have been given protection in the UK under the Syrian resettlement programme are survivors of torture and/or other forms of violence.¹¹ They have been prioritised by the UK government because of their high levels of vulnerability and the opportunities this country can provide to help them rehabilitate.

By contrast, survivors of torture who arrive in the UK by their own means often face a long and painful struggle to secure protection. Survivors in treatment at Freedom from Torture consistently say that securing legal status quickly through the asylum system is the most significant problem they face. While there is often a long road to recovery ahead, the sense of security gained from refugee status or

another form of legal protection is a fundamental basis from which a survivor can begin to heal, move on with their lives and contribute positively to their new community here in the UK.

In order to secure legal protection, an asylum claimant must provide evidence to support their case. Those who claim to have been tortured may submit a medico-legal report documenting physical and/or psychological evidence of torture and providing an independent clinical opinion on the consistency between this evidence and the claimant's account of torture.



Espen Rasmussen/Panos

Pressures from within the asylum system have led to the production of much longer, more detailed medico-legal reports. Yet, as this research shows, these reports are frequently mishandled by asylum caseworkers.

Over the years, the length of our medico-legal reports has risen steadily from approximately five pages in the 1990s to approximately 20 pages in 2016. These highly detailed reports require significant resources to produce. This in itself reduces the number of cases for which we are able to prepare this expert evidence while also slowing down the asylum decision-making process for the Home Office.

This research examines in detail 50 asylum claims that have been refused by asylum caseworkers at the initial decision stage, to gain a better understanding of how medico-legal reports produced by Freedom from Torture's Medico-Legal Report Service have been treated since the policy instruction was issued in 2014. Home Office "Reasons for Refusal" letters issued to asylum claimants are systematically analysed alongside the medico-legal reports that were available to asylum caseworkers and in light of accepted international standards for the documentation of torture set out in the Istanbul Protocol and the Home Office policy instruction. Appeal determinations, where these were available, have also been reviewed in order to understand the

basis on which initial decisions were overturned, as far as this relates to the treatment of the medical evidence.

The evidence set out in this report demonstrates that serious deficiencies in the treatment of medico-legal reports by asylum caseworkers persist, and that internal processes of scrutiny and quality control at the Home Office do not correct these errors at the initial decision stage. This leads to lengthy legal appeals, which are costly to the public purse and subject already vulnerable people to a protracted and often traumatic legal process in which their personal integrity and credibility continue to be subject to question and doubt.

KEY FINDINGS

The research highlights recurring and systematic errors in Home Office handling of expert medical evidence of torture resulting in a very high rate of decisions overturned on appeal, with the claimant eventually being granted asylum.

76% of cases in the research where the final outcome is known resulted in a grant of asylum following a successful legal appeal.

Particular examples of poor handling of medical evidence highlighted in the research include:

- **Asylum caseworkers fail to apply the correct standard of proof for asylum claims**

100% of cases in the research, on the face of it, involve the asylum caseworker failing to apply the appropriate standard of proof to establish a past history of detention and torture

- **Asylum caseworkers replace the expert opinion of a clinician with their own opinion on clinical matters or make clinical judgments beyond their qualifications**

74% of cases in the research involve the asylum caseworker substituting their own opinion for that of the clinician on the cause of injuries

- **Asylum caseworkers wrongly question the clinical expert's qualifications and expertise in the documentation of torture**

30% of cases in the research involve the asylum caseworker disputing or questioning the qualifications and expertise of the clinician

- **Asylum caseworkers take the wrong approach to medical evidence when assessing the credibility of the asylum claim**

84% of cases in the research involve the asylum caseworker dismissing the medical evidence because they have already reached a negative credibility finding

- **Asylum caseworkers misunderstand the internationally agreed torture documentation methodology and/or the clinical interpretation of findings**

54% of cases in the research demonstrate poor understanding by the asylum caseworker of how the Istanbul Protocol applies to torture claims

As Freedom from Torture's 2013 report "*The Poverty Barrier*"¹² finds, torture survivors commonly remain in the asylum system for many years until they are finally granted refugee status, during which time they are not permitted to support themselves and remain dependent on support from the Home Office, in often precarious and impoverished circumstances. The report documents the negative impact of these delays on torture survivors' prospects for rehabilitation from

torture, with the result that many people experience a deterioration in their mental health while waiting for their claim for asylum to be processed. They may then face long-term dependency on the state, despite their strong wish to find security and recover their strength and independence as soon as possible, so as to become active and productive members of our society in which they seek refuge.¹³

KEY RECOMMENDATIONS

1) **The Home Secretary should order immediate measures to improve decision-making in asylum cases involving medical evidence of torture, starting with the roll-out to all asylum caseworkers of the full day training module which the Home Office developed but never launched.**

Leadership from the Director of Asylum Operations and asylum casework managers is essential as a means of ensuring this training translates into asylum decisions for torture survivors that are "right the first time".

This leadership should involve regular communications to senior caseworkers and caseworkers about the importance of improved decision-making in cases involving medical evidence of torture, reinforced by systems - including routine oversight, quality audits of decisions and remedial action if problems continue - capable of demonstrating to Ministers, Freedom from Torture and other stakeholders whether practice is improving or not.

2) **An independent public audit should be undertaken by a body with the requisite legal expertise, such as the UN High Commissioner for Refugees, into the application in practice of the standard of proof in asylum claims in the UK, including cases involving expert medical evidence of torture.**

This independent public audit should enjoy the full cooperation of the Home Office. Survivors of torture, those with experience of providing expert evidence in asylum claims and legal and other civil society organisations in the refugee field should be among those given an opportunity to provide evidence.

A full set of recommendations is available at section 5 below.

For information about the research method and a detailed analysis of the case set, please refer to Annexes 1 and 2 at the end of the report.

2.1. About Freedom from Torture's Medico-Legal Report Service

The Medico-Legal Report service at Freedom from Torture produces detailed forensic reports documenting and evaluating physical and psychological injuries attributed to torture. The purpose of the medico-legal report is to assist decision-makers in individual asylum applications, and for these purposes Freedom from Torture report writers act strictly as independent experts. Legal representatives refer people to Freedom from Torture if they consider there may be evidence of torture that can be documented in a medico-legal report as part of an asylum application.

The Medico-Legal Report Service at Freedom from Torture has been accepted by the UK Home Office in an Asylum Policy Instruction, as *“having recognised expertise in the assessment of the physical, psychological, psychiatric and social effects of torture.”*¹⁴

Referrals are accepted if they meet the selection criteria: the person describes experiences within our remit of torture; they are likely to have physical or psychological evidence attributed to torture to examine and the documentation of torture is likely to make a material difference to the asylum claim. Reports are prepared in five Freedom from Torture centres around the UK by trained, specialist clinicians according to standards set out in the Istanbul Protocol.

The torture documentation process includes reviewing documents related to the asylum application, taking a history as narrated by the person, and assessing the history in relation to clinical findings in accordance with the standards set out in the Istanbul Protocol and Freedom from Torture's own methodology.¹⁵

Clinical findings are obtained through a full physical examination, including an assessment of physical symptoms and the observation and documentation of all lesions, a full mental state examination and the documentation of psychological symptoms and signs of torture. Previous clinical diagnoses and treatment of physical or psychological ill health arising from torture, where known, are also considered as part of

the overall clinical assessment. Lesions attributed to torture are differentiated - by the person themselves and independently by the doctor - from those with a non-torture attribution such as accidental injury, self-harm or a medical intervention such as surgery.

The consideration of the likelihood of other possible causes for physical lesions and the psychological findings is integral to the process of providing the expert opinion. Clinicians are also required, as per the standards set out in the Istanbul Protocol and recognised in the Home Office Asylum Policy Instruction on medico-legal reports, to consider the possibility of fabrication in assessing the narrative given. In reaching their conclusions they will seek to establish the degree of congruence between the narrative; other available evidence, including that given in the protection claim (such as physical evidence of torture or any diagnoses or treatment from other healthcare professionals); and the psychological presentation, including giving any clinical explanation for inconsistencies.

2.2. The Istanbul Protocol

The Istanbul Protocol, endorsed by the United Nations, contains the first set of internationally recognised standards for the effective examination, investigation and reporting of allegations of torture and ill treatment. It was primarily developed to support torture prevention by providing states with a tool to document torture effectively in order to hold perpetrators to account through a legal process, for which the *“highest level of proof”* is required. However, the use of the Protocol in other contexts, such as asylum procedures, was also envisaged, for which a *“relatively low level of proof of torture”* is required (paragraph 92). The UK Home Office has itself endorsed the use of the Istanbul Protocol in the asylum context¹⁶, as have the UK courts.¹⁷

To formulate a clinical opinion for the purpose of reporting evidence of torture, the Istanbul Protocol states that the doctor (or other clinician) should question whether the physical and psychological findings of the clinical examination are consistent with the attributed cause of torture, taking into account the overall clinical picture, the cultural

and social context of the person, the time frame of the alleged events and other stress factors potentially affecting the person (paragraph 105). A medical evaluation should be objective and impartial and based on the doctor's clinical expertise and professional experience. Furthermore, clinicians who conduct these evaluations should have specific training in the forensic documentation of torture (paragraph 162).

The Istanbul Protocol gives detailed guidance on the documentation and evaluation of specific forms of torture, and recommends, for physical lesions, at paragraph 187, that for *"each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient"*. In the same paragraph it is recommended that the following schema be used to describe this:

"(a) Not consistent: the lesion could not have been caused by the trauma described;

(b) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;

(c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes;

(d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes;

(e) Diagnostic of: this appearance could not have been caused in any way other than that described."

Importantly, at paragraph 188, the Istanbul Protocol states: *"Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story."*

The Protocol also recommends that the documentation process include a psychological

evaluation, since this can provide *"critical evidence of abuse among torture victims"*. This is important evidence, both because *"torture often causes devastating psychological symptoms"* and because *"torture methods are often designed to leave no physical lesions and physical methods of torture may result in physical findings that either resolve or lack specificity"* (paragraph 260).

The goal of the psychological evaluation is to assess *"the degree of consistency between an individual's account of torture and the psychological findings observed"* and it should include an assessment of social functioning as well as clinical impressions (paragraph 261). Relevant to this assessment is the *"emotional state and expression of the person during the interview, his or her symptoms, the history of detention and torture and the personal history prior to torture..."* Additional factors such as the difficulties endured by the person due to their forced migration and resettlement should be described and taken into account (paragraph 288).

The Protocol recommends that a relevant psychiatric diagnosis should be made, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or International Classification of Diseases (ICD-10), if the person has symptom levels consistent with it. However it is also emphasised that if a survivor of torture does not have symptom levels required to fully meet diagnostic criteria, it should not be assumed that the person was not tortured.¹⁸

At paragraph 290, the Istanbul Protocol states that that the clinician should carefully evaluate consistencies and inconsistencies, including the possibility of fabrication or exaggeration of the account of torture, while bearing in mind that inconsistencies in testimony can occur for many reasons, including *"... memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time or fragmentation and repression of traumatic memories."*

2.3. Home Office policy on the treatment of medical evidence of torture

The Asylum Policy Instruction, “Medico-Legal Reports from the Helen Bamber Foundation and the Medical Foundation¹⁹ Medico-Legal Report Service”, states unequivocally that the Home Office accepts the expertise of Freedom from Torture in the assessment of torture. It also recognises that our clinicians are “*objective and unbiased*” and that medico-legal reports we produce “*should be accepted as having been compiled by qualified, experienced and suitably trained clinicians and health care professionals.*”²⁰

Asylum caseworkers are instructed to accept reports from experts who provide details of their qualifications, training and experience and “*if the report has been compiled using the standards and terms employed by, for example, the Istanbul Protocol*” (3.1). They are advised to take great care when assessing expert medical evidence, which should be “*understood fully, and given proper weight in the consideration process*” (3.3). The opinion of the medical expert with regard to the “*degree of consistency between the clinical findings and the account of torture or serious harm*” should be given “*due consideration ... on the understanding that this does not impinge on the caseworker’s duty to make an overall finding on credibility*” (3.3). Asylum caseworkers are further informed that they can assume clinicians at Freedom from Torture will consider the possibility of a false allegation of torture, since this is a requirement of the Istanbul Protocol and an integral part of their methodology, as noted above (3.3).

The Asylum Policy Instruction states that medico-legal reports are “*expert evidence*” and that the role of these reports is not simply to “*report on the credibility of a claim of torture*”, but also to present and evaluate additional information related to the claimed history of torture that the person has not previously disclosed (3.3). An additional Asylum Policy Instruction issued in 2015 dealing with the assessment of credibility states that “*underlying factors*” may lead to inconsistencies in testimony and late disclosure of evidence:

“*A true account is not always detailed or consistent in every detail. Caseworkers must take into account any personal factors, which may explain why a claimant’s testimony might be inconsistent with other evidence, lacking detail, or there has been late disclosure of evidence. These factors may include (the list is not exhaustive): age; gender; variations in the capacity of human memory; physical and mental health; emotional trauma; lack of education; social status and cultural traditions; feelings of shame; painful memories, particularly those of a sexual nature ... The barriers to disclosing sexual violence include shame and avoidance of past horrors, and a claimant’s oral testimony may not be a complete chronological narrative ...*”²¹

It is therefore clear from policy guidance that the introduction of new information in a medico-legal report, compared with the information given by the person during the asylum interview or elsewhere, should not in and of itself count against the credibility of the person, simply on the basis that discrepancies exist. In fact, it is one of the functions of the medico-legal report to address any inconsistencies in the account related to the claimed torture, in light of the clinical evidence in the round.

With regard to the standard of proof and weight to be attached to the medical evidence when assessing the overall claim, the Asylum Policy Instruction on medico-legal reports states the following: “*The Protocol, the central importance of which is accepted by the UK courts in the asylum context, makes clear that reports which document and evaluate a claim of torture for asylum proceedings need only provide ‘a relatively low level of proof of torture [or serious harm]’. Therefore, the Foundations’ report in support of the applicant’s claim of torture or serious harm cannot be dismissed or little or no weight attached to them when the overall assessment of the credibility of the claim is made*” (3.3).

RESEARCH FINDINGS

QUALITY OF DECISION-MAKING

Research findings related to key elements of decision-making practice in asylum cases involving medical evidence of torture have been categorised (see Annex 1, Method) and are presented as follows:

- The application by asylum caseworkers of the correct standard of proof and assessment of the weight of expert medical evidence;
- The use of subjective opinion and clinical judgments by asylum caseworkers on matters for which the clinician has stated an expert opinion;
- Questioning by asylum caseworkers of the qualifications and expertise of medico-legal report authors to document the physical and psychological consequences of torture;
- The assessment by asylum caseworkers of credibility and use of the expert medical evidence; and
- Asylum caseworkers' understanding of the medico-legal report methodology and interpretation of the clinical findings.

3.1. Standard of proof and weight of expert medical evidence

This section is focused on asylum caseworkers' approach to the application of the standard of proof for asylum claims and the weight given to expert evidence. The role of the decision-maker and the standard of proof for asylum claims are discussed below. This is followed by findings from the research, including case examples. The incidence of specific problems in the application of the standard of proof by the asylum caseworker and the assessment of how much weight to give the medical evidence have been reviewed in light of Home Office guidance and the Istanbul Protocol.

Role of the decision-maker and standard of proof

It is the task of the decision-maker to establish all the material facts of an asylum claim on the basis of the available evidence, as part of the process of assessing the overall credibility of the claim (for further analysis of the assessment of credibility, see section 3.4 below). Material facts include those surrounding a claimed history of detention and torture that would establish if the claim falls within the provisions of the Refugee Convention and other treaties giving rise to protection obligations, including the European Convention on Human Rights, and the likelihood of the person facing a risk of further torture or other persecution on return to their home country. However, the level of proof needed to establish such facts in the asylum context is relatively low compared with civil and criminal standards - it is only a "reasonable degree of likelihood".

"Standard of proof"

A low standard of proof ("reasonable degree of likelihood") applies to asylum claims, since the implications for the person of a wrong decision are potentially so serious - a real risk of torture, other types of persecution or even death if they are forced to return to the country they fled from.

This contrasts with criminal cases, where the far higher standard of proof ("beyond reasonable doubt") is intended to minimise the risk of innocent people being deprived of their liberty due to a wrong decision.

The Asylum Policy Instruction on medico-legal reports states that, in accordance with the Istanbul Protocol, "reports which document and evaluate a claim of torture for asylum proceedings need only provide a relatively low level of proof of torture [or serious harm]" ..., and that such reports "cannot be dismissed

or little or no weight attached to them when the overall assessment of the credibility of the claim is made”.

Asylum caseworkers are instructed not to argue that “no weight can be applied to the report”, and to state clearly the reasoning behind the rejection of an allegation of torture or serious harm (3.3). The Home Office’s 2015 Policy Instruction on Assessing Credibility and Refugee Status confirms the low level of proof and reminds asylum caseworkers that it should be borne in mind throughout the process. This Policy Instruction states that if the evidence provided by the person “indicates that the fact is ‘reasonably likely’, it can be accepted” (5.2). This lower standard of proof applies to a medico-legal report, just as it does to the evidence as a whole.

Home Office Asylum Policy Instruction on assessing credibility

“... A caseworker does not need to be ‘certain’, ‘convinced’, or even ‘satisfied’ of the truth of the account - that sets too high a standard of proof. It is enough that it can be ‘accepted’” (5.2).

Findings: standard of proof and weight of expert medical evidence

The overall consideration of the expert medical evidence in these 50 asylum claims is strikingly poor with caseworkers in all cases, on the face of it, failing to give appropriate weight to the evidence contained in the medico-legal report and failing to apply the appropriate standard of proof required to establish a past history of detention and torture.

While not all the asylum claims of the cases in the research have been concluded, a significant proportion have been decided (29 cases, 58%, have a positive decision or a negative decision with no further legal action at present), of which the overwhelming majority have been allowed on appeal (22 cases, 76%, see Annex 2, Outcome of the asylum

claim). Consideration of the weight given to the evidence and application of the correct standard of proof were specifically referred to in the judicial determination in many of these cases.

Of overarching concern is the apparently widespread assumption by asylum caseworkers that lesions assessed as anything less than “diagnostic” of torture by the doctor (no other possible causes), using the Istanbul Protocol consistency schema (see above), have little or no significance as evidence of torture. Asylum caseworkers argue that since the cause of the injuries has not been categorically proved to be torture (with other causes definitively ruled out), and since other possible causes of the injuries exist, even if the doctor has explored them and deemed them to be a less likely cause, the evidence carries little or no weight. This is grossly inconsistent with the standard of proof, and the Asylum Policy Instruction, which makes it clear that the low standard of proof applies to the consideration of the medical evidence as well as to the whole claim. Moreover, such definitive conclusions are generally unusual in forensic medicine.

Even lesions that are assessed to be “consistent” with torture according to the Istanbul Protocol schema are evidence of torture that should be given due consideration. When, as is usual, there is additional evidence in the form of lesions assessed with a higher level of consistency according to the Istanbul Protocol schema, and psychological evidence demonstrably linked to the reported history of torture, the medico-legal evidence as a whole should be considered sufficient evidence of torture according to the low standard of proof and given evidential weight. As stated in the Asylum Policy Instruction: “... Caseworkers ... need to bear in mind that the standard of proof is that of a ‘reasonable degree of likelihood’ which is lower than ‘the balance of probabilities’. The Foundations will not produce reports unless there is clinical evidence that is at least ‘consistent with’ the claimant’s account of torture or serious harm according to the terms used in the Istanbul Protocol.”²²

Note that many of the other decision-making problems identified below contribute to the misapplication by caseworkers of the standard of proof in particular cases and/or raise more general questions about the approach taken to the standard of proof in the UK asylum jurisdiction. Of particular relevance are poor practice in the assessment of the claimant's credibility (see section 3.4) and the increasing tendency for asylum caseworkers to allege that scarring could have been inflicted by the asylum claimant, or at their behest by a third party, as a means of fabricating torture evidence for the purposes bolstering an asylum claim (see section 3.5).

Case examples: standard of proof and weight of evidence

- i) Case 19 (weight of evidence, standard of proof)

Home Office written reasons for refusing asylum:

*"... In considering the medical evidence provided it is accepted that your injuries are consistent with that of being beaten and from [form of torture] as per Dr *'s findings ... It is not accepted that your injuries were inflicted ... by the security services in [country of origin] ..."*

"... When considered in the round, little weight is attached to the report and it is considered that it does not allow the Secretary of State to depart from the Immigration Judge's findings referred to in your Appeal Determination ... It is therefore not accepted that your injuries are the result of ill-treatment by the security services in [country of origin] ..."

The medico-legal report provides a lengthy account of the person's experiences in detention and elsewhere and the doctor's assessment of the relative impact of these different experiences on the person's health. Nineteen scars were found to be highly consistent with the torture described and the psychological evidence was linked to the traumatic experiences described. Allowing the appeal, the Immigration Judge made the following findings:

Judge's determination:

*"... It is clear on the psychological evidence not only that of Dr * in the main report ... but other practitioners both before him and since, that the Appellant suffers from [post-traumatic stress disorder] such that his symptoms of disorder are highly consistent with him having previously been a victim of torture. The physical evidence of torture in no less than 19 areas was found to be highly consistent with the torture described. The findings of torture are said to be linked to the psychological evidence. It is not feasible in the circumstances of the medical findings, to attribute causation to an accidental occurrence etc. The force of the evidence suggests ill-treatment.*

"... The standard of proof is to the lower standard and there must be an overall scrutiny of the totality of the evidence... it is shown, particularly bearing in mind the medical findings that the Appellant was a victim of torture."

- ii) Case 7 (standard of proof)

Home Office written reasons for refusing asylum:

*"... You have submitted a report from [Freedom from Torture23] in support of your treatment in detention ... Dr * reports that many of the scars and lesions found on your body are consistent with or highly consistent with your account of ill treatment while detained, while she made a diagnosis of severe depression and symptoms of Post-Traumatic Stress Disorder. Reference is made to the Istanbul Protocol ... Under the Istanbul Protocol the term 'consistent with' means that the lesion could have been caused by the trauma described but it is non-specific and there are many other possible causes, while the term 'highly consistent' means that the lesion could have been caused by the trauma described, but there are few other possible causes. From this it is clear that Dr * has not categorically stated that the scars or lesions on your body were caused in the manner you have claimed, nor could she. Thus whilst a medical report may or may not give an opinion on your physical or psychological condition being consistent with your story, it cannot be considered in isolation*

and cannot normally be regarded as providing by itself, a clear and independent corroboration of your account of how these injuries were sustained. The mere fact of the existence of scars does not, in itself, indicate that the injuries were sustained in the manner you have described ...”

The case was allowed on appeal and the Immigration Judge made the following findings:

Judge’s determination:

“... I have considered all the evidence submitted by the Appellant in this appeal and applied the lower standard of proof to it. Taking into account both the Appellant’s written and oral testimony I find that she is a credible witness.

The evidence of the Appellant supported by the evidence from [Freedom from Torture] established that the Appellant can discharge the burden of proof upon her.”

3.2 Substitution of opinion or a clinical judgment

This section is focused on substitution of subjective opinion by the asylum caseworker for the expert opinion of the clinician, based on the clinical evidence and their expertise; and clinical judgments by the caseworker that they are not qualified to make. Guidance given to asylum caseworkers on this issue through the Asylum Policy Instruction is summarised below. This is followed by findings from the research, including case examples. The incidence of 14 specific decision-making errors involving substitution of opinion or a clinical judgment by asylum caseworkers is recorded in the research. These fall into the following three areas of expert clinical opinion: the link between the clinical evidence and torture; the link between the psychological evidence and credibility issues; and clinical diagnosis of psychological disorders such as post-traumatic stress disorder and depression and the assessment of symptoms.

Asylum Policy Instruction

Because asylum caseworkers are not clinicians, the Home Office Asylum Policy Instruction directs them not to “dispute the clinical findings in the report or purport to make clinical judgements of their own about medical evidence or medical matters generally” (paragraph 3.3). Specific examples of what that might look like are given, and asylum caseworkers are advised to seek the advice of a senior caseworker if in doubt:

“... Examples of clinical judgements that are inappropriate for the caseworker to make include:

- ▶ what in the caseworkers’ opinion ought to be physically possible or survivable;
- ▶ speculation as to alternative causation of physical or psychological injuries;
- ▶ questioning the accuracy of a diagnosis (based on selective quoting of the diagnostic criteria);
- ▶ substitution of the caseworkers [sic] own opinion on late disclosure or discrepancies in the testimony when a clinical explanation has been provided in the [medico-legal report] or
- ▶ speculation with regard to the amount of detail with which a particular traumatic event ought to be remembered.

It is also inappropriate for caseworkers to provide their own subjective opinion either about the applicant’s behaviour, for example the reasons for not having sought or received treatment previously, or for refusing to consent to an examination. Some other examples include:

- ▶ the use of information obtained via the Internet about diagnostic criteria or medication;
- ▶ the use of statements made by an applicant at interview that they ‘feel well’ to subsequently dispute medical problems identified and documented by the Foundation;

► selective quoting from the [medico-legal report] to challenge representations made by the claimant that the report supports when read properly and in its entirety ..." (paragraph 3.3).

What qualifications do asylum caseworkers need?

Asylum caseworkers are not required to have any clinical qualifications. The Home Office requires²⁴ that they have one of the following:

A minimum of two A Levels (A*-E grade) and GCSEs at grade A*-C in both maths and English

OR

Significant experience in a role requiring complex decisions in a regulatory or legislative capacity in a rules based environment, including conducting interviews in order to obtain evidence, analysing evidence, making sound decisions based upon evidence and communicating evidence both orally and in writing.

Findings: Substitution of opinion or a clinical judgment

It was found that asylum caseworkers made errors related to the substitution of clinical opinion with their own subjective judgment in 49 of the 50 cases reviewed (98%). These are examined in detail below.

The link between the clinical evidence and torture

The most prevalent and fundamental problems in this area relate to the assessment of the link between the clinical evidence documented in the medico-legal report and the attributed cause of torture. In the majority of cases (74%), asylum caseworkers disagree

with the opinion of the clinician on the assessment of possible causes other than torture of physical and/or psychological injuries observed and documented in the report.

Figure 1a: The link between the clinical evidence and torture

Substitution of clinical opinion and subjective judgment by asylum caseworker	Incidence	Number of cases
Alternative causation of physical or psychological injuries	74%	37
Assessment of link between the psychological evidence and torture	74%	37
Assessment of link between the physical evidence and torture	58%	29

For the documentation of physical injuries, where it is appropriate to do so according to forensic practice and the Istanbul Protocol, the doctor fully explores other possible causes of injuries indicated by the person's history and/or by the clinical picture. The doctor then states their opinion, based on the totality of the evidence in front of them, on whether or not the cause of torture is more likely. In more than half the cases (58%), asylum caseworkers reject or ignore the detailed assessment of the evidence and substitute their own opinion, which is that other causes mentioned, or other causes altogether, are equally or more likely to have caused the injuries documented in the medico-legal report.

The view of the expert clinician about the link between the psychological evidence - mainly symptoms of post-traumatic stress disorder - and the account of torture given by the person is also rejected by a majority of asylum caseworkers (74% of cases). Caseworkers either offer their own opinion about the more likely cause of psychological symptoms - for example the experience of being a

refugee and living in exile or the breakdown of a relationship - or state that the clinical opinion is entirely reliant on the account given, and thus carries little weight. In both cases, asylum caseworkers fail to engage with the depth of evidence in the medico-legal report exploring the particular psychological symptoms and their link to specific events recalled by the person, together with the other elements of analysis of the clinical picture given by the medico-legal report author. In addition, the defining feature of post-traumatic stress disorder is overlooked, namely that the symptoms arise from the person's experience of a specific traumatic and life-threatening event, and that re-experiencing symptoms such as nightmares, hallucinations, flashbacks and other intrusive recollections link back to that specific event.²⁵ The so-called "ordinary experiences of an asylum seeker" would not amount to this definition of a causal event or be sufficient to cause post-traumatic stress disorder.

The link between the psychological evidence and credibility issues

Other than the issue described above, the most prevalent problem with the treatment of psychological evidence is the substitution of the asylum caseworker's own opinion for the expert clinical opinion in relation to discrepancies and inconsistencies in the information given by the claimant (44% of cases).

Figure 1b: The link between the psychological issues and credibility

Substitution of clinical opinion and subjective judgment by asylum caseworker	Incidence	Number of cases
Discrepancies in the account	44%	22
What is likely to be remembered/other recall issues	30%	15
Reasons for not having sought or received treatment previously	18%	9
Late disclosure of torture	12%	6
Reasons for refusing to consent to an examination	2%	1

Inconsistencies in the details of the claim, for example within a single interview or between the interview record and other statements made by the person, routinely result in asylum caseworkers concluding that the person has not given a credible account of what has happened to them, which seriously undermines their claim for asylum. Despite guidance given in policy instructions and detailed explanations given in medico-legal reports (with reference to relevant scientific literature and to the Istanbul Protocol, paragraphs 142-3), asylum caseworkers frequently choose to reject clinical opinion that provides an explanation of likely reasons for inconsistencies in the way the person recalls events and the late disclosure of torture.

The medico-legal report itself may contain new or different information, including the disclosure of forms of torture not previously mentioned by the person or circumstances surrounding the claimed detention and torture not previously described or remembered differently. In fact, research shows that survivors of torture, particularly sexual forms of torture, can have great difficulty disclosing their experiences, and late disclosure or non-disclosure are

common. This is due to shame and stigma associated with sexual torture and an overwhelming desire to avoid re-living the experience by having to describe the details to another person. For male survivors of sexual torture (usually perpetrated by other men) there can be the added effect of transgression of gender norms, gender identity and cultural taboos, and a fear that the experience may have permanently affected their sexuality.²⁶

It is known that disclosure can be affected by many factors, including the degree of trust and rapport established, the gender of the interviewer and interpreter and the context of the interview, for example interrogatory or medical/therapeutic.²⁷ Even central details of a highly traumatic experience may not be recalled clearly on each occasion that the experience is described, and this can be due to an effect not only of the way in which memories are recalled, but also the specific effect of trauma on memory, especially in a person found to have developed post-traumatic stress disorder. Post-traumatic stress disorder has further adverse effects on the quality and nature of details recalled of the trauma itself. Disclosure will often be more detailed in the relatively therapeutic setting of a medical appointment or in psychological therapy sessions.²⁸

The incidence of caseworkers giving their subjective opinion on a number of other clinical matters was also recorded in the research. Specific examples were caseworkers questioning the credibility of the claim of torture and discounting the psychological evidence of torture given in the medico-legal report on the basis that the person has not sought or received treatment for a psychological condition attributed to torture; or because the person has not consented to an examination, for example of the genital area when rape has been disclosed. Despite Home Office guidance stating that caseworkers should not give their subjective opinion on these specific issues (see excerpt from Asylum Policy Instruction 3.3 cited above), these errors still occurred in ten cases (see figure 1b above), although the incidence was below that of other errors.²⁹

Figure 1c: Clinical diagnosis and the assessment of injuries and symptoms

Substitution of clinical opinion and subjective judgment by asylum caseworker	Incidence	Number of cases
Accuracy of a clinical diagnosis	40%	20
Clinical ability to date injuries in relation to the timeline	20%	10
How much evidence there should be/why there is not more	12%	6
Assessment of the congruence of the timeline with the physical evidence	12%	6
What ought to be physically possible or survivable	8%	4
Change in prevalence of symptoms over time and/or with treatment	2%	1

Despite the Asylum Policy Instruction reminding asylum caseworkers that it is not their role to dispute clinical findings in medico-legal reports, including the accuracy of a clinical diagnosis (3.3), in 40% of cases this error was found.

Most commonly asylum caseworkers give no weight to the considered expert opinion of the clinician that the person is suffering post-traumatic stress disorder, although some examples include various physical disorders. For example, they dismiss a diagnosis of post-traumatic stress disorder given in the medico-legal report on the basis that the person is not reported to be receiving medication or other forms of treatment for the condition. Other examples include the asylum caseworker disputing clinical opinion on the link between the symptoms of post-traumatic stress disorder and the torture described, and

dismissing significant evidence of symptoms of post-traumatic stress disorder on the basis that the doctor has stated that the diagnostic threshold has not been met or on the basis that their diagnosis has not been corroborated by a second clinical opinion.

Six asylum caseworkers (12%) make inappropriate judgments contradicting the clinician's findings with respect to the congruence of the timeline given by the person for events surrounding the claimed torture and the clinical evidence. In some instances, this is based on errors in the calculation of dates or in the dates themselves as represented in the refusal letter. In other instances, the asylum caseworker wrongly disputes the clinician's finding that the timeline is broadly congruent with the physical evidence, on the basis that accurate dating of lesions is not possible given the time lapse between injury and examination.

One asylum caseworker makes a clinical judgment related to changes in the prevalence of symptoms of mental health conditions over time and differences in diagnoses that have been made in the medico-legal report and in other medical documents.

A further four asylum caseworkers (8%) disagree with the clinician's opinion in the medico-legal report on what ought to be physically possible or survivable in the circumstances described by the person. Examples of this include whether a person could have escaped from detention in the manner described given the forms of torture endured, and whether a person could cope with a particular form of employment given the nature of injuries they claim to have sustained.

Six asylum caseworkers (12%) make a clinical judgment in relation to how much and what type of physical or psychological evidence of injury there should be as a result of certain forms of torture, such as beatings with blunt instruments or rape and other forms of sexual violence.

All of these forms of clinical judgment are in contravention of explicit guidance given in the Asylum Policy Instruction.

In relation to how much evidence of torture is likely to be present, the Istanbul Protocol states that not all forms of torture result in physical injuries that leave

enduring lesions, and that the absence or limited nature of such evidence "*should not be construed to suggest that the torture did not occur*" (paragraph 161). Similarly, paragraph 234 states that not all forms of torture have the same psychological impact and that the effects of torture on a person's mental health are different in different individuals; and paragraph 236: "*not everyone who has been tortured develops a recognisable mental illness*".³⁰

Case examples: Substitution of subjective opinion and clinical judgment by the asylum caseworker

- iii) Case 44 (clinical opinion on reasons for discrepancies in the account, causation of psychological symptoms and assessment of physical injuries is disputed)

Home Office further submissions letter:

*" ... Dr * found a number of small marks on your [part of the body] which were consistent with your account of being [form of torture]. However, it is noted that there are a number of other possible causes ... and therefore little weight can be placed on the [medico-legal report] in support of your claim to have been [form of torture] during your detention.*

... It is also considered to negatively impact your credibility that you made no mention of your alleged [form of torture] during detention when given the opportunity to do so on two previous occasions ... Your failure to mention your [form of torture], clearly a central aspect of your alleged torture, is considered a serious discrepancy in your account.

... you omitted to mention any incident of the police cutting your [part of the body] ... and therefore it is considered that you have provided an inconsistent account of your alleged torture and the scars on your [part of the body] could have been a result of another cause.

... It is also noted from the [medico-legal report] that you suffer certain mental health issues, whilst it is accepted that these symptoms may match some of

the criteria for [post-traumatic stress disorder], it is not accepted that these mental health issues are a result of your claimed torture by the police.”

The case is allowed on appeal and the Immigration Judge makes the following findings:

Judge’s determination:

“... On the medical evidence, the Respondent in submission highlights the distinction between lesions consistent with what the Appellant said occurred but non-specific with many other possible causes and highly consistent which is more persuasive but cannot be decided definitively whether caused as the Appellant said ...

*... I accept Dr **’s evidence. It is extremely detailed and objective. It is based on a series of interviews with the Appellant. There is a detailed history. She is clear where other causes of the injury may be possible and has produced a detailed analysis of each injury and given detailed reasoning for her conclusions about the psychological injuries. She has not pre-empted the role of Tribunal in finding facts on the evidence, but has made it clear that the overall position is consistent with the Appellant’s account ...”*

- iv) Case 22 (psychological evidence and discrepancies)

Home Office written reasons for refusing asylum:

“... You have also stated that any discrepancies should be attributed to your physical and mental state whilst conducting your interview. Whilst your claimed medical conditions and history has been taken into account, it is noted that, as recently as [date], you were not found to be suffering from any mental health conditions. Furthermore, it is not considered that your claimed weakened mental state can mitigate the serious credibility issues that have been raised above, the serious lack of knowledge you have demonstrated and cannot be used to mitigate those parts of your claim ... which run counter to available objective information.”

The Immigration Judge allowed the case on appeal and made the following findings in relation to the applicant’s credibility:

Judge’s determination:

“... I have looked at the documentation in the round and conclude that it is material documentation on which I can place reliance. The Appellant has made a genuine effort to substantiate his claim and all material factors have been submitted and his statements in relation to what happened to him in [country of origin] are coherent and plausible and do not run counter to available and specific and general information relevant to his case. He has sought protection at the earliest time after he suffered abuse and in my view his credibility has been established.

... I find that as recently as [date] the Appellant was detained and tortured.”

- v) Case 48 (clinical judgment, what ought to be physically possible or survivable)

Home Office written reasons for refusing asylum:

“... It is considered that your statements regarding your claimed second detention are inconsistent ... if it were accepted that your injuries were so severe that it was believed you would die, it is inconsistent that these injuries would permit you to escape detention by jumping over a wall. As it is not accepted that you escaped detention it is also not accepted that you were detained a second time ...

... It is concluded that the scarring described in the medico legal report was not suffered in the context you have described ...”

The case was allowed on appeal and the Immigration Judge made the following findings:

Judge's determination:

“... Dr * has considerable experience and expertise in evaluating and assessing potential or actual torture or ill-treatment; her report was prepared in accordance with the Istanbul Protocol; and she has considered and in some cases opted for alternative accidental or occupational causes of the injuries presented by the Appellant. Where she considered a particular scar or lesion was non-accidental, she has explained why she reaches that conclusion; and I accept her careful and detailed evidence. Overall, it seems to me that given the considerable number, type and distribution of the non-accidental injuries identified by Dr * on the Appellant's body, there is really only one possible conclusion, which is that the Appellant has been subjected to sustained torture or acute ill-treatment. That is what the appellant says occurred at the hands of the [country] authorities. I suppose it is theoretically possible that such treatment could have been inflicted on him by people other than the [country] authorities; but if so who were they - no one else has been suggested or identified; and why would the Appellant himself not identify them, since it is likely that the outcome would be the same?”

vi) Case 35 (clinical judgment, how much evidence of torture would be expected, what is physically possible)

Home Office written reasons for refusing asylum:

“...The report does very little to support your claim. It recites your account and then finds that you are mildly clinically depressed as a result of [post-traumatic stress disorder] ... Whilst what is said in the report, the level of psychological damage is remarkably low considering the sustained level of mistreatment you claim to have endured ...

... If you had been subjected to some seven weeks of torture, it is considered that you would have been in very poor health and it is reasonably likely to have

been identified by one of the persons you passed in [name of] airport or in [name of] airport. In neither place does it appear that your state of physical well-being was identified and therefore your health cannot have been as bad as you claim ...

... It is also noted that you do not appear to have any further physical injuries, despite the level of torture you claim ... That you had no broken bones is considered so highly fortunate on your part so as to defy objective belief ...”

The case was allowed on appeal and the Immigration Judge made the following findings:

Judge's determination:

“... I find the medical report to be thorough and cogent. It is compliant with the Istanbul Protocol ... I accept the conclusion of Dr * that the presentation of the appellant is directly related to his ill treatment and torture during detention. I find her report is highly corroborative of the truth of the appellant's account ...”

3.3. Qualifications and expertise to document physical and psychological consequences of torture

This section is focused on asylum caseworkers' handling of the medico-legal report writer's qualifications and expertise in the documentation of torture. The qualifications and training of doctors and other clinicians who prepare medico-legal reports at Freedom from Torture and guidance given to asylum caseworkers through Asylum Policy Instructions are summarised below. This is followed by findings from the research, including case examples.

Qualifications and expertise of medico-legal report authors at Freedom from Torture

Most medico-legal reports from the Medico-legal Report Service at Freedom from Torture, including in this case set, are prepared by medical doctors trained in the documentation of physical and psychological consequences of torture in accordance with standards

set out in the Istanbul Protocol. The majority of these are general practitioners, so their prior training and practice gives them a breadth of experience in all medical fields. Some of the doctors have other or additional specialist qualifications and experience in fields such as paediatrics, dermatology, gynaecology and psychiatry. The majority of general practitioners have extensive experience in psychiatry and managing psychiatric patients, from time spent working in psychiatry departments during their training and from their daily general practice in the community. The diagnosis and treatment of psychiatric conditions such as post-traumatic stress disorder and depression that are commonly experienced by refugees and torture survivors are within the field of expertise and experience of general practitioners who will regularly carry out mental health assessments, and are not solely the province of psychiatrists.

In addition, Freedom from Torture's specialised training on examination of survivors of torture and documentation of torture for medico-legal reports is comprehensive. It includes the documentation and assessment of injuries attributed to torture and training on psychiatric conditions common to survivors of torture and refugees. Specific consideration is given in training to the assessment of the person's description of how injuries were sustained (both psychological and physical), the immediate and later effects of the injuries and the doctor's objective examination findings. Inter-examiner variability is minimised as far as possible through regular update training for the doctors, and consistent quality standards are maintained through a review process, with each report receiving a legal and medical review before it is finalised.

Most Freedom from Torture medico-legal reports are prepared by medical doctors who act as independent experts and see the person only for the purpose of preparing a report. However, some reports (five in this case set) are prepared by treating clinicians at Freedom from Torture, who are fully qualified psychological therapists specialised in working with torture survivors. These reports are based on a number of treatment sessions over a period of time and will focus only on psychological matters. This type of report may be considered especially valuable

where the person has been receiving psychological therapy for some time or where it becomes apparent that that the person is highly traumatised and that a full disclosure and picture of the impact of torture can only emerge during therapy. Psychological therapists at Freedom from Torture also receive specialised training in the preparation of medico-legal reports and the legal and medical review processes apply equally to this type of report. As with doctors who act in the capacity of an independent expert, clinicians who prepare medico-legal reports for their clients sign an undertaking, which states that they understand their duty as an expert witness and that the report is written to the same expert witness standards.

Asylum Policy Instruction

In its Asylum Policy Instruction, the Home Office recognises that the Medico-legal Report Service at Freedom from Torture has the expertise to prepare medico-legal reports providing a comprehensive assessment of the effects of torture, including physical and psychological injury (3.1). The Policy Instruction states that medical doctors and other clinicians at Freedom from Torture are recognised to be "*objective and unbiased*" and that the reports they prepare have been "*compiled by qualified, experienced and suitably trained clinicians and health care professionals*". It is noted that the Home Office will accept reports giving an assessment of mental health conditions "*whether completed by a GP, clinical psychologist, consultant psychiatrist, other health care professional or other expert with extensive experience in this field.*" Asylum caseworkers are instructed that no report should be given little weight on the grounds that the author is not suitably qualified and that any concern about the qualifications of the author should be referred back to the legal representative as the commissioner of the report (3.1).

Findings: Qualifications and expertise to document physical and psychological consequences of torture

Asylum caseworkers make positive reference to the qualifications and expertise of the medico-legal report author in three of the 50 refusal letters, although they go on to dismiss the clinical findings in all three cases. One states that the doctor is suitably qualified to produce a medico-legal report; the other two mention the doctor's status as a "medical professional" or a "specialist" before disputing their clinical opinion. However, and despite the guidance given in the Policy Instruction, in nearly a third of cases (30%) the asylum caseworker disputes or questions the qualifications and expertise of the medico-legal report author, albeit indirectly in four of these cases.

Figure 2: qualifications and expertise of medico-legal report author at issue, incidence and number of cases

Qualifications and expertise of medico-legal report author	Incidence	Number of cases
Qualifications and expertise are disputed or questioned	30%	15
Qualifications and expertise are positively described	6%	3
No reference to qualifications and expertise	64%	32

Fourteen of the 15 medico-legal reports where the qualifications and expertise of the author are questioned are independent expert reports, prepared by general practitioners (GPs) in 13 cases and in one case by a psychiatrist. Asylum caseworkers dispute the qualifications of the doctor to give an opinion on psychological matters and in particular to discuss symptoms or diagnose post-traumatic stress disorder in most cases. As stated in the Asylum Policy

Instruction, the Home Office accepts that doctors and other clinicians who prepare medico-legal reports at Freedom from Torture have the necessary qualifications and expertise to assess mental health conditions. Furthermore, the rigorous methodology adopted in the preparation of a medico-legal report includes a critical assessment of the person's account as described above. While it may not be the role of the medical expert to consider the credibility of the entire asylum claim, it is their role to consider the possibility of fabrication of the clinical picture, both physical and psychological, as stipulated in Freedom from Torture's medico-legal report methodology and at paragraph 105 (f) of the Istanbul Protocol:

105. In formulating a clinical impression for the purpose of reporting physical and psychological evidence of torture, there are six important questions to ask:

(a) Are the physical and psychological findings consistent with the alleged report of torture?

(b) What physical conditions contribute to the clinical picture?

(c) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(d) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where in the course of recovery is the individual?

(e) What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.)? What impact do these issues have on the victim?

(f) Does the clinical picture suggest a false allegation of torture?

The other case (of the 15) where the qualifications and expertise of the report author are disputed is an expert report prepared by a psychological therapist who is the treating clinician. The decision-maker criticises the clinician for not commenting or giving an opinion on physical injuries attributed to torture in their report, which she is not instructed or

qualified to do (as stated in her report). The clinician is also criticised for going beyond her professional expertise in giving an opinion on the mental health condition of the person and the consistency of this with the claimed history of torture, which she is qualified (through professional expertise, training and experience), and had been explicitly instructed, to do.

Case examples: Qualifications and expertise to document the consequences of torture

vii) Case 2 (qualification to diagnose mental health conditions)

Home Office written reasons for refusing asylum:

“... Your brother... has claimed that you suffer panic attacks and [sic] often disturbed by flashbacks and talk about committing suicide as a result of the torture you claim to have suffered. It is noted that none of the information provided in this statement has been supported by a person qualified to comment on your state of health, including the [Freedom from Torture] report ...”

The medico-legal report in this case records re-experiencing features, waking in fear and suicidal thoughts and the conclusion of the doctor is that the underlying cause of these psychological symptoms is torture. The Immigration Judge hearing the successful appeal in this case makes the following finding on the issue of the qualifications and expertise of the doctor:

Judge's determination:

“... It is a lengthy, detailed and balanced report, which I accept has been prepared by a doctor with suitable qualifications and expertise to provide expert opinion. I find considerable weight in the arguments made ... that the respondent has failed to grapple with this report in the reasons for refusal letter ...”

viii) Case 7 (qualification to diagnose mental health conditions)

Home Office written reasons for refusing asylum:

“... You have submitted a report from [Freedom from Torture] in support of your treatment in detention ... Dr * reports that many of the scars and lesions found on your body are consistent with or highly consistent with your account of ill treatment while detained, while she made a diagnosis of severe depression and symptoms of Post-Traumatic Stress Disorder ... The mere fact of the existence of scars does not, in itself, indicate that the injuries were sustained in the manner you have described.

... Turning to the diagnosis of post-traumatic stress symptoms. Dr * has set out her qualifications as a General Practitioner but appears to have no apparent psychiatric qualifications or experience ...

... On this basis it is not accepted that the medical evidence [supports] your claim as it pertains to beating and rape in detention ...”

The case is allowed on appeal and the Immigration Judge makes the following findings:

Judge's determination:

“... I have considered all the evidence submitted by the Appellant in this appeal and applied the lower standard of proof to it. Taking into account both the Appellant's written and oral testimony I find that she is a credible witness.

“... The evidence of the Appellant supported by the evidence from [Freedom from Torture] established that the Appellant can discharge the burden of proof upon her ...”

ix) Case 32 (qualification to diagnose mental health conditions)

Home Office written reasons for refusing asylum:

"... The author of the report sets out their qualifications, but appears to have no apparent psychiatric qualifications or experience ...

... It is considered that it is the overriding duty of a doctor to cite areas within their expertise, and to cite areas that are not within their expertise. It is therefore considered that the reference to [post-traumatic stress disorder] cannot be considered reliable when a doctor does not have the appropriate psychiatric qualifications ..."

The Immigration Judge allows the appeal and makes the following finding on the issue of the qualifications and expertise of the doctor:

Judge's determination:

*"... I find that the report of Dr * is reliable and that he has dealt with matters within his report that were asked of him and within the scope of his expertise ..."*

x) Case 10 (qualification to diagnose mental health conditions)

Home Office written reasons for refusing asylum:

*"... Whilst we do not dispute her findings as a medical professional it is noted that Dr * is not a specialist in any one given area of medicine, but has trained as a general practitioner. We accepted that she has had training in the areas of psychiatry, provided by [Freedom from Torture], but this is not registered training to practise in this specialist area ..."*

The Immigration Judge allows the appeal and makes the following finding on the issue of the qualifications and expertise of the doctor:

Judge's determination:

*"... I attach significant weight to the report of Dr * for a number of reasons. Dr * is a leading expert in the field of victims of torture and reporting on the physical, emotional and mental health aspects of torture ..."*

3.4. The assessment of credibility and use of the expert medical evidence

This section is focused on asylum caseworkers' overall treatment of the expert evidence in medico-legal reports, related to the assessment of credibility. The assessment of credibility within asylum claims and the role of the medical expert are discussed below. This is followed by findings from the research, including case examples. Based on Home Office guidance and the Istanbul Protocol, as well as previous Freedom from Torture research and an earlier audit of cases, the incidence of specific problems in the overall consideration of expert medical evidence by the asylum caseworker in the 50 cases has been reviewed. Elements of decision-making practice specifically reviewed are: the use of clinical findings in the medico-legal report to assess the credibility of the claimed history of torture as well as the overall credibility of the claim.

Assessment of credibility

The assessment of credibility forms the core of the refugee status determination process. It requires an evaluation of the truthfulness of an applicant's given history and their reason for seeking asylum. Given that corroborative evidence is very often lacking in asylum claims, the assessment of credibility based on the internal coherence of the person's testimony, its external consistency with country of origin information or other forms of objective evidence, and its inherent plausibility, are at the centre of the decision-making process.³¹

For survivors of torture a medico-legal report can play a key role in the assessment of the credibility of their claim, since it documents evidence of physical and psychological injuries that are attributed to torture and provides an objective, expert evaluation of the consistency of this clinical evidence with the history they have given. This evidence might prove to be crucial in their asylum claim since, as stated in the Immigration Rules, “... the fact that a person has been subject to persecution or serious harm, or to direct threats of such persecution or harm, will be regarded as a serious indication of the person’s well-founded fear of persecution or of a real risk of their suffering serious harm, unless there are good reasons to consider that such persecution or serious harm will not be repeated.”³²

It is understood by all parties and is emphasised in Home Office policy instructions issued to asylum caseworkers, that it is ultimately for the decision-maker to evaluate the overall credibility of an asylum claim, taking account of all the evidence in the round and applying the appropriate standard of proof.³³

It is also emphasised that expert evidence such as medico-legal reports should be considered carefully as part of this evidence and given due weight in the assessment of overall credibility, and must not be left for consideration after the credibility of the claim has been decided.³⁴

Role of the medical expert

In this context it is the role of the clinical expert, who provides a medico-legal report documenting evidence of torture, to objectively evaluate their clinical findings and give an opinion on the consistency of these with the history given by the person and the attributed cause of torture. The clinician must assess the possibility of fabrication of the clinical picture, physical and psychological, and must not comment on the overall credibility of the claim. Clinicians who prepare reports for Freedom from Torture are specifically trained in this task and all medico-legal reports undergo a legal and clinical review process to ensure that they comply with this and other legal and policy requirements and the relevant clinical quality standards. The methodology adopted by clinicians at Freedom from Torture adheres to the Istanbul Protocol, which gives guidance at paragraph

122 on the purpose of forensic examination and documentation of torture as follows:

... The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient’s allegation of abuse and to communicate effectively the physician’s medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and psychological sequelae of torture.

The examiner should be prepared to do the following:

- (a) Assess possible injury and abuse, even in the absence of specific allegations by individuals, law enforcement or judicial officials;*
- (b) Document physical and psychological evidence of injury and abuse;*
- (c) Correlate the degree of consistency between examination findings and specific allegations of abuse by the patient;*
- (d) Correlate the degree of consistency between individual examination findings with the knowledge of torture methods used in a particular region and their common after-effects;*
- (e) Render expert interpretation of the findings of medical-legal evaluations and provide expert opinion regarding possible causes of abuse in asylum hearings, criminal trials and civil proceedings;*
- (f) Use information obtained in an appropriate manner to enhance fact-finding and further documentation of torture.*

Assessment of credibility in practice

Concerns about the assessment of credibility in asylum claims and application of the correct standard of proof by Home Office asylum caseworkers have been raised in a number of previous reports, including

those of the Quality Initiative (QI) project carried out by the UK office of the United Nations High Commissioner for Refugees (UNHCR) over a number of years.³⁵ Six reports were submitted to Home Office Ministers between 2005-2009 in which there was a common finding, that asylum caseworkers had taken an “*incorrect approach to assessing an asylum seeker’s credibility and establishing the facts of the claim*”.³⁶ According to the 2013 report from Amnesty International/Still Human Still Here on the assessment of credibility in asylum decisions, “... *QI reports found that, amongst other deficiencies, there was a failure to give the applicant the benefit of the doubt when their account appeared credible, speculative argument was frequently used, a single untrue statement was relied on to dismiss the credibility of the entire claim, and there was a failure to follow UK case law.*”³⁷ Amnesty International/Still Human Still Here reported the following findings on the basis of their own research: “... *In 42 of the 50 randomly selected cases we analysed (84 per cent of the research sample), the Immigration Judge indicated that the primary reason for an initial decision being overturned was that the [Home Office] case owner had wrongly made a negative assessment of the applicant’s credibility. In all these cases, the case owners had not properly followed the [Home Office’s] own policies on assessing credibility.*” Mistakes identified in the assessment of credibility included the use of “*speculative arguments*” or “*unreasonable plausibility findings*”; not properly considering the available evidence; and using a small number of inconsistencies to dismiss the application (executive summary).

The Home Office issued new guidance on the assessment of credibility in 2015, which seeks to address and remedy these and other concerns about asylum caseworker practice in this core area of refugee status determination, and to give practical guidance to caseworkers to help them better carry out this complex task.³⁸

Findings: Assessment of credibility and use of the expert medical evidence

In more than a quarter of the cases (28%) the asylum caseworker fails altogether to give consideration to the clinical findings contained in the medico-legal report as they relate to the account of torture given by the person. This is a fundamental error in decision-making practice and a clear contravention of the policy guidance.

Figure 3: Errors in the consideration of medical evidence

Errors in the consideration of expert medical evidence	Incidence	Number of cases
Applies a negative credibility finding to dismiss the medical evidence	84%	42
Fails to consider the physical <u>and</u> psychological evidence in relation to the torture account	74%	37
Fails to consider the psychological evidence in relation to credibility issues	52%	26
Gives an incorrect summary of clinical findings	32%	16
Fails to explicitly consider the clinical findings in relation to the torture account	28%	14
Draws conclusions based on summary findings without taking account of detailed findings	22%	11

more common error is the failure to consider both the physical *and* the psychological evidence in relation to the claimed history of torture, which happens in 74% of cases. Here many asylum caseworkers ignore the psychological evidence altogether, which might include a diagnosis of post-traumatic stress disorder, with specific symptoms discussed in detail and directly linked to the reported history of torture and other traumatic aspects of the detention experience. In other cases, the asylum caseworker mentions the psychological findings, but only considers them briefly in relation to issues such as the availability of mental health facilities in the country of origin or the person's fitness to travel should their asylum claim be refused, or their fitness to take part in an interview process.

However, the most common error in the use of the clinical findings, found in 84% of cases, is the dismissal by the asylum caseworker of the clinical evidence of torture in the medico-legal report on the basis that they have already decided that they do not accept or believe all or elements of the person's account.

Home Office Asylum Policy Instruction on medico-legal reports

*"... Caseworkers are required to consider all evidence in the round; including expert medical evidence and a conclusion on the overall credibility of an account of past events must not be reached without careful consideration of the contents of the Foundation's [medico-legal report]. Caseworkers must have in mind the approach to assessing the credibility of past events set out in the Karanakaran judgment, which emphasises that evidence should not be excluded where some weight may be attached to it."*³⁹

The overwhelming majority of asylum caseworkers in this case set make strong negative findings on the overall credibility of the person's history before considering the medical evidence, in clear contravention of Home Office policy. They then consider whether the medical evidence can overturn

the view they have already reached. In asylum claims where the medical evidence is submitted in further submissions for a "fresh claim", decisions about the credibility of the person deriving from their initial asylum claim often continue to be relied on without proper consideration of the new evidence contained in the medico-legal report, and despite the fact that this medical evidence was not available to the original decision-maker/s. Where reasons are given, asylum caseworkers state that since they or other decision-makers have found the claim or the applicant⁴⁰ to be lacking in credibility, and since, in their view, the medico-legal report relies only on the person's testimony, it cannot be given weight and would not lead to a different decision on the overall claim by an Immigration Judge. This is to ignore the expertise of the medico-legal report author in reaching an informed clinical opinion on the totality of the evidence in front of them, including the person's testimony, and to ignore the policy guidance cited above.

Directly related to this, in over half of the cases (52%) the asylum caseworker fails to consider the specific findings and opinion within the psychological examination that relate to the negative assessment of the credibility of the applicant. This evidence might concern, for example, reasons for discrepancies in the account, inconsistent recall of details of the torture or detention history or late disclosure of a particularly shaming form of torture such as rape. As noted above, policy guidance instructs asylum caseworkers to take account of such new information presented in the medical report.

In a smaller but significant number of cases (32%) the asylum caseworker presents an incorrect summary of the clinical findings in the refusal letter, and relies on these to conclude that the medical evidence is in some way deficient or does not provide sufficient evidence of torture to meet the required standard of proof, and it is thus given no evidential weight.

In a number of other cases (22%), conclusions on the evidence are apparently reached by the asylum caseworker on the basis of summary findings found at the end of the medico-legal report or other selected passages, without reference to detailed clinical

findings in the whole of the report. The report is then incorrectly criticised for not including sufficient consideration of, for example, possible alternative causation of injuries or discrepancies in the account. The entire findings of the report are then dismissed. This is in direct contravention of the Asylum Policy Instruction, which states that it is inappropriate for asylum caseworkers to provide their own subjective opinion, based on “selective quoting from the [medico-legal report] to challenge representations made by the claimant that the report supports when read properly and in its entirety” (3.3).

Case examples: Assessment of credibility and use of the expert medical evidence

- xi) Case 17 (failure to consider the medical evidence, assessment of credibility)

Home Office written reasons for refusing asylum:

“... It is noted that the medical report is useful evidence to help corroborate an account which has to be considered in the round. Your account was very carefully considered by the Secretary of State in the Reasons for Refusal Letter dated [date]. The oral and other evidence was found to contain discrepancies which reach to the very core of your claim and your credibility was not accepted.

Para 26: ... The nature of these inconsistencies is such that when all the evidence is carefully weighed in the round, and the medical report is not viewed in isolation, it is considered you have failed to demonstrate this evidence can be relied upon.

Para 75: ... Your Medical Report submitted with is [sic] application states that you are suffering from anxiety but you have failed to provide any evidence that you are receiving any treatment or medication in the UK for this condition.”

Other than the reference to anxiety, the refusal letter in this case does not consider any of the evidence related to the reported history of torture, including

rape, in the medico-legal report. The medico-legal report notes that the person has been referred to their general practitioner for symptoms of anxiety. The Immigration Judge, who allowed the case on appeal, made the following findings:

Judge’s determination:

“... The refusal letter did not give any detailed analysis of the report but set out principles, particularly in case law, and said that whilst it was accepted that anyone who was tortured would find it difficult to speak about the event, it was considered that his account was not credible. There was no specific assessment of the report ...

... In his conclusions the Doctor said that there were 13 scars consistent with the attribution of torture as well as a number attributed to non-torture causes and the appellant had distinguished between these. He pointed to the fact that rape and beatings frequently leave no permanent physical scars and he pointed to a specific examination which contributed to the wider picture supporting the appellant’s claim that he had been repeatedly raped. He specifically identified that his psychological assessment was not based solely on the account given by the appellant but took into account his manner of speech, posture, body language, gestures and expressions and the objective findings on examination of his mental state.

...The expert’s credentials suggest that he is well placed to make his assessment and the assessment was made with regard to the Istanbul Protocol ...”

- xii) Case 31 (incorrect suggestion that alternative possible causes have not been considered, dismissal of the medical evidence without full consideration)

Home Office written reasons for refusing asylum:

“... While there is no evidence to doubt the credentials of Dr * to produce this report, this report is self-serving ... Dr * confirms that the account you

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S29 have given her is consistent with her examination; S29
S30 however, no alternative explanation as to how these
injuries occurred has been sort [sic] or explored by
the medical expert. Dr * states that self-infliction
is highly unlikely, however she fails to confirm that
S32 these injuries could have been sustained in any other
way.”

S33 The Immigration Judge, who allowed the case on
appeal, made the following findings:

Judge's determination:

S35 “... I find that the new medical evidence is, when
considered both individually and cumulatively,
highly persuasive and I attach significant weight to
it in terms of providing support for the appellant's
account. I find that this evidence, when considered
in the round with the other evidence before me and
applying the low standard of proof, supports the
Appellant's claim that she was tortured in the way
she described ...

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... The Respondent accepts Dr *'s credentials and
the only real criticism raised in the Refusal Letter
regarding her Report is that Dr * does not consider
any other possible cause for the injuries. I do not
accept this to be a valid criticism of the Report. It
is clear ... that Dr * has been careful in respect of
each documented injury to consider other possible
causes.”

xiii) Case 26 (failure to consider clinical
evidence, applies previous nega-
tive credibility finding to dismiss the
evidence)

Home Office written reasons for refusing asylum:

“... you have submitted [Freedom from Torture]
report in support of your claim to have been
tortured. In this report it was found that you have
scars which you claim were caused by cigarettes
whilst you were in detention, and the report states
that “it would be impossible to self-inflict the
regular marks she has ... when assessing the overall
impact of the lesions and taken together scar group
S2, S3, S5 and S7 are diagnostic of her claimed

S28 attribution of cigarette burns” ... Consideration has
been given to the finding, but as it is not accepted
that you have been detained in the manner in which
you claim, it is not accepted that these scars were
caused as a result of this alleged detention ...”

S31 This was the only consideration given to the detailed
medical evidence in the medico-legal report and the
psychological evidence was not considered at all. In
allowing the appeal the Immigration Judge made the
following findings:

Judge's determination:

“... I have also taken into account the medico legal
report of Dr * of [Freedom from Torture]. Paragraph
68 of the report confirms that there are 29 scars
which are diagnostic of cigarette burns having
excluded other possibilities such as chicken pox,
insect bites, vaccination scars and accidental injury.

... Importantly the report considered ... the possibility
that the marks were self-inflicted ... In relation to
the possibility of third party inflicting the injuries
for the purpose of manufacturing an asylum claim
the Doctor considers this unlikely given both the
Appellant's difficulty in exposing her body even to a
female doctor in a clinical setting and also given the
number of the marks and resulting pain.

... I therefore accept that the marks are cigarette
burns caused when the Appellant was detained by the
authorities as she describes.

... I have also taken into account that part of the
report which contains the Doctor's psychological
opinion which I accept is not simply based on an
acceptance of what the Appellant has told her
happened but also on the Doctor's objective clinical
assessment of the Appellant's mental state in the
course of three consultations. The doctor concludes
that she has symptoms that meet the diagnostic
criteria for [post-traumatic stress disorder] ... she
suffers from depression ... has generalised anxiety
disorder ... and that she would contemplate suicide,
these findings are consistent with the ill treatment
claimed by the appellant. The appellant did not
seek to embellish her account which enhances her
credibility and further information was 'teased' out

of the Appellant 'in the secure and safe environment of an examination by a female Doctor and female interpreter.'

... I therefore accepted that the Appellant was detained and ill-treated by the [country] authorities as she claims and has visible scars and mental health issues as a result of her treatment ..."

3.5 Medico-legal report methodology and interpretation of the findings

This section is focused on asylum caseworkers' practice related to the methodology of the report and the report author's interpretation of the clinical findings. The methodology adopted by the Medico-Legal Report Service at Freedom from Torture, key standards for documentation of torture set out in the Istanbul Protocol and guidance given to asylum caseworkers through Asylum Policy Instructions are all summarised below (see also sections 1.1 - 1.3 for information about these). This is followed by findings from the research, including case examples. Asylum caseworker practice that relates to their understanding of medico-legal report methodology, the Istanbul Protocol and the interpretation of clinical findings, is categorised and recorded in the research. The specific issues recorded are: asylum caseworkers' responses to doctors' use of Istanbul Protocol terms to describe the degree of consistency between physical injuries (lesions) and the attributed cause of torture given by the person and, related to this, the consideration of alternative possible causes of the injuries documented; the consideration of fabrication of the account of torture including through "self-infliction by proxy"⁴¹; and the objectivity of the doctor in assessing the account given and the clinical evidence before them.

Findings: Medico-legal report methodology and interpretation of the findings

Asylum caseworkers were critical of the methodology and/or interpretation of clinical findings in the medico-legal report in 45 of the 50 cases (90%). Only one asylum caseworker made a positive comment on these issues, which was that the report conforms to the guidelines set out in the

Istanbul Protocol. The lack of positive reference to medico-legal reports by asylum caseworkers, in terms of content or findings, contrasts with comments made by Immigration Judges in their Determinations of the same asylum claims. In allowing the appeal, many Judges made positive reference to the strength of the medico-legal report, both in terms of methodology and interpretation of the clinical evidence. For example, Immigration Judges variously commented that the medico-legal report is: ... "reliable and carefully constructed and detailed"; "lengthy, detailed and balanced"; "a critical and objective analysis of the injuries and/or symptoms displayed"; "carefully and methodically prepared"; "detailed and based on independent clinical observations"; and "a reasoned explanation based on clinical observation and experience on why [the doctor] regards the Appellant's account of torture as credible" ...

Use of the Istanbul Protocol to assess the clinical evidence, including degree of consistency with torture and alternative possible causes of injuries

In more than half of the cases, asylum caseworkers demonstrate a lack of understanding of how the guidelines and standards contained in the Istanbul Protocol should be applied when considering evidence of torture contained in a medico-legal report for an asylum claim (54% of cases). In the majority of cases, asylum caseworkers incorrectly criticise the clinician's assessment of the degree of consistency between the physical and/or psychological injuries and the attributed cause of torture (70% of cases), and in more than a third of cases, they wrongly criticise the doctor's specific use of Istanbul Protocol terms (36% of cases). Asylum caseworkers' reasoning and conclusions are therefore often flawed regarding the compliance of the medico-legal report with the standards described in the Istanbul Protocol and whether the evidence in the medico-legal report supports the account of torture to an appropriate level of proof (reasonably likely).

Figure 4a: Methodology and interpretation of findings - degree of consistency

Methodology and interpretation of findings - consistency	Incidence	Number of cases
Asylum caseworker misunderstands the Istanbul Protocol, paragraph 187	54%	27
Asylum caseworker incorrectly criticises the assessment of degree of consistency	70%	35
Asylum caseworker incorrectly criticises use of Istanbul Protocol terms - degree of consistency	36%	18
Asylum caseworker misrepresents the clinical findings - degree of consistency	42%	21

The most persistent errors concern the use of the schema provided at paragraph 187 of the Istanbul Protocol (see above) to describe the degree of consistency observed in the clinical examination between physical evidence (lesions) and the attributed cause of torture, and related to this, the consideration by the doctor of possible alternative causes of the physical injuries documented in the medico-legal report. As noted above, many asylum caseworkers demonstrate a lack of understanding about the correct use of the Istanbul Protocol, while many other caseworkers inaccurately represent the doctor's findings in the refusal letter and their evidence is then dismissed on the basis of this error (42% of cases).

A common source of error is the mistaken belief that the consistency schema described at paragraph

187 of the Istanbul Protocol should also be applied to the assessment of psychological evidence. This means that when the clinician correctly gives their opinion on the causal link between psychological symptoms and the history of detention and torture described using every day or clinical language they are incorrectly criticised for not using the Istanbul Protocol consistency schema and their opinion is dismissed.

A similar error concerns the mistaken belief that the consistency schema must also be used when summarising the overall opinion of the doctor about whether the clinical picture supports the history of detention and torture given, based on all the physical and psychological evidence in front of them. Paragraph 105 of the Istanbul Protocol states: "... *In formulating a clinical impression for the purpose of reporting physical and psychological evidence of torture, there are six important questions to ask: (a) Are the physical and psychological findings consistent with the alleged report of torture? ...*" Doctors may use the word "consistent" in this everyday sense in the report summary to describe their overall findings, which the asylum caseworker interprets according to paragraph 187 of the Istanbul Protocol. The caseworker then concludes that the clinical evidence is non-specific and adds nothing to the claim, irrespective of the strength of the detailed findings contained in the body of the report, and of the fact that this overall conclusion is all that is required to meet the standard of proof for an asylum claim.

Most concerning, though, is the apparently widespread assumption by asylum caseworkers that lesions assessed as anything less than "diagnostic" of torture by the doctor (no other possible causes), using the Istanbul Protocol consistency schema, have little or no significance as evidence of torture (see section 3.1, where this has been discussed in relation to the application of the correct standard of proof).

However, the most prevalent finding related to the consideration of the methodology and interpretation of the clinical evidence in the medico-legal report by asylum caseworkers is criticism of the assessment of alternative possible causes for injuries documented (78% of cases).

Figure 4b: Methodology and interpretation of findings - other causes

Methodology and interpretation of findings - other causes	Incidence	Number of cases
Asylum caseworker criticises consideration of other causes	78%	39
Asylum caseworker misrepresents the clinical findings - other causes	60%	30

The Istanbul Protocol and good forensic practice indicate that doctors should give proper consideration to, and document in the medico-legal report, other possible causes of injuries attributed by the person to torture, where it is relevant and meaningful to do so. According to the Istanbul Protocol schema, this should be done where there are lesions assessed by the doctor to be either “typical” of or “highly consistent” with the given history of torture. All medico-legal reports prepared by doctors at Freedom from Torture comply with this requirement and yet the detailed discussion and conclusions drawn by the doctor on the possibility of alternative causes are ignored or inaccurately represented by asylum caseworkers in 60% of the cases reviewed. Caseworkers conclude that they can give no weight to the medico-legal report since other causes of the injuries documented in the report are possible, irrespective of the detailed assessment of the clinical findings. Again, as stated in the Asylum Policy Instruction: “... *The Protocol, the central importance of which is accepted by the UK courts in the asylum context, makes clear that reports which document and evaluate a claim of torture for asylum proceedings need only provide ‘a relatively low level of proof of torture [or serious harm]’. Therefore, the Foundations’ report in support of the applicant’s claim of torture or serious harm cannot be dismissed or little or no weight attached to them when the overall assessment of the credibility of the claim is made ... Caseworkers should*

not argue that no weight can be applied to the report. If the allegation of torture or serious harm has been rejected, the [reasons for refusal letter] must state clearly the reasoning behind the rejection of the claim.”⁴²

Consideration of the possibility of fabrication and “self-infliction by proxy”, and objectivity of the doctor

It is clear from the description of Freedom from Torture’s medico-legal report methodology and from the standards set out in the Istanbul Protocol (see section 1.2) that clinicians documenting the consequences of torture are required routinely to consider the possibility of fabrication or exaggeration of the account when assessing the narrative given by the person, and in reaching their conclusions on the totality of the clinical evidence.

Day-to-day medical practice as well as more specialist forensic clinical practice also routinely involves this type of assessment. The Asylum Policy Instruction specifically draws asylum caseworkers’ attention to this: “... *Foundation clinicians can be assumed to have considered the possibility of ‘a false allegation’ of torture in forming a clinical view as this is required by the Istanbul Protocol: Paragraphs 105(f) and 287(vi) require the report writer to consider whether the clinical picture suggests a false allegation of torture...*” (paragraph 3.3).

In all cases in the research, Freedom from Torture clinicians had appropriately considered the possibility of fabrication and had noted this in their report. Despite this, asylum caseworkers are critical of the consideration of the possibility of fabrication in 42% of cases. In most they incorrectly assert that the clinician has not properly considered fabrication and has based their clinical assessment on an uncritical acceptance of the account given by the person.

Figure 4c: Methodology and interpretation of findings at issue - fabrication and objectivity

Methodology and interpretation of findings - fabrication and objectivity	Incidence	Number of cases
Asylum caseworker criticises consideration of fabrication	42%	21
Asylum caseworker criticises consideration of self-infliction by proxy	8%	4
Asylum caseworker questions the objectivity of the doctor	40%	20

In recent years, it has become more common for asylum caseworkers to allege that scarring could have been inflicted by the asylum claimant, or at their behest by a third party, as a means of fabricating torture evidence for the purpose of bolstering an asylum claim. These practices are often referred to as: “self-infliction by proxy”.

In Freedom from Torture’s experience, “self-infliction by proxy” arguments tend to be made by asylum caseworkers more frequently in cases involving Sri Lankan nationals.

A Home Office Country of Origin Information Service report on Sri Lanka from May 2011 cited a letter from the British High Commission in Colombo which referred to an allegation of self-infliction of injuries attributed to torture. The letter and the allegation were subsequently cited in Home Office and Tribunal decisions, mainly in Sri Lankan asylum claims, including a number of those referred to Freedom from Torture’s Medico-Legal Report Service.

In 2012 the letter was withdrawn from a revised Home Office country of origin information report following a complaint by Freedom from Torture that the allegation was based on an unsubstantiated and anonymous statement by a member of the Sri Lankan security forces.

In May 2014, in a case known as KV (*Scarring - medical evidence*)⁴³, the Upper Tribunal (Immigration and Asylum Chamber) gave the following guidance on the consideration of the possibility of self-infliction by proxy of injuries attributed to torture in asylum claims: “... Where there is a presenting feature of the case that raises [self-infliction by proxy] as a more than fanciful possibility of the explanation for scarring [...] a judicial fact-finder will be expected

to address the matter, compatibly with procedural fairness, in deciding whether, on all the evidence, the claimant has discharged the burden of proving that he or she was reasonably likely to have been scarred by torturers against his or her will.” Since the issue of this determination, medical experts are required to consider the possibility of self-infliction by proxy as an alternative possible cause of injuries, but only “where there is a presenting feature of the case” that raises this as a “more than fanciful explanation” for injuries observed.⁴⁴

The possibility of self-infliction by proxy is raised by asylum caseworkers in four decisions in the case set, and in each the doctor is criticised for not having addressed the issue properly in the medico-legal report. In two of these asylum claims the medico-legal report was prepared before KV, although the decision post-dates the issue of the Upper Tribunal’s guidance.

In each of these cases the medico-legal report author fully considers other possible causes of injuries documented in the report, as required by the Istanbul Protocol, and finds the cause of torture more likely on consideration of the evidence in the round. Both asylum claims have been allowed on appeal and in one the Immigration Judge comments that the issue of self-infliction by proxy raised by the asylum caseworker is “speculative” and that the medico-legal report is “highly corroborative” of the person’s account. In one of the two other cases where self-infliction by proxy is raised, the doctor is criticised on the basis that they have not “fully reasoned why they believe this scar is diagnostic of the ill treatment described” and why it could not have been self-inflicted, even though by definition a finding of “diagnostic with” does not require detailed reasoning or consideration of other possible causes. In this case and in the fourth case in which the doctor concludes that the injuries could not have been caused except by deliberate third party action, no lack of congruence is found in the history or examination findings that indicate the possibility of self-infliction by proxy. While one of these asylum claims is still in process, the other has been allowed on appeal, with the Immigration Judge finding “... nothing in the respondent’s refusal letter which amounts to a

significant reason for rejecting the conclusions drawn by Dr *”.

The Asylum Policy Instruction states that clinicians from Freedom from Torture’s Medico-Legal Report Service are “objective and unbiased” and yet this research finds that more than a third of asylum caseworkers question the objectivity of the medico-legal report author (40% of cases). Linked to the consideration of fabrication and of alternative causes of injuries documented in reports, asylum caseworkers commonly assert that the clinician has based their assessment of the clinical evidence on a self-reported account of torture, which means that they and/or their report is not objective or that their findings are not “objectively verified”. As noted above, clinicians involved in the documentation of torture, as in any clinical practice, do not automatically accept everything they are told but consider what is said, what is not said, the manner in which it is said and the responses to specific clinical questions in light of their clinical experience and specific training and their objective findings on examination. While asylum caseworkers commonly assert that the psychological evaluation in particular has no objective verification, in practice the evaluation of mental state is not based on symptoms reported by the person. The mental state examination is a specific part of the clinical examination process that is objective, as distinct from self-reported symptoms that are subjective. The overall psychological evaluation contains both objective and subjective elements in addition to specific responses to clinical questions, and may also take into account medical records from other health care professionals who have made independent assessments of the person.

Case Examples: Medico-legal report methodology and interpretation of findings

xiv) Case 34 (standard of proof, use of Istanbul Protocol, sufficiency of evidence)

Home Office written reasons for refusing asylum:

“... You have submitted a Medico-Legal Report ... The report makes reference to two scars on your [part of the body] which are ‘highly consistent with having been caused by blunt trauma ... However, the report also states that these scars ‘could have been caused by an accidental fall or something falling on him ...

... It is noted that these scars have not been diagnosed as ‘typical’ or ‘diagnostic’ of the treatment that you described. It has also been noted that despite the fact that the report categorizes these scars as ‘highly consistent with your account’ it goes on to give multiple, alternate explanations as to how you could have acquired these injuries ...

... Therefore, it has been determined that this report adds no weight to your claim that you were ill-treated in the [country of origin] ...”

The doctor gave full consideration in the medical report to possible alternative causes and the possibility of fabrication of injuries and gave his clinical opinion that the attributed cause of torture was more likely. The detailed evidence of post-traumatic stress disorder symptoms directly linked to torture was ignored in the refusal letter. In allowing the appeal the Immigration Judge made the following findings in relation to the medical evidence:

Judge’s determination

“... what he does adduce in support of his claim is a medical report, which examines the nature and extent of his physical injuries. Whilst it does not fall into the highest category of support possible for his claim, I am satisfied that it is more than persuasive

that his claim of physical mistreatment is a true one. The type, location and appearance of the scars are consistent with his claim and I can safely reject the possibility that they occurred in some other way at some other time. There is also the supporting evidence of his suffering from [post-traumatic stress disorder]. I acknowledge that asylum claims see many such reports but this does not mean that I must reject this one. The report is carefully and methodically prepared and concludes with a [post-traumatic stress disorder] finding ...

... I have reminded myself of the low standard of proof to be applied. The appellant need only show “a reasonable likelihood” or a “serious possibility” of their story being true to succeed ...”

xv) Case 42 (medico-legal report methodology, causation of injuries, assessment of credibility before medical evidence is considered)

Home Office written reasons for refusing asylum:

“... It is noted that Dr *’s report is based on your account of events in [country of origin], and he has based his findings on this.

... Your claimed account of torture includes scars on your [parts of the body] ... Given the findings at Paragraphs 24-29 it is not accepted that these scars were obtained in ... the way you have described.

... Dr * has further stated that the scars ... are diagnostic of third party assault. While Dr * has stated that they could not have been caused by accident or self-inflicted, he has not considered or asked you whether they could have been a result of any other third party assault. As stated ... Dr *’s assessment is based on your account of claimed events in [country of origin]. However due to your inconsistent and incredible account, this has not been accepted. It is considered that third party assault does not necessarily mean they were obtained in

30 prison whilst you were tortured ... it is considered
that your injuries could have been established in any
number of ways.

32 Para 37: Given this ... it is not accepted that you
obtained the scars in the way you described ...”

33 The refusal letter does not consider the detailed
evidence of physical injury in the medico-legal
report, nor the psychological evidence, which is
specifically linked to the torture described. The
Immigration Judge allowed the appeal and made the
following findings in relation to the medical evidence:

Judge's determination:

“... The medical evidence from Dr * is that his account
of the torture undergone and its psychological
effects is all entirely consistent with the scarring and
... injury; and this conclusion effectively disposes of
the reservations in the Reasons for Refusal Letter.

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“... Those reservations were, I find, based on very
little; merely a scepticism about some aspects of the
appellant's account ... I find the appellant's account
to be credible ...”

xvi) Case 48 (medico-legal report meth-
odology, role of the medical expert,
assessment of causation, assessment
of credibility before medical evi-
dence is considered)

Home Office written reasons for refusing asylum:

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575 →
“... In KV the Upper Tribunal commented that while
medico legal reports will make a critical evaluation
of a claimant's account of scarring said to have been
caused by torture, reports are not to be equated
with an assessment to be undertaken by decision-
makers in a legal context.

“... With this in mind, it is noted that paragraph 81
of the medico legal report states: 'I do not consider
that Mr x's account is likely to be false as over the
course of three extended interviews, he gave a
consistent and detailed account of events around his
detention and ill treatment.'

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“... Furthermore, the report concludes at paragraph
87: 'In summary, Mr x's eloquent and consistent
history, as well as his physical and psychological
examination findings support his account.'

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“... It is considered that the role of the medical
professional in the preparation of a medico
legal report is to provide a clinical assessment
of injuries presented by an applicant, either
physical or psychological, or both. The role of the
medical professional is not to consider and test the
applicant's account and decide whether it is credible.

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“... It is noted that Dr * did not consider whether
there were any other possible causes for the
scarring to your head and body ... Dr * discounted any
other possible causes simply because you 'related
no injuries related to work or sport prior to ...
detention'.

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“... Dr * noted 36 scars to your head and body ...
sixteen which she concludes are consistent, highly
consistent or diagnostic to the assaults you claim to
have suffered in detention ...

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“... Although Dr * considers scars L1, L3, L5, L6 and L7
to be highly consistent with non-accidental injury,
that does not mean that the injuries were received
in the manner you have claimed.

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“... In the Home Office decision maker's assessment of
your asylum claim, several areas of issue have been
identified which have resulted in your claim to have
been detained a second time being rejected.

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“... It is considered that these issues remain. It is
concluded that the scarring described in the medico
legal report were not suffered in the context you
have described ...”

549 →
550 →
551 →
The Immigration Judge allowed the appeal and made
the following findings in relation to the medical
evidence:

Judge's determination:

552 →
553 →
554 →
555 →
“... That [medico-legal] report complies with the
Istanbul Protocol, in that a critical and objective
analysis of the injuries and/or symptoms displayed
has been undertaken ... she identified 5 scars ... as

being highly consistent with his account of beatings; 8 scars elsewhere on his body consistent with having been beaten with [implement]; and 3 scars diagnostic of having been burnt ... all of them being highly consistent with the Appellant's account. Additionally, Dr * diagnosed the Appellant as currently suffering from chronic post-traumatic stress disorder (PTSD) consistent with his account of assault and threats whilst in detention ...

... Dr * has considerable experience and expertise in evaluating and assessing potential or actual torture or ill-treatment; her report was prepared in accordance with the Istanbul Protocol; and she has considered and in some cases opted for alternative accidental or occupational causes of the injuries presented by the Appellant. Where she considered a particular scar or lesion was non-accidental, she has explained why she reaches that conclusion; and I accept her careful and detailed evidence. Overall, it seems to me that given the considerable number, type and distribution of the non-accidental injuries identified by Dr * on the Appellant's body, there is really only one possible conclusion, which is that the Appellant has been subjected to sustained torture or acute ill-treatment ..."

xvii) Case 22 (role of medical expert, assessment of causation including self-infliction, psychological evidence and discrepancies)

Home Office written reasons for refusing asylum:

"... It is noted that Dr * actually concluded that the scars on your [part of the body] are 'diagnostic of deliberate acts'. Therefore, even if the doctor's conclusions are taken at their highest, it must only be accepted that these scars were caused deliberately. The doctor cannot and should not, be expected to state by whom, and in what circumstances, these scars were caused.

... It is accepted that you have a number of scars on your body. Because your account has not been found credible (as outlined above), it cannot be concluded that you received this scarring in the circumstances that you claim. It is not accepted that the findings

of Dr * undermine this conclusion in any way. Consequently, whilst it is accepted that you have a number of scars across your body, their existence is not considered to outweigh the credibility findings (above) and therefore they are not considered to add weight to your assertions (which have been found not to be credible) that you were tortured ..."

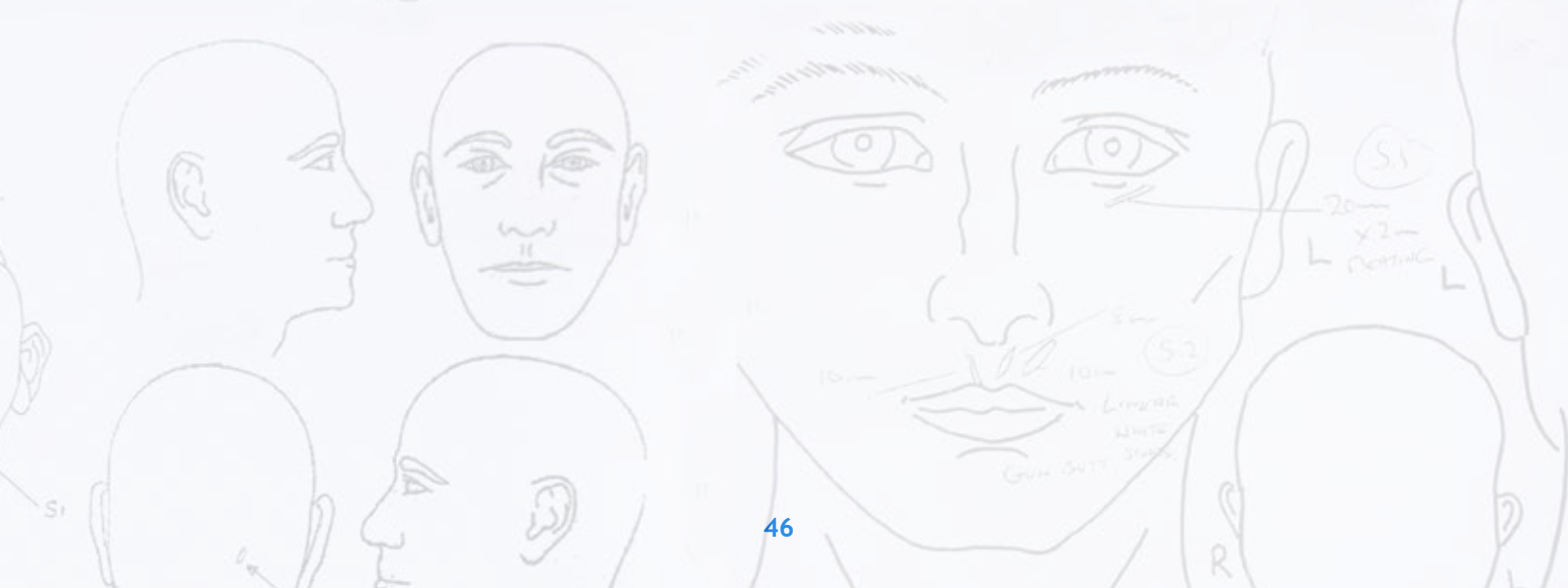
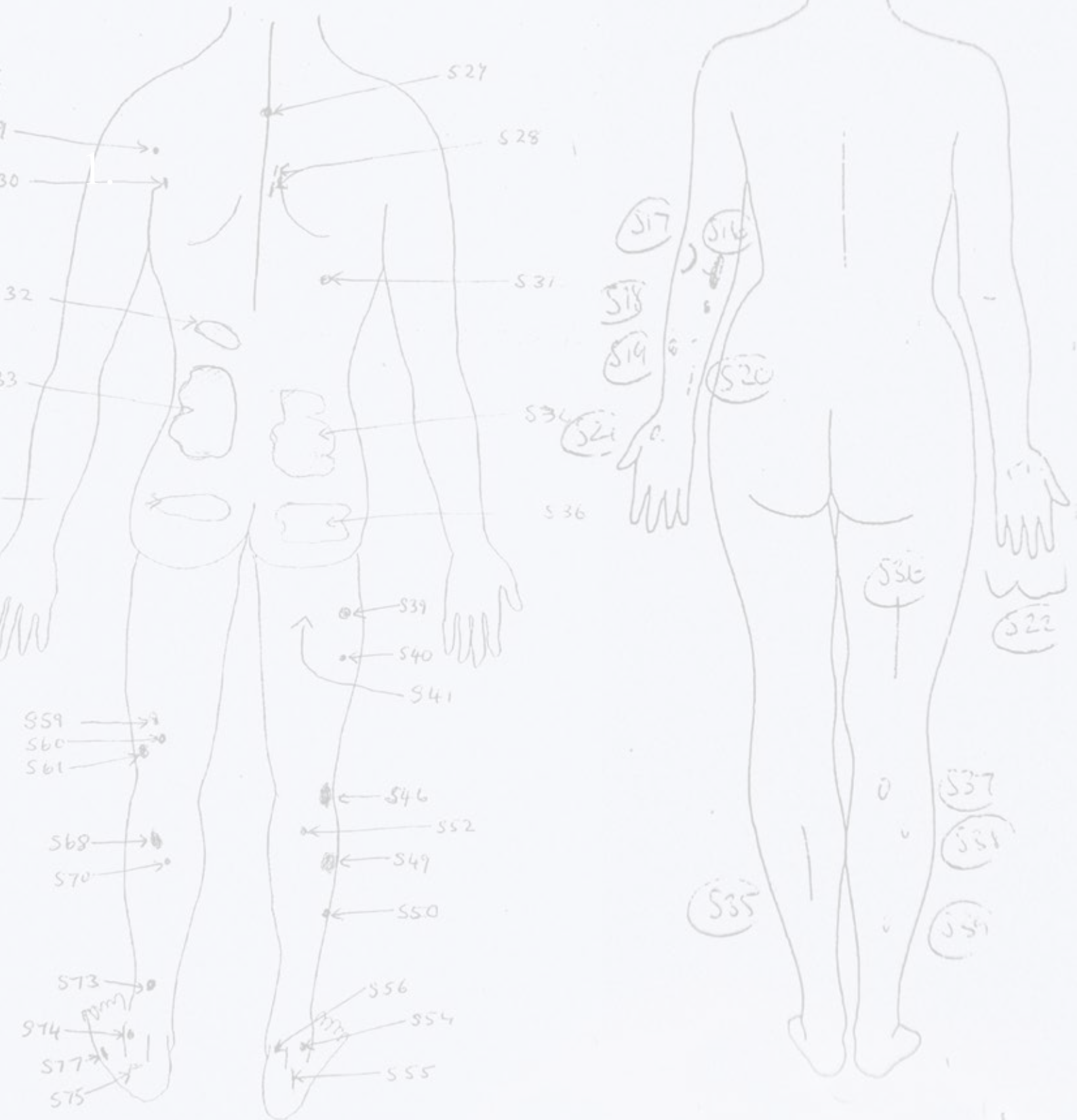
The Immigration Judge allowed the case on appeal and made the following findings in relation to the medical evidence:

Judge's determination:

"... I have looked at the documentation in the round and conclude that it is material documentation on which I can place reliance. The Appellant has made a genuine effort to substantiate his claim and all material factors have been submitted and his statements in relation to what happened to him in [country of origin] are coherent and plausible and do not run counter to available and specific and general information relevant to his case. He has sought protection at the earliest time after he suffered abuse and in my view his credibility has been established.

... Further there is the important evidence of Dr * and even the Respondent accepts that the Appellant has "a number of scars on his body". That seems to be an understatement where there are the number documented. They are said to be highly consistent with the account of the Appellant and whilst on the basis of the injuries alone, some could have been self-inflicted and the others, at his instruction, in order to improve his chances of gaining asylum, it seems to me on the basis of his detailed, consistent and coherent account and the evidence relating to [country of origin] that I reject those two alternative explanations.

... I find that as recently as ... the Appellant was detained and tortured."



CONCLUSION

This research has analysed a series of 50 Reasons for Refusal Letters from Home Office asylum caseworkers, all of which demonstrate poor decision-making practice and in particular poor treatment of expert medical evidence.

It is acknowledged that, because of our criteria for case selection (see Annex 1), our case set is limited to cases in which the poor treatment of the medico-legal report is at issue and has become a ground for appeal. However, by focusing on this case set the research is able to highlight systematic caseworker errors that lead to poor decision-making. Moreover, it has not been possible to compare the treatment of medical evidence in these refused asylum claims with those where a grant of asylum is made, as detailed reasons for grant letters are not issued to claimants or their legal representatives in these circumstances.

their understanding of this form of evidence and of how medico-legal reports should be used in the asylum decision-making process.

Our research shows that guidance in Home Office Asylum Policy Instructions outlining the correct approach to medico-legal reports and to assessing credibility in asylum claims has not been applied in practice. For example, asylum caseworkers question the qualifications and expertise of doctors and other clinicians at Freedom from Torture to document evidence of torture. More frequently, they dispute the clinician's expert opinion, preferring their own views on clinical matters or explanation of the findings.

In most cases, the caseworker does not properly engage with the detailed evidence and carefully explained clinical opinion. Instead selected findings and elements of opinion are commented on and disputed, and the evidence as a whole is not fully considered before being effectively dismissed.

Asylum caseworkers frequently base their dismissal of the medical evidence on the fact that they, or other decision-makers, have already decided that factual elements of the claim, or the claim as a whole, are not credible. Instead of viewing all the evidence in the round before reaching an opinion on credibility, as they are required to do, they conclude that the medical evidence cannot convince them to change their decision on the credibility of the material facts of the asylum claim.

In reaching this view, asylum caseworkers demonstrate a poor understanding of the standard of proof applicable to asylum claims, medico-legal report methodology and the role of the Istanbul Protocol in asylum claims. As clearly explained in policy guidance, the evidence need only establish that it is "reasonably likely" that the factual basis of the asylum claim is true for it to be accepted by the caseworker. This standard of proof also applies to expert medical evidence as a component of the asylum claim.

In the 50 asylum decisions reviewed in this research, asylum caseworkers appear to require a level of certainty in the medical evidence that is not only way

“When you are not believed, and when you have a medical report that is written by someone who is recognised and qualified to do it, and it is not accepted, this means that something is not working in the system

Member of the Survivors Speak OUT network

In the claims in this case set where the appeal process has been completed, the majority were granted asylum and the Immigration Judge made positive findings in relation to the medical evidence. The fact that 76% of claims were granted asylum following a successful appeal, as against an average grant rate of 30% for appeal cases⁴⁵, supports the finding that there is a serious problem with the treatment of expert medical evidence of torture by asylum caseworkers.

Caseworker errors highlighted in the research demonstrate that further training and support of asylum caseworkers is urgently needed to improve

beyond the required “reasonable likelihood”, but is actually impossible to attain. It seems to be expected that the medico-legal report show beyond doubt, not only that the cause of injuries documented in the report is torture, but also that torture occurred in the exact circumstances described by the asylum applicant. This is grossly inconsistent with the standard of proof that applies to asylum claims. Moreover, such definitive conclusions are generally unusual in forensic medicine.

If the evidence does not meet this impossible evidential threshold, then it is rejected altogether. For example, if injuries are described to be anything less than “diagnostic” of the attributed cause of torture, according to Istanbul Protocol terminology, then the clinical opinion on the overall evidence is given little or no weight. Or if some injuries are described as “consistent” with the torture described, but are relatively non-specific in appearance, then the clinical opinion on the overall findings, which may contain a great deal of other corroborative evidence, is similarly given little or no weight. If the doctor properly explores other possible causes of particular physical or psychological injuries observed, before concluding that the claimed cause of torture is the most likely when the evidence is viewed as a whole, asylum caseworkers dismiss this opinion, finding that if other possible causes exist then the medical evidence has no weight.

A high level of inaccuracy and omission is prevalent in the way asylum caseworkers report the content and findings of medico-legal reports in their written reasons for refusing the asylum claim. For example, asylum caseworkers frequently claim incorrectly that the clinician has omitted to consider possible alternative causes of physical or psychological injuries, when they have exhaustively done so. Or, the clinician’s findings on some injuries, particularly those assessed to have a lower level of consistency with the attributed cause of torture, are commented on but all the remaining evidence explored in the medico-legal report is ignored.

Psychological findings are rarely considered by asylum caseworkers as corroborative evidence of torture and, if considered at all, are addressed only in relation to

the person’s current health state and potential fitness to return to their home country. Detailed findings of symptoms of post-traumatic stress disorder such as recurrent nightmares and flashbacks that specifically relate to episodes of torture are simply overlooked or dismissed on the basis that psychological findings are based on subjective accounts and “cannot be objectively verified”. The fact that the clinical opinion on these and other symptoms and their cause has been reached through a comprehensive examination process, which is fully documented in the medico-legal report, including objective elements as well as the subjective account, is ignored.

Our research suggests a high level of cynicism and scepticism in the approach of asylum caseworkers to medical evidence. This is commented on by a number of Immigration Judges reviewing the claims on appeal. There appears to be an underlying presumption that the claimed history of torture and the surrounding circumstances are likely to be false and that the clinical opinion reported in the medico-legal report is largely dependent on the clinician having accepted that the account given by the person is true.

It appears in these cases as though medical evidence is viewed as an obstacle to be “got around” in the process of reasoning why an asylum claim should be refused, rather than something that can be helpful to the decision-maker and potentially provide corroboration of key elements of the claim.

Freedom from Torture recognises that there are many asylum caseworkers who do a very difficult job extremely well, including deciding asylum claims involving expert medical evidence; however, these 50 cases have demonstrated the widespread nature of poor practice and the fact that it is not limited to particular asylum caseworkers, teams or regional offices, nor to particular profiles of asylum claims. These findings indicate systemic problems and the need for a substantive, systems-level approach to finding a solution and the necessary improvement in practice.

Mistreatment by asylum caseworkers of medical

ACK

S29 → evidence of torture leads to long and costly legal appeals and a need for claimants to be financially supported in the asylum system for many months and even years throughout this process.

S30 →

S32 → For survivors of torture who need asylum, this experience of legal limbo and the impact of being disbelieved and having their medical evidence mishandled can be psychologically devastating. Until they are granted legal protection, they are kept living in fear of forced removal back to the country where they have been tortured and trapped in a state of insecurity and dependence, all of which impedes their chances of rehabilitation and social integration.

S33 →

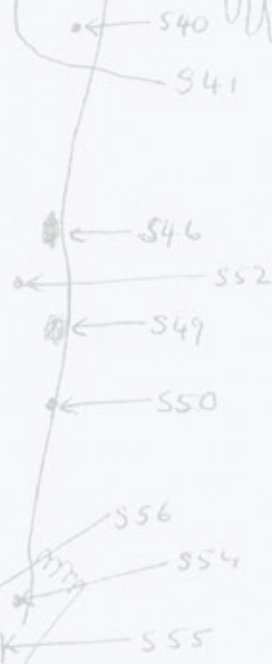
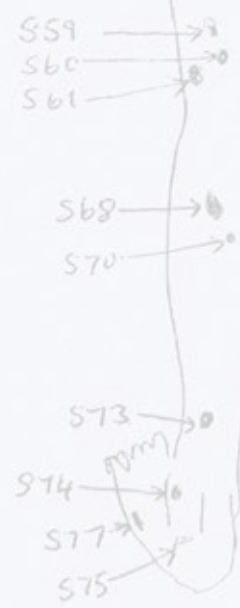
S35 →

Appeal processes are an essential element of a well-functioning justice system. However, ensuring that the right decisions are reached the first time around

S28 → is better both for claimants, especially survivors of torture and others who are highly vulnerable, and taxpayers.

Ministers and taxpayers should therefore be highly concerned about an apparent over-reliance by the Home Office on asylum appeals to correct straightforward failures by caseworkers to comply with Home Office policy on how to handle to medical evidence of torture.

Freedom from Torture wishes to acknowledge the positive signals from senior Home Office officials about the need to tackle these problems. The challenge now is to convert good intentions into changed practice, for the benefit of survivors of torture and in the broader public interest.

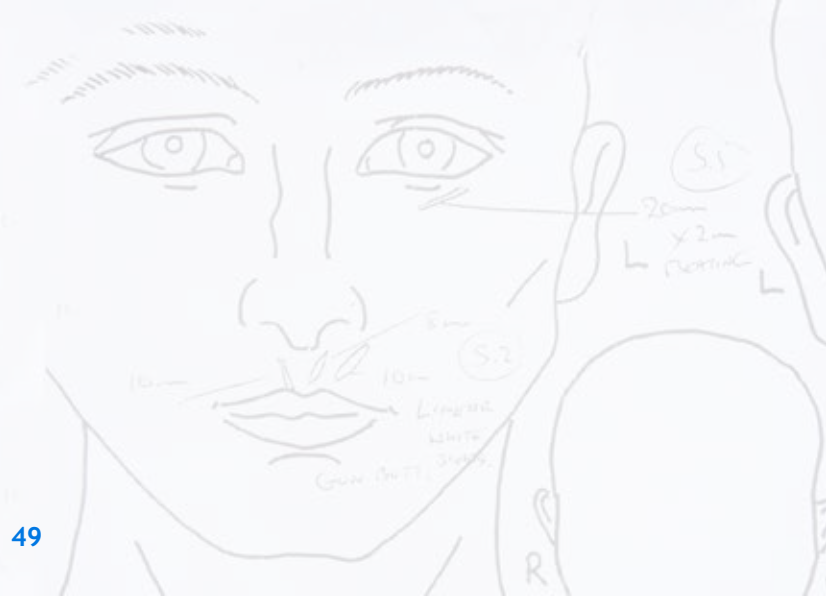
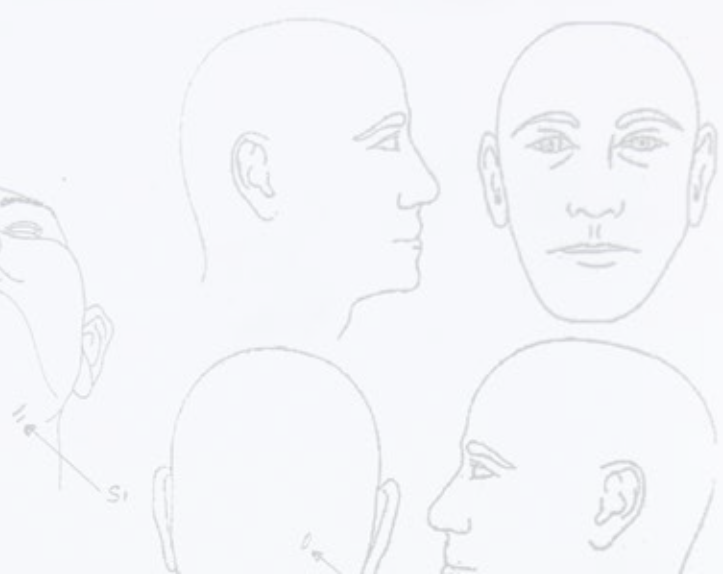


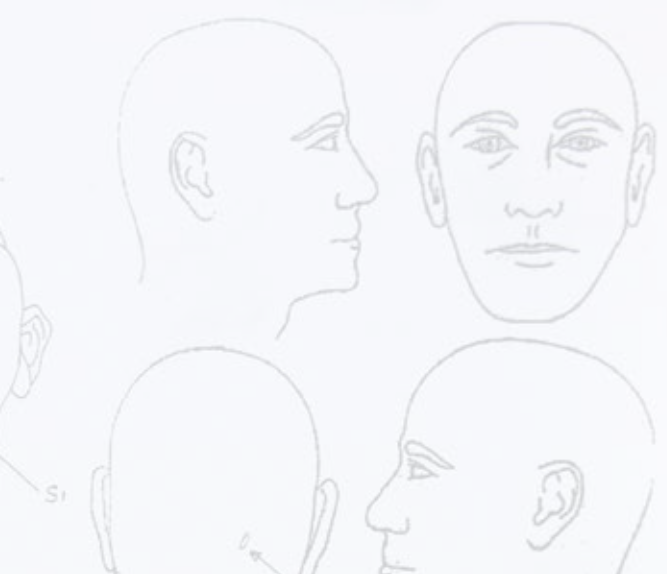
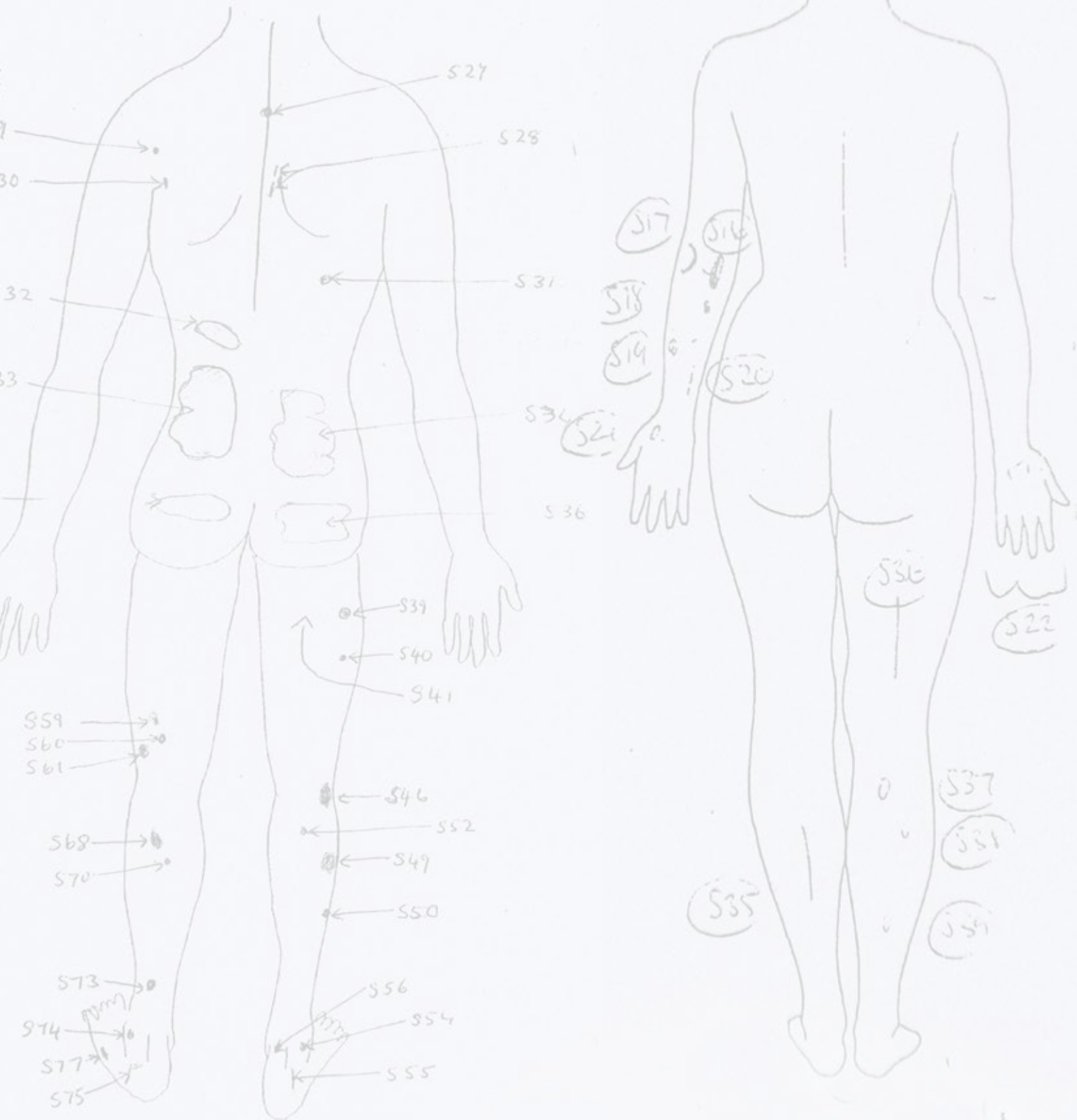
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S39





RECOMMENDATIONS

- 1) **The Home Secretary should order immediate measures to improve decision-making in asylum cases involving medical evidence of torture, starting with the roll-out to all asylum caseworkers of the full day training module which the Home Office developed but never launched.**

Leadership from the Director of Asylum Operations and asylum casework managers is essential as a means of ensuring this training translates into asylum decisions for torture survivors that are “right the first time”.

This leadership should involve regular communications to senior caseworkers and caseworkers about the importance of improved decision-making in cases involving medical evidence of torture, reinforced by systems - including routine oversight, quality audits of decisions and remedial action if problems continue - capable of demonstrating to Ministers, Freedom from Torture and other stakeholders whether practice is improving or not.

- 2) **An independent public audit should be undertaken by a body with the requisite legal expertise, such as the UN High Commissioner for Refugees, into the application in practice of the standard of proof in asylum claims in the UK, including cases involving expert medical evidence of torture.**

This independent public audit should enjoy the full cooperation of the Home Office. Survivors of torture, those with experience of providing expert evidence in asylum claims and legal and other civil society organisations in the refugee field should be among those given an opportunity to provide evidence.

- 3) **The Home Office must ensure that, in the event of any revisions, its Asylum Policy Instruction on the treatment of medical evidence of torture continues to reinforce the following principles:**

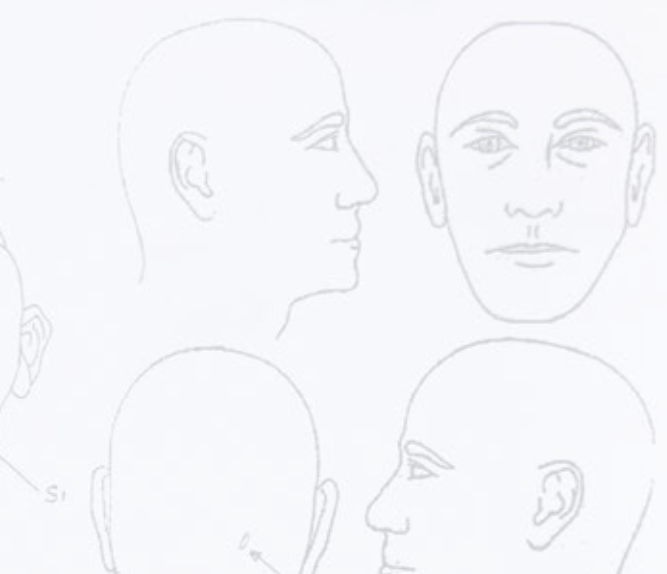
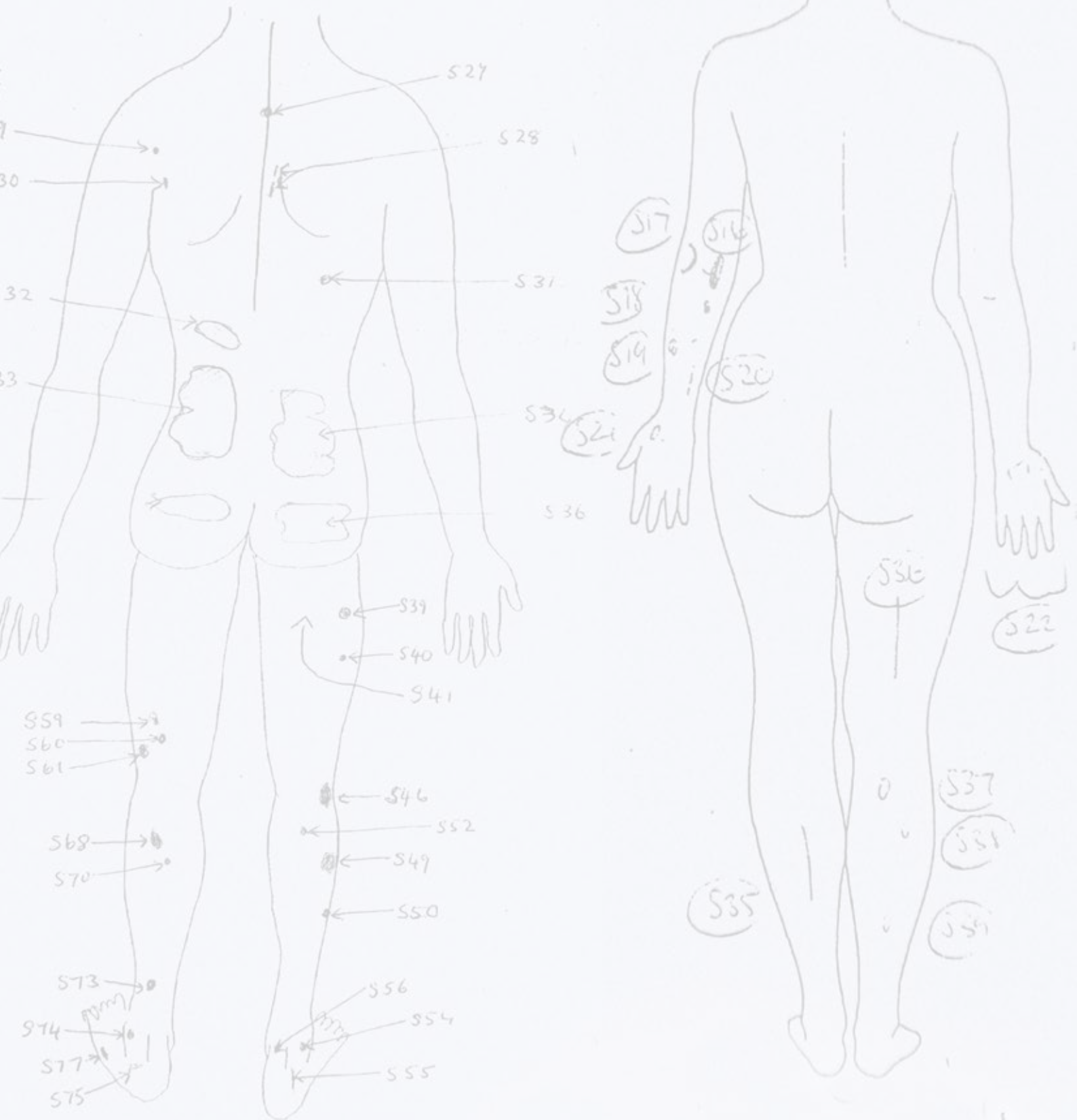
- The standard of proof in asylum claims is “reasonable likelihood” and medical evidence that is produced by suitably qualified experts and

that meets this threshold should be accepted;

- All evidence must be considered in the round, including expert medical evidence, and a conclusion on the overall credibility of a claim must not be reached before consideration of an expert medical report where one is available;
- The evidence of doctors, including General Practitioners (GPs) trained in the documentation of torture, must be accepted as expert medical opinion on the clinical sequelae of torture, both physical and psychological;
- The caseworker’s opinion must not be substituted for expert medical opinion on matters specific to the clinical documentation of torture, without the support of alternative equally qualified expert medical opinion;
- Psychological evidence can provide valuable corroboration of a claim of torture and should be considered in the round alongside other evidence of torture;
- If the asylum caseworker is minded to reject a claim involving medical evidence of torture, the case must be discussed with a senior caseworker; and
- In cases where a medico-legal report is submitted after the claim is refused by the Home Office, the case should be reviewed before any appeal takes place.

- 4) **The Home Affairs Committee of Parliament should launch an initiative to monitor Home Office handling of asylum claims involving torture allegations as part of its regular scrutiny of the work of the Home Office Immigration Directorates.**

This should include a focus on the high appeal overturn for claims involving expert medical evidence of torture prepared by Freedom from Torture and the effectiveness of measures taken by the Home Office to solve the problems identified in this research.



Context and aim of the research

This research follows Freedom from Torture's 2011 report, "*Body of Evidence*"⁴⁶, which examined treatment of medico-legal reports at appeal stage and identified a number of areas of concern about practice at the Immigration and Asylum Chamber of the Tribunal. Since the publication of this earlier report, Freedom from Torture has engaged with the Tribunal, mainly through training, in an effort to achieve more consistency in the approach of Immigration Judges to expert medical evidence of torture, and to improve their understanding of the evidence, of the standards for torture documentation set out in the Istanbul Protocol and of the methodology adopted by clinicians producing reports at Freedom from Torture. Freedom from Torture is planning further research to examine the success of these initiatives.

While "*Body of Evidence*" focused on decision-making by the Tribunal, the report also indicated a high overturn rate of Home Office decisions in asylum claims involving medico-legal reports (69%), and made findings on poor treatment of medical evidence by asylum caseworkers in those claims where medico-legal reports were available at the initial decision stage.⁴⁷ Following this publication, in January 2014 the Home Office released an Asylum Policy Instruction on medico-legal reports from Freedom from Torture, which deals with a number of process issues but also gives important guidance to asylum caseworkers on how to handle medico-legal reports as part of the decision-making process (Section 3).⁴⁸ These parts of the guidance were a positive response by the Home Office to decision-making problems outlined in "*Body of Evidence*", which Freedom from Torture strongly welcomed.

The aim of the present research is to examine asylum caseworkers' treatment of Freedom from Torture's medico-legal reports since the issue of this policy instruction, through close analysis of a cohort of recently decided asylum claims. Decision-making practice is analysed through a detailed and systematic review of 50 medico-legal reports and the corresponding Home Office refusal letters (Reasons for Refusal Letter). Asylum caseworkers' reference

to and use of the medico-legal reports is assessed against a pre-defined set of quality criteria that are based on: practice guidelines contained in the Asylum Policy Instruction, standards set out in the Istanbul Protocol and findings of previous research, reported in "*Body of Evidence*".⁴⁹ Where available, appeal determinations are also reviewed to assess judicial treatment of these asylum claims, and in particular the treatment of the medical evidence.

Case set

The case set is not a random sample of all asylum claims where Freedom from Torture has submitted a medico-legal report, for reasons described below. It is a purposive sample, and selection criteria for inclusion of cases in the research are as follows: i) a medico-legal report from the Medico-Legal Report Service at Freedom from Torture has been submitted in evidence in an individual's asylum claim; ii) the Home Office has refused the asylum claim following submission of the medico-legal report, with the decision issued since January 2014; iii) Freedom from Torture's Head of Doctors has issued a clinical response letter dealing with the consideration of the medical evidence, at the request of the asylum applicant's legal representative and iv) there is consent from the person to use their documents for research. All cases fitting these criteria are included in the research.

Home Office refusal letters in asylum claims where Freedom from Torture has prepared a medico-legal report are sent to the applicant's legal representative and are often difficult for Freedom from Torture to obtain, despite this being requested as a matter of routine. The research therefore includes only cases where the legal representative has requested and been provided with a clinical response letter following refusal of an asylum claim. The clinical response letter, prepared by the Head of Doctors at Freedom from Torture, deals with the treatment of the medical evidence in the asylum decision. In these cases, the legal representative will necessarily supply us with the Home Office refusal letter; in addition, the sustained contact makes it easier for us to obtain the final outcome of the asylum claim and Tribunal determination once the appeal has been heard.

Fully reasoned decisions to grant asylum are not made available to applicants or to their legal representatives, unlike refusal letters. Unfortunately, it is therefore not possible to include asylum claims in the research where there has been a decision to grant asylum at the first instance following submission of a medico-legal report. This means that it is not possible to assess how asylum caseworkers have made use of medical evidence in asylum claims that are granted in the first instance and draw out examples of good practice. It is also not possible to compare treatment of the evidence in these claims with those that are refused. However, as legal representatives request “response letters” from our Medico-Legal Report Service when they have concerns about the treatment of medical evidence in the decision, this case set lends itself to a deep and systematic examination of the problems that occur.

As this is not a random sample of all asylum claims involving medical evidence of torture, provided by Freedom from Torture or other providers, including both those resulting in grants and refusals, we cannot infer the overall prevalence of poor decision-making in relation to medical evidence from these findings. Grants of asylum at first instance following submission of a medico-legal report from Freedom from Torture clearly do occur, and this is welcomed. However, it is likely that the issues highlighted in these 50 asylum claims indicate a much broader trend, given that “response letters” were issued in around 17% of claims where Freedom from Torture issued a medico-legal report during the relevant period.

Research method

A bespoke database was created to code and analyse data from Home Office refusal letters. A series of structured fields capture key quality criteria and elements of decision-making practice and track incidence of poor practice. Free text fields allow for the collation of specific examples, via excerpts from refusal letters and summary notes. Structured fields have been developed with reference to previous research, including “*Body of Evidence*”, earlier Freedom from Torture unpublished research and an earlier unpublished Freedom from Torture audit of clinical response letter cases; guidance given in the Home Office Asylum Policy Instruction, and standards set out in the Istanbul Protocol.

Key elements of decision-making practice are grouped in the following categories:

- The application by asylum caseworkers of the correct standard of proof and assessment of the weight of expert medical evidence;
- The use of subjective opinion and clinical judgments by asylum caseworkers on matters for which the clinician has stated an expert opinion;
- Questioning by asylum caseworkers of the qualifications and expertise of medico-legal report authors to document the physical and psychological consequences of torture;
- The assessment by asylum caseworkers of credibility and use of the expert medical evidence;
- Asylum caseworkers’ understanding of the medico-legal report methodology and interpretation of the clinical findings; and

Data analysis

Due to the use of structured data fields, it is possible to carry out basic quantitative analysis on the findings, with a view to describing the prevalence of the particular issues identified in this case set. Due to the relatively small numbers, especially in sub-groups of cases, and given that the case set is not a random probability sample, statistical significance tests on the findings have not been carried out. Qualitative (thematic) analysis has been carried out on excerpts from refusal letters related to the decision-making issues identified above, to give context and enable a more detailed and specific description of the decision-making practice observed in these cases.

As noted above, it is recognised that the research findings cannot be generalised to all asylum claims involving medico-legal reports from Freedom from Torture. However, a number of demographic and process factors are reviewed in order to assess whether there are any unusual features in the case set, other than the selection criteria (including request by the legal representative for a clinical response letter from Freedom from Torture, following refusal of the asylum claim). This is to allow for an assessment of whether the research findings are indicative of practice beyond the 50 asylum claims reviewed. The factors reviewed include: age, sex and country of origin of the asylum claimant for whom the medical evidence was produced; stage of the asylum claim at which the medico-legal report was submitted to the Home Office (initial claim or as part of further submissions for a “fresh claim”); type of medico-legal report (report produced by an independent doctor or by the treating clinician at Freedom from Torture), report author and issuing centre; Home Office decision-maker, legal representative and outcome of the asylum claim following refusal by the Home Office. Sub-groups within the case set are identified in order to review asylum caseworker practice in relation to particular types of claim.

As described below, the demographic profile of people whose cases are included in the research is similar to the general profile of clients referred to Freedom from Torture for a medico-legal report. The reports are typical of those produced by our Medico-Legal Report Service during this time period. All are expert reports and are subject to legal and clinical reviews that ensure the appropriate quality standard is met. There are no clusters of decision-makers in the case set. In fact, the 42 asylum caseworkers that prepared the 50 refusal letters are located in different teams in Home Office regional offices across the UK. Only two regional offices are responsible for more than five decisions, Liverpool and Cardiff, and in both cases a number of different teams and asylum caseworkers are involved.

The characteristics of the case set indicate that the poor decision-making practice identified in this research is more widespread among Home Office asylum caseworkers. However, it is important to

acknowledge that we have not had sight of asylum claims involving medico-legal reports that are granted at the initial decision stage, in which more positive examples of treatment of medical evidence might be found.

The outcome of the asylum claims in this case set are reported where known and they indicate a very high decision overturn rate of 76% on appeal, with most judges making positive reference to the medical evidence, which they found material to their determination of the asylum claim. Although this grant rate is based on relatively small numbers (29 of the 50 cases) it certainly indicates that there is a problem with the quality of Home Office decision-making in asylum claims involving medico-legal reports from Freedom from Torture.

Demographic profile

There are 14 different countries of origin among the people whose cases are included in the research, although the majority are from three countries: Sri Lanka, Iran and the Democratic Republic of the Congo (DRC). These countries are also the top three nationalities of people referred to Freedom from Torture for medico-legal reports, according to internal monitoring.

Figure 6: Country of origin, number of people and incidence in case set.

Country of origin	Number of cases	Incidence
Sri Lanka	16	33%
DRC	9	19%
Iran	6	13%
Cameroon	3	6%
Pakistan	3	6%
Afghanistan	2	4%
Ethiopia	2	4%
Guinea	2	4%
Russia	2	4%
Côte d'Ivoire	1	2%
India	1	2%
Israel	1	2%
Malaysia	1	2%
Sudan	1	2%

There are 36 men and 14 women in the case set (72% and 28% respectively) and their ages range from 20 to 54 years old (age at the time the medico-legal report was produced) with the majority aged 26-40 (median age 33, average 34). This age and gender profile is fairly typical for people referred to Freedom from Torture for medico-legal reports.

Stage of the asylum claim

In 30 of the 50 asylum claims the medico-legal report was prepared for submission to the Home Office before the initial decision had been made in the person's asylum claim (60%). The remaining 20 medico-legal reports (40%) were submitted to the Home Office as part of further submissions for a "fresh claim", following a previously unsuccessful asylum claim. In these claims an in-country right of appeal was granted.⁵⁰ In all cases (as per the criteria for inclusion) "response letters" dealing with the

treatment of the medical evidence were prepared by the Head of Doctors at Freedom from Torture at the request of the legal representative following refusal of the claim, and submitted to the Immigration and Asylum Chamber of the Tribunal in an appeal.

Type of medico-legal report, author and issuing centre

Forty-five of the 50 medico-legal reports are Freedom from Torture expert reports prepared by doctors trained in the forensic torture documentation process, examining physical and psychological evidence of torture claimed by the person. Five of the medico-legal reports are psychological therapy reports issued by treating clinicians at Freedom from Torture, who are also trained in the expert witness report writing process, documenting the psychological consequences of torture only.

The medico-legal reports were issued from five different Freedom from Torture centres around the UK, although most were issued from our largest centres in London and Manchester (31 and 15 reports respectively). These two centres issue the majority of Freedom from Torture medico-legal reports. Thirty-five different doctors prepared the 45 medico-legal reports with no doctor preparing more than three reports and the majority preparing only one report (25 doctors). Five different clinicians prepared the other five reports, including a psychiatrist, a clinical psychologist and three psychotherapists.

Home Office decision-makers and legal representatives

Reasons for Refusal Letters (henceforth refusal letter) for the 50 asylum claims were issued between January 2014 and December 2015 by 42 different asylum caseworkers, in 31 different teams, based in 13 Home Office decision-centres in locations across the UK. These were: Bedford - Yarl's Wood, Cardiff, Croydon, Glasgow, Hounslow, Leeds, Liverpool, London - Beckett House and Harmondsworth, Manchester, Peterborough, Sheffield and Solihull.

One person wrote the refusal letter for three different claims and in four cases the name of the asylum caseworker was not included in the refusal letter. Asylum caseworkers in 12 different teams in Liverpool made the largest number of decisions⁵¹ (19, 38% of all decisions), followed by Cardiff, where eight decisions were issued from five different teams (16%). All other decision centres issued less than five refusal letters.

Figure 7: Number of cases and teams issuing refusal letters, by Home Office decision centre.

Decision centres	Number of cases	Number of teams
Liverpool	19	12
Cardiff	8	5
Beckett House	4	1
Harmondsworth	4	1
Solihull	3	1
Leeds	3	2
Croydon	2	2
Yarls Wood	2	2
Glasgow	1	1
Manchester	1	1
Hounslow	1	1
Sheffield	1	1
Peterborough	1	1

Forty different legal representatives based in 24 law firms around the UK represented the 50 asylum applicants. Only six of the legal representatives had more than one client in the case set and only four of the law firms represented more than two of the asylum applicants.

Outcome of asylum claim

As per the selection criteria (see Annex 1, Case set) all the people whose cases are included in the research (initial claims and “fresh claims”) were refused asylum following submission of the medico-legal report. An additional submission of medical evidence at the appeal stage was made in all cases, in the form of a clinical response letter prepared by the Head of Doctors at our Medico-legal Report Service, which addresses the treatment of the medical evidence by the Home Office decision-maker.

Final outcomes are not known in all the asylum claims. Of the 29 cases with a final decision that is known, 22 have been granted asylum following a successful appeal; a **grant rate (and therefore decision overturn rate) of 76% for asylum claims with a final decision that is known to us**. When all cases are included, both those with known and unknown outcomes, the grant rate is 44%. All 22 asylum claims were allowed on appeal by Immigration Judges at the Immigration and Asylum Chamber of the Tribunal.

According to available information from legal representatives, most of those without a final outcome are involved in further appeals (18 undecided cases, 36%). Seven cases had been dismissed on appeal and at the time of the research there was no further legal action (14%). For a further three cases, no information was available to Freedom from Torture due to lack of contact from the legal representative.

Figure 8a: Outcome of asylum claim, cases with a final known outcome (29 cases).

Case outcome	Number	Incidence (in 29 cases)
Legal status granted	22	76%
Appeal dismissed - no further action	7	24%

Figure 8b: Outcome of asylum claim, all cases (50 cases).

Case outcome	Number	Incidence (in 50 cases)
Legal status granted	22	44%
Refused - case ongoing	18	36%
Appeal dismissed - no further action	7	14%
No information available	3	6%

Findings for sub-groups of cases

Medico-legal report was issued i) before the initial decision on the asylum claim and ii) in further submission for a “fresh” asylum claim

The demographic profile of people was not markedly different in these two groups of cases, although there were proportionately more people from the Democratic Republic of the Congo in the “fresh claim” group (5/20 compared with 4/30). The grant rate following appeal (decision overturn rate) was higher in the “initial decision” group than in the “fresh claim” group (16/20, 80%, compared with 6/9, 66%, as a proportion of cases with a final decision only). In 15 of the 16 “initial decision” cases allowed on appeal, the Immigration Judge explicitly disagrees with the treatment of the medical evidence by the Home Office. In four of the nine “fresh claim” cases in which there is a final decision, the Immigration Judge supports the negative findings of previous decision-makers in relation to the medical evidence and in five of the six cases allowed on appeal, they disagree with the earlier findings.

At issue in a high proportion of asylum claims in both groups was: the interpretation of the clinical findings and consideration of possible alternative causes of injuries, the assessment of the consistency between the clinical findings and the attributed

cause of torture, the assessment of credibility and the consideration of the psychological evidence. There was no marked difference in the treatment of the medical evidence in these two groups of cases, other than a slightly higher incidence in the “fresh claim” group of deficiencies in the treatment of psychological evidence in relation to the claim of torture and inconsistencies in the person’s account

Psychological therapy reports prepared by treating clinicians

These reports are unremarkable in terms of profile of the person by comparison with the wider case set. Two applicants had submitted the report before the initial decision on the asylum claim and the other three had submitted reports as part of further submissions for a “fresh claim”. None of the applicants had been granted asylum following appeals, although there was ongoing legal action in three claims. The medical evidence was not at issue in one of the other two claims but there was no further legal action, and for one claim the outcome was unknown.

Issues in the refusal letters include the qualifications of the medico-legal report author in one case and a range of other issues in all the cases including: the link between the psychological evidence and the attributed cause of torture; the methodology of the report and an alleged over-reliance on the account given by the person; the assessment of possible alternative causes of psychological injuries and consideration of fabrication, the accuracy of clinical diagnoses and the weight to be given to the medical evidence. No judicial determinations were available in these cases.

Cases decided in the Liverpool regional office

The 19 cases decided in Liverpool are unremarkable in profile, other than that the majority are “fresh claims” (14/19, 74%, compared with 40% in the whole case set), which is unsurprising given that there is a dedicated team located in Liverpool dealing with this type of case. Seven of the 19 claims had been granted asylum following an appeal (37% of 19 cases), although the majority of the remaining claims had ongoing appeals at the time of the research (10

cases, with one further case awaiting a decision). Only one asylum claim had been refused with no further legal action.

Issues in the refusal letters were, most commonly: the assessment of the consistency of the clinical evidence with the attributed cause of torture and the use of Istanbul Protocol terms to describe this; the assessment of alternative possible causes of injuries, the link between the psychological evidence and torture and the application of a negative credibility prior to consideration of the medical evidence.

Cases granted asylum following appeal

Appeal determinations are available for 19 of the 22 asylum claims allowed on appeal. The 19 appeals were heard by 18 different Immigration Judges in eight different Tribunal hearing centres around the UK in the following locations: Birmingham, London - Harmondsworth, Hatton Cross and Taylor House, Loughborough, Manchester, Newport and Stoke-on-Trent. Determinations were issued between April 2014 and June 2016. In all determinations the Immigration Judge makes positive findings in relation to the medical evidence and in most they explicitly disagree with the assessment of the Home Office caseworker, and this is material to their decision to allow the appeal.

There are eight countries of origin among the people whose asylum claims are granted, with the majority coming from the Democratic Republic of the Congo and Sri Lanka (eight and six cases respectively).

Proportionately more people from the Democratic Republic of the Congo are in this sub-group of claims that were allowed on appeal than in the wider case set (eight out of nine in the case set), although numbers are small. Conversely, proportionately fewer are from Sri Lanka and Iran (six out of sixteen in the case set and two out of six in the case set respectively). The male/female breakdown is virtually the same as for the wider case set (73% male and 27% female).

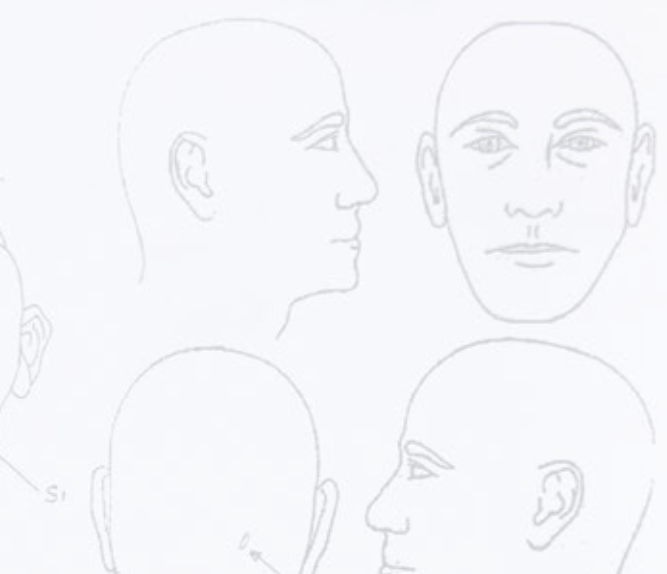
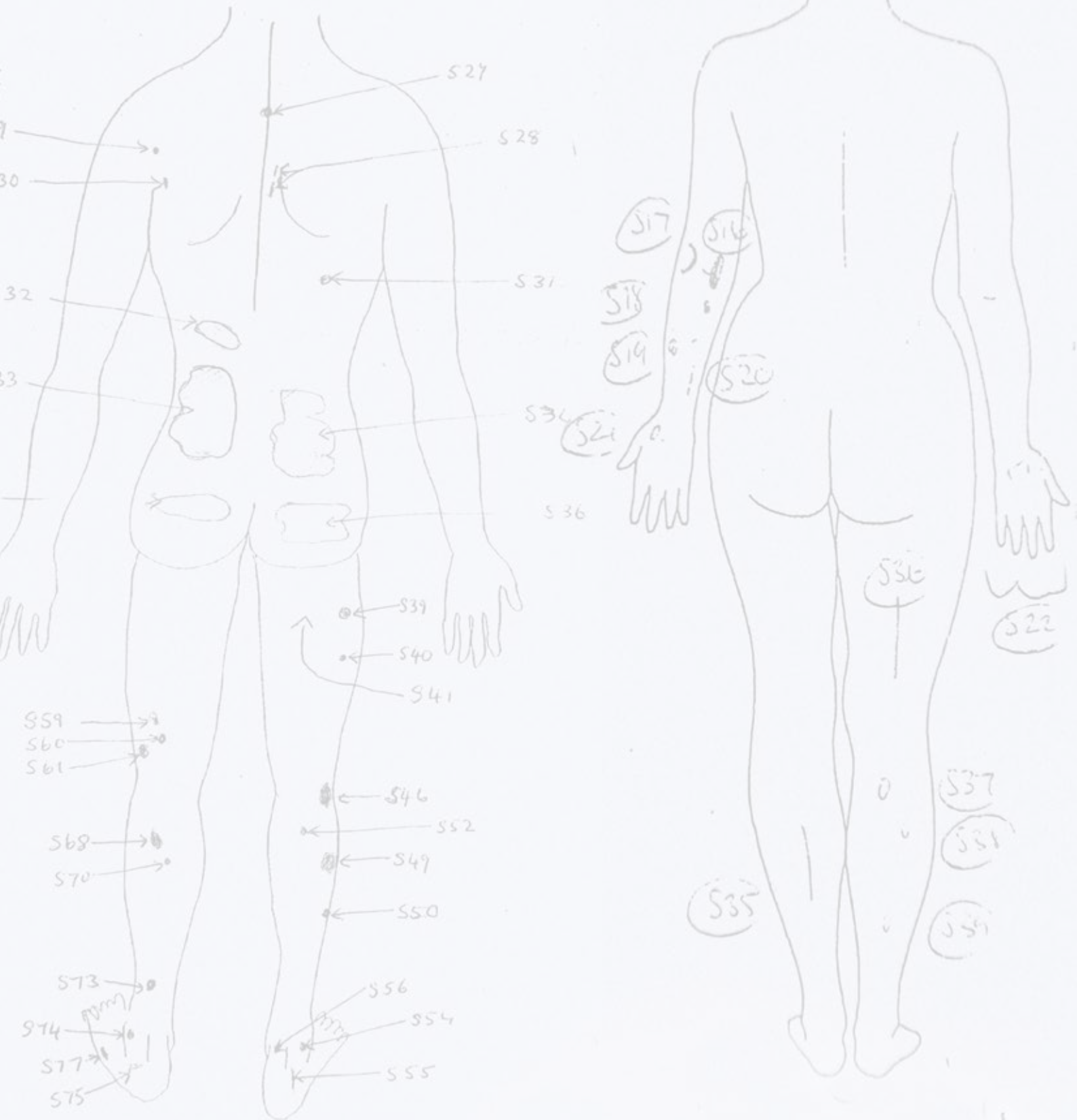
The majority of applicants had submitted a medico-legal report at the initial stage of their asylum claim (72%), with six submitting the medico-legal report as part of an application for a “fresh claim” (27%). A higher proportion of claims allowed on appeal had

therefore submitted their medico-legal report at the initial decision stage, compared with the whole case set (72% compared with 60%). Refusal letters for the 22 claims allowed on appeal were issued by 20 different asylum caseworkers based in 10 Home Office regional centres and applicants were represented by 19 different legal representatives based in 14 law firms around the UK. Only three of the legal representatives had more than one client in the case set and only one of the law firms represented more than two of the applicants.

Issues in these refusal letters were, most commonly: the assessment of the consistency of the clinical evidence with the attributed cause of torture; the assessment of alternative possible causes of injuries; the link between the psychological evidence and torture; and the application of a negative credibility prior to consideration of the medical evidence.

Cases refused with no further legal action

The seven people whose claims have been refused with no further legal action are from five countries; two are from Iran and Sri Lanka and one from each of three other countries. Numbers are small and do not indicate a profile that is distinguishable from the overall case set. In six of the seven asylum claims a standard medico-legal report was submitted and in the seventh case a psychological therapy report from a psychotherapist was provided. All seven claims were decided by different asylum caseworkers based in different offices. Four claimants had submitted a medico-legal report at the initial stage of their claim, and three as part of an application for a “fresh claim”. Appeal determinations were available for four of the seven claims dismissed on appeal; different Immigration Judges in three different Tribunal hearing centres around the UK heard the appeals. Three of the four Immigration Judges accepted the evidence of the medico-legal report, in so far as it established that injuries had been inflicted deliberately by a third party, but did not accept the person’s account of the circumstances in which this had occurred and did not accept that they would face ongoing risk. The fourth Immigration Judge did not accept the findings of the medico-legal report in relation to discrepancies in the account and the possibility of fabrication.



Case study 1: Case number 22

Profile	Medical Evidence	Decisions
Nationality Sri Lankan	Medico-Legal Report Documents 46 scars found by the clinician to be evidence of torture. Documents evidence of post-traumatic stress disorder and depression found by the clinician to be directly related to torture.	Home Office decision Asylum claim refused
Gender Male	Other medical evidence Letter from a London Mental Health Trust giving a diagnosis of post-traumatic stress disorder.	Tribunal determination Allowed on appeal

Ravi's case⁵²

Ravi is a student from Sri Lanka who was living in the UK on a student visa. He travelled home following the end of the Sri Lankan civil war and shortly after arriving he was detained and tortured for seven days. His torture involved immersion and burning with cigarettes and a hot metal object. He returned to the UK on a valid visa within days of his torture and claimed asylum at port. Upon arrival, an ambulance was called and he was taken to hospital and treated for multiple burns.

Ravi's medico-legal report documents 48 scars, 46 of which were found by the clinician to be evidence of torture. It also documents evidence of depression and symptoms of post-traumatic stress disorder found by the clinician to be directly related to torture.

The Home Office refused Ravi's asylum claim. There are a number of problems with how the asylum caseworker handles the medical evidence. For example, the caseworker:

- Selectively quotes from the medico-legal report and wrongly suggests that it does not comply with the Istanbul Protocol⁵³;
- Speculates about alternative causes of Ravi's scars and in particular suggests the possibility of self-infliction of injuries;

- Does not consider the medico-legal report when making an overall credibility finding, and does not apply the correct standard of proof when considering the medical evidence; and
- Misunderstands both the methodology for a psychological assessment used by Freedom from Torture clinicians, and the fluctuating nature of mental health symptoms; and makes a clinical judgment about whether Ravi's psychological condition could explain discrepancies in his account.

On appeal, the Immigration Judge finds Ravi's account credible. In particular, based on the expert opinion of the Freedom from Torture clinician that the scars are highly consistent with Ravi's account, the Judge rejects the asylum caseworker's suggestion that Ravi's injuries could have been self-inflicted. The Judge finds that Ravi has been detained and tortured.

The appeal was allowed on asylum grounds and on human rights grounds.

In detail: Home Office treatment of the medical evidence

Interpretation of scars in the medico-legal report

*“... The medical practitioner who has written this report - Dr * - considered your scarring in two parts. Firstly, he addressed those scars found on the front of your body. He concluded that ‘it was very difficult to surmise of an alternative reasonable explanation to that of [your] attribution that they had been caused by [your] having been burnt with lighted cigarettes’ ([medico-legal report] para 38). It is noted that Dr *’s conclusion is therefore not compliant with the Istanbul Protocol. Furthermore, Dr * suggested that severe skin infections can give rise to small scars on the skin, but then appears to have ruled this alternative cause out simply on the basis that all of the scarring is grouped together on your [part of the body] ([medico-legal report] para 38). Finally, Dr * has not addressed whether these scars could have been self-inflicted (which it is considered that they could be).*

*Secondly, Dr * addressed those scars found on your back. He states that ‘Each individual burn could have been caused by a variety of circumstances’ ([medico-legal report] para 42), but then only goes on to discount one set of circumstances. Furthermore, it is noted that Dr * actually concluded that the scars on your back are ‘diagnostic of deliberate acts’ ([medico-legal report] para 42). Therefore, even if the doctor’s conclusions are taken at their highest it must only be accepted that these scars were caused deliberately. The doctor cannot, and should not, be expected to state by whom, and in what circumstances, these scar were caused.”*
(Reasons for refusal letter)

Compliance with the Istanbul Protocol

The asylum caseworker quotes selectively from the medico-legal report to suggest that the report does not comply with the Istanbul Protocol. However, the clinician does assess the scars mentioned using the consistency schema set out at paragraph 187 of the Istanbul Protocol in other parts of the medico-legal report. The quoted section is the clinician’s

consideration of possible alternative causes for the scars, not his consideration of how consistent the scars are with Ravi’s account.

Clinical judgments

The asylum caseworker goes on to make clinical judgments about the scars, suggesting on two occasions that the clinician does not properly rule out alternative causes, and on one occasion that the clinician’s detailed reasons for ruling out a specific alternative cause are insufficient. The Home Office policy on medical evidence⁵⁴ states that it is inappropriate for an asylum caseworker to speculate about alternative causes of physical or psychological injury, since this amounts to a clinical judgment that the caseworker is not qualified to make.

The asylum caseworker also suggests that some of Ravi’s injuries could have been self-inflicted. However, it is the clinician’s expert opinion that there are no other reasonable explanations for the injuries than the one Ravi provided, which is a clinical judgment.

Credibility finding and expert medical evidence; standard of proof

*“It is accepted that you have a number of scars on your body. Because your account has not been found to be credible (as outlined above), it cannot be concluded that you received this scarring in the circumstances that you claim. It is not considered that the findings of Dr * undermine this conclusion in any way. Consequently, whilst it is accepted that you have a number of scars across your body, their existence is not considered to outweigh the credibility findings (above) and therefore they are not considered to add weight to your assertions (which have been found not to be credible) that you were tortured.”*

(Reasons for refusal letter)

The asylum caseworker uses a negative credibility finding that has been made before the medico-legal report is considered to dismiss the medical evidence. The Home Office policy on medical evidence states that an overall finding on the credibility of an account must not be reached without full consideration of

the contents of the medico-legal report. A credibility finding should not be made without the medical evidence, and should not be used to dismiss the medical evidence.

The statement that the findings in the medico-legal report do not undermine in any way the asylum caseworker's negative credibility finding or add weight to Ravi's account of torture suggests that the caseworker has not applied the appropriate standard of proof in this case. Given the low standard of proof used in asylum cases - "reasonable likelihood" - scars that are highly consistent with an applicant's account provide strong evidence of torture that should be taken into account by the asylum caseworker. The Home Office policy on medical evidence states that a Freedom from Torture medico-legal report cannot be dismissed or given little or no weight when assessing the credibility of a claim.

Psychological evidence and the methodology of a medico-legal report

*"... Finally, Dr * addressed your psychological state. It is noted that he did not diagnose you with [post-traumatic stress disorder] ([medico-legal report] para 48), but did state that you demonstrated signs of depression ([medico-legal report] 46) (although this conclusion does appear to have been reached on the basis that he has accepted the account you have given him to be true). It is noted at this point that, although you arrived at interview with a number of medicines for [body part] pain, you did not adduce any evidence to confirm that you have received counselling, seen a medical practitioner, or currently take any medication, for any mental health condition. Following your substantive asylum interview, you submitted a number of documents regarding your mental health condition. You have submitted a letter ... which confirms that you have been diagnosed with [post-traumatic stress disorder]. However, it is again stressed that ... Dr * did not, in your medical report, diagnose you with [post-traumatic stress disorder]. Similarly, you were assessed by the Mental Health practitioner at [name of health centre], and they concluded that you were not suffering from any mental health conditions at this time...*

... You have also stated that any discrepancies should be attributed to your physical and mental state (addressed above) whilst conducting your interview. Whilst your claimed medical conditions and history have been taken into account, it is noted that, as recently as [date] you were found not to be suffering from any mental health conditions. Furthermore, it is not considered that your claimed weakened mental state can mitigate the serious credibility issues that have been raised above, the significant lack of knowledge you have demonstrated, and cannot be used to mitigate those parts of your claim (particularly those related to your ethnicity) which run counter to available objective information."
(Reasons for refusal letter)

Methodology of the medico-legal report

The asylum caseworker incorrectly suggests that the clinician reached his conclusions solely on the history as reported to him by Ravi. In fact, Freedom from Torture clinicians involved in the documentation of torture, as in any clinical practice, do not automatically accept everything they are told but consider what is said, what is not said, the manner in which it is said and the responses to specific clinical questions in light of their clinical experience and specific training and their objective findings on examination. Freedom from Torture medico-legal reports contain expert clinical opinion on psychological matters that is based on both subjective elements (self-reported symptoms) and objective elements (mental state examination) of the psychological examination, which are clearly explained and distinguished in the report.

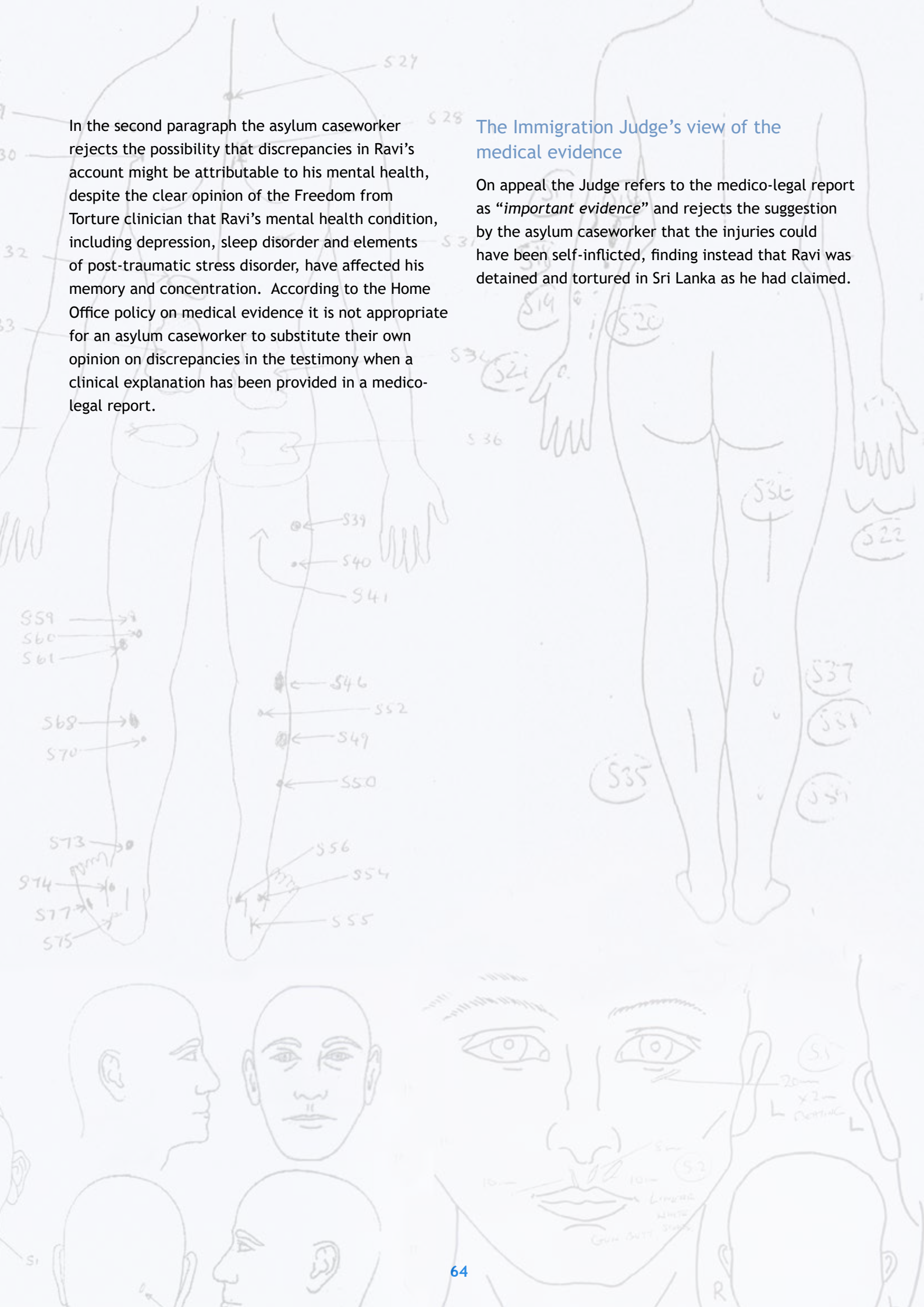
Consideration of mental health issues

The asylum caseworker displays a misunderstanding of the fluctuating nature of mental illness when they suggest that different diagnoses made over time by different clinicians necessarily undermine each other. The asylum caseworker also implies that because Ravi is not currently receiving medication or a course of treatment for mental illness, the findings made in the medico-legal report are less valid. These are clinical judgments that the asylum caseworker is not qualified to make.

In the second paragraph the asylum caseworker rejects the possibility that discrepancies in Ravi's account might be attributable to his mental health, despite the clear opinion of the Freedom from Torture clinician that Ravi's mental health condition, including depression, sleep disorder and elements of post-traumatic stress disorder, have affected his memory and concentration. According to the Home Office policy on medical evidence it is not appropriate for an asylum caseworker to substitute their own opinion on discrepancies in the testimony when a clinical explanation has been provided in a medico-legal report.

The Immigration Judge's view of the medical evidence

On appeal the Judge refers to the medico-legal report as "*important evidence*" and rejects the suggestion by the asylum caseworker that the injuries could have been self-inflicted, finding instead that Ravi was detained and tortured in Sri Lanka as he had claimed.



Case study 2: Case number 35

Profile	Medical Evidence	Decisions
Nationality Iranian	Medico-Legal Report Documents post-traumatic stress disorder and mild clinical depression found by the clinician to be directly related to torture. Documents two scars found by the clinician to be evidence of torture.	Home Office decision Asylum claim refused
Gender Male	Other medical evidence Photographs provided by the legal representative showing injuries found by the clinician to be evidence of torture.	Tribunal determination Allowed the appeal

Ali's case ⁵⁵

Ali, a young man from Iran, was arrested at an anti-government demonstration and was detained for one month. In detention he was beaten and whipped. He was smuggled out of the country on the day of his release and claimed asylum soon after arriving in the UK.

The Freedom from Torture medico-legal report for Ali documents two scars found by the clinician to be evidence of torture. The clinician also found that photographs of Ali's injuries taken by his legal representative soon after he arrived in the UK are further evidence of the torture Ali described. The clinician diagnoses Ali with post-traumatic stress disorder and mild clinical depression, directly related to torture.

The Home Office refused Ali's asylum claim. There are a number of problems with how the Home Office handles the medical evidence. For example, the asylum caseworker:

- Misunderstands the torture documentation process and the medico-legal report methodology, claiming the report is based on self-reporting, and does not apply the correct standard of proof when considering the medical evidence;

- Substitutes the clinician's expert opinion with their own opinion about psychological evidence in the medico-legal report, claiming that the extent of the psychological evidence is 'remarkably low' considering the torture Ali describes;
- Substitutes the clinician's expert opinion with their own opinion about the physical evidence including about how quickly scars heal, the condition Ali would have been in after he escaped detention, the injuries Ali "should" have, and speculates as to alternative causes for Ali's injuries; and
- Fails to fully consider the psychological evidence, stating incorrectly that there was no medical evidence of Ali having memory difficulties.

On appeal, the Immigration Judge found the medico-legal report "*highly corroborative of the truth of the appellant's account*", and accepted the clinician's conclusion that the physical and psychological injuries documented in the medico-legal report were caused by torture.

The appeal was allowed on asylum grounds.

In detail: Home Office treatment of the medical evidence

Methodology of the Medico-legal report, standard of proof and clinical judgments

You have produced a report from [Freedom from Torture]. This report does very little to support your claim. It recites your account and then finds that you are mildly clinically depressed as a result of [post-traumatic stress disorder] (of which the acuteness is not stated) and that you have a scar on your head and another to your left side. Whilst what is said in the report [sic], the level of psychological damage is remarkably low considering the sustained level of mistreatment you claim to have endured and the physical injuries reported upon could have, with respect to the Dr., been inflicted in a great many ways not associated with torture.

(Reasons for refusal letter, Para 18)

Medico-legal report methodology

The asylum caseworker incorrectly suggests that the clinician reached her conclusions solely on the history as reported to her by Ali. In fact, Freedom from Torture clinicians involved in the documentation of torture, as in any clinical practice, do not automatically accept everything they are told but consider what is said, what is not said, the manner in which it is said and the responses to specific clinical questions in light of their clinical experience and specific training and their objective findings on examination. The Home Office policy on medical evidence⁵⁶ states that medico-legal reports are expert evidence, not simply a report on the credibility of a claim of torture.

Standard of proof

In asylum cases there is a low standard of proof, described as “reasonable likelihood”. To state that the medico-legal report does very little to support Ali’s claim that he was tortured, despite clinical evidence including a diagnosis of post-traumatic stress disorder which is directly related to torture, suggests the asylum caseworker is not applying the correct standard of proof. The Home Office policy on medical evidence states that asylum caseworkers

should not attach little or no weight to medico-legal reports from Freedom from Torture, when they are assessing the overall credibility of the asylum claim.

Clinical judgments

The asylum caseworker makes a clinical judgment that they are not qualified to make when they suggest that the level of psychological evidence is “*remarkably low*” considering the extent of mistreatment Ali describes. Moreover, the Istanbul Protocol⁵⁷ acknowledges that the psychological consequences of torture will be different for each individual, so the severity of a condition should not be taken as an indicator of the severity of torture suffered. The Home Office policy on medical evidence states that it is not the role of asylum caseworkers to dispute clinical findings or make clinical judgments of their own about medical evidence or medical matters generally.

Interpretation of the clinical evidence, and clinical judgments

“... If you had been subjected to some seven weeks of torture, it is considered that you would have been in very poor physical health and it is reasonably likely to have been identified by one of the persons you passed in Tehran airport or in [name] airport. In neither place does it appear that your state of physical well-being was identified and therefore your health cannot have been as bad as you claim at the time of your travel.

Conversely, if you were only tortured for the first month and not for the last three weeks of your detention then the alleged lashing to your back becomes difficult to accept. You have provided photos which you claim are evidence of lashing whilst in detention... [a]ssuming they were taken between [dates] then the injuries would still be some three weeks old, but by the time the Dr. saw you they had completely healed with no visible scarring. Although the [Secretary of State for the Home Department] is not a medical expert, it is not accepted that injuries of three weeks as suggested in the photos would completely disappear in such a short time frame.

That [Freedom from Torture] did not consider the

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(Reasons for refusal letter)

Interpretation of the clinical evidence and clinical judgments

By making claims about Ali's likely physical health after experiencing the torture he described and speculating about whether, given this health state, he would have been fit to travel and able to pass unidentified through two airports, the asylum caseworker makes clinical judgments that they are not qualified to make. On this basis the caseworker questions the credibility of Ali's claim of torture.

The asylum caseworker then discusses the photographs of injuries attributed to whipping provided by Ali's legal representative, that are considered in the medico-legal report, and speculates about the time period within which such injuries would be expected to heal. On the basis of this inappropriate clinical judgment the caseworker rejects the opinion of the clinician, who found that the injuries were fully healed by the time of the examination some months after the photographs were taken. The clinician stated that this is in keeping with what would be expected for this type of injury, and congruent with the timeline Ali had given.

Objectivity of the clinician

The asylum caseworker then wrongly suggests that the because the clinician has not commented on these "seemingly implausible happenings", with reference to the injuries having healed by the time of the clinical examination, they are not a "genuinely objective expert". Besides the fact that this allegation was based on an inappropriate clinical judgment by the caseworker, it also contravenes the Home Office policy on medical evidence. This states that Freedom from Torture clinicians who produce

medico-legal reports should be recognised by asylum caseworkers as "objective and unbiased", with the necessary expertise to assess medical evidence of torture.

Alternative causation of the injuries - "self-infliction by proxy"

The asylum caseworker also criticises the clinician for not considering if the injuries documented in the photographs could have been inflicted by someone at Ali's behest, as a means of fabricating torture evidence for the purpose of bolstering his asylum claim. Such practices are often referred to as "self-infliction by proxy". In May 2014 the case known as KV made it a requirement for medical experts to consider this possibility, although only "where there is a presenting feature of the case" that raises this as a "more than fanciful explanation" for injuries observed.⁵⁸ Ali's medico-legal report was prepared before KV was promulgated. However, the clinician had fully considered other possible causes of the injuries documented in the photographs, as required by the Istanbul Protocol and Freedom from Torture's methodology, and found that the cause of torture was more likely. As noted above, Home Office policy on medical evidence states that it is not the role of asylum caseworkers to speculate about alternative causes for injuries when a clinical opinion has been given.

Extent of physical injuries

"... It is also noted that you do not appear to have any further physical injuries, despite the level of torture you claim... That you had no broken bones is considered so highly fortunate on your part so as to defy objective belief."

(Reasons for refusal letter)

The asylum caseworker speculates on the extent of physical injury that Ali would be expected to have sustained as a result of the torture he described, and concludes that since he does not have broken bones his account cannot be credible. This is another example of the caseworker making a clinical judgment that they are not qualified or entitled to make, according to Home Office policy. Moreover,

according to the Istanbul Protocol the absence of physical evidence cannot be taken to mean that torture did not occur.

Psychological evidence, memory difficulties

“... It is also noted that you were vague and evasive during your asylum interview. It appears that you were happy to answer questions to which you had rehearsed an answer to, but when asked for further details you could not remember. In the absence of medical evidence to confirm you are prone to such memory difficulties, this is considered as damaging to your overall credibility.”

(Reasons for refusal letter)

The caseworker wrongly claims that there is no evidence in the medico-legal report to confirm that Ali is prone to memory difficulties, and finds that this has negatively affected his credibility. In fact, Ali's memory difficulties are documented in four different paragraphs of the medico-legal report. The clinician

finds that Ali meets the diagnostic criteria for post-traumatic stress disorder, including re-experiencing symptoms of intrusive memories, flashbacks, dissociative episodes and nightmares and “numbing symptoms of not being able to recall important events of torture or his flight from Iran.”

The Immigration Judge's view of the medical evidence

On appeal the Immigration Judge stated that the medico-legal report is “thorough and cogent” and acknowledged that it is compliant with the Istanbul Protocol. The Judge also commented on the asylum caseworker's suggestion of “self-infliction by proxy”, stating that it was “speculation only” and that the Home Office “has not sought to bring any medical evidence ... to support such a theory.” Overall the Judge accepts “the conclusion of Dr * that the presentation of the appellant is directly related to his ill treatment and torture during detention ... [and finds] her report is highly corroborative of the truth of the appellant's account.”

Case study 3: Case number 36

Profile	Medical Evidence	Decisions
<p>Nationality</p> <p>Democratic Republic of Congo</p>	<p>Medico-Legal Report</p> <p>Documents post-traumatic stress disorder and a moderately severe depressive illness found by the clinician to be directly related to torture.</p> <p>Documents symptoms commonly reported by rape victims, and joint pains found by the clinician to support the account of torture.</p>	<p>Home Office decision</p> <p>Asylum claim refused</p>
<p>Gender</p> <p>Female</p>	<p>Other medical evidence</p> <p>Psychiatric report prepared by a Consultant General Adult Psychiatrist.</p>	<p>Tribunal determination</p> <p>Allowed the appeal</p>

Cesarine's case ⁵⁹

Cesarine was referred to Freedom from Torture by her legal representative after disclosing that she was physically and sexually assaulted by soldiers while detained in the Democratic Republic of Congo (DRC).

The Freedom from Torture medico-legal report for Cesarine documents a moderately severe depressive illness and post-traumatic stress disorder, which the clinician finds to be evidence of torture. The report also documents physical symptoms and injuries in keeping with rape and blunt force trauma, and the clinician notes that her account of torture includes additional injuries that are unlikely to leave permanent scarring.

The Home Office refused Cesarine's claim. There are a number of problems with how the asylum caseworker handles the medical evidence. For example, the asylum caseworker:

- Questions the clinician's qualifications to make a diagnosis of post-traumatic stress disorder and fails to consider the psychological evidence of torture;
- Makes an error when considering the methodology of the medico-legal report;
- Draws a negative conclusion about the credibility of Cesarine's account due to inconsistencies

in the detail of the evidence, without considering the expert clinical opinion in the medico-legal report on the issue of memory difficulties and errors in recall often experienced by survivors of torture; and

- Misunderstands the guidance given in the Istanbul Protocol⁶⁰ for the assessment of consistency between injuries and their attributed cause of torture.

On appeal, the Immigration Judge found that the medico-legal report provides "*powerful, supportive and compelling evidence that the appellant was subject to physical and sexual violence and torture*". The Judge finds that the asylum caseworker's decision to give little weight to the medico-legal report is "*wrong and based on a failure to correctly analyse [the] report.*"

The appeal was allowed on asylum grounds and on human rights grounds.

In detail: Home Office treatment of the medical evidence

Qualifications of the medico-legal report author

“... The [medico-legal report] (Para 71) states ‘... [applicant’s name] has symptoms that meet ICD-10 diagnostic criteria for post traumatic stress disorder and these started not long after she was detained’. This is consistent with section ‘c’ of the [Istanbul Protocol] which directs report writers to utilise the appropriate diagnostic criteria for assessing psychological affects and components of traumatic events. However it is noted that Dr * is a General Practitioner with no professional qualification in either psychiatry or clinical psychology ([medico-legal report], Appendix A) that would be necessary to make a psychological diagnosis. In addition, it is noted that Dr *’s qualifications are inconsistent with the psychological diagnosis made.”

(Reasons for refusal letter)

The asylum caseworker suggests that a clinician needs a professional qualification in either psychiatry or clinical psychology to make a psychological diagnosis such as post-traumatic stress disorder. This is incorrect. General Practitioners are qualified to make diagnoses of the full range of psychiatric conditions, and do so in their daily work. Moreover, it is recognised in the Home Office policy on medical evidence⁶¹ that clinicians at Freedom from Torture are experts in the assessment of the psychological and psychiatric effects of torture.

Otherwise the asylum caseworker does not address the psychological evidence in the refusal letter. The psychological examination and findings are a critical part of the clinician’s assessment of an account of torture. In Cesarine’s case, the clinician found her psychological symptoms to be strong evidence of torture.

Methodology of the medico-legal report

“... The [medico-legal report] does not indicate if the claimant was seen in person or the report was produced through the use of notes or medical history. In addition, the time and date of the examination

is not present on the report, this is inconsistent with Section ‘a’ of the [Istanbul Protocol] which states that The name of the subject and name and affiliation of those present at the examination; the exact time and date, location, nature and address of the institution [sic].”

(Reasons for refusal letter)

The asylum caseworker states that it is not clear if or when Cesarine was seen by the clinician who produced the medico-legal report and suggests that the report has not been prepared according to the methodology set out in the Istanbul Protocol. In fact, this information is provided on the front page of the report, which clearly sets out the location and dates when the clinician examined Cesarine. The clinician makes specific reference in the report to Cesarine’s demeanour throughout the examination, which further demonstrates that she was seen in person. The implied critique of the report methodology is therefore unfounded and suggests the asylum caseworker has not read the medico-legal report with due care, as the Home Office policy on medical evidence instructs caseworkers to do.

Expert clinical opinion on memory difficulties and errors in recall

“... It is further noticed that in your [witness statement] (Para, 28) you state that on [sic] the second period of detention you were taken into a cell and questioned and beaten by two military officer[sic] who were Colonels ... However in your [Asylum Interview Record] (Q, 102) when asked who beat you stated [sic] “The Police”, it is noted that you made no reference to military personal [sic] in your [Asylum Interview Record]. It is considered that your omission of such a detailed fact in your [Asylum Interview Record] goes further too [sic] negatively affect your credibility.”

(Reasons for refusal letter)

The asylum caseworker makes reference in the refusal letter to a number of inconsistencies in the detail of accounts Cesarine has given of her experiences, including the one cited above, suggesting that this damages her credibility. The asylum caseworker makes no reference to the clinician’s discussion of these inconsistencies and

her reference to clinical literature on the impact of violent or stressful events and post-traumatic stress disorder on memory and recall:

“... There is a body of evidence that post-traumatic stress disorder can adversely affect recall and that recall for violent or stressful events may be inaccurate. There is also evidence that recounting violent events can lead to intrusive flashback memories and that these make it very difficult for an interviewee to concentrate and to follow the questions being asked. These and other factors that can result in discrepancies between successive statements are discussed in the literature.”

(Medico-legal report)

The Home Office policy on medical evidence makes it clear that medico-legal reports are expert evidence and may contain information that the person was unable to convey during the asylum interview or elsewhere, but has been able to disclose during sessions with the clinician. According to this policy, asylum caseworkers are instructed not to dispute clinical findings in the medico-legal report and substitute their own opinion on medical matters, including discrepancies in testimony for which a medical explanation has been given.

Application of the Istanbul Protocol

“... The Medical report states ... ‘I am unable to demonstrate a degree of consistency in accordance to the Istanbul Protocol’ although the medical report references the consistency principle it chooses not to utilise the principle in consideration of the scars...”

... As the above findings do not utilise the accepted Consistency Principles no weight can be placed on these findings as they lack the objective quantitative accuracy that is required.

Looking at the [medico-legal report] in the whole [sic] and given the inconsistencies inline [sic] with the Istanbul Protocol and the Consistency Principles little weight has been placed on the report.”

(Reasons for refusal letter)

The asylum caseworker suggests that the clinician has chosen not to use the consistency schema that is

provided at paragraph 187 of the Istanbul Protocol to assess Cesarine’s scars, and that the findings of the medico-legal report have therefore been given little weight. According to the Istanbul Protocol methodology, the clinician documenting evidence of torture should assess the consistency of lesions or other injuries with the attributed cause given by the person, and then describe the level of consistency using the schema set out at paragraph 187. As Cesarine is unaware of the particular lesion prior to the examination, she is unable to describe the cause of that injury, other than by describing in general terms the torture that took place. The use of the Istanbul Protocol consistency schema would therefore not be appropriate. The clinician gives the following explanation in the summary of the medico-legal report:

“... She has no scars that she attributes to these assaults but the assaults she describes would not necessarily be expected to scar (paragraphs 62, 63 and 64). She has one scar (S4) of which she was unaware until my examination as it lies on the back of her thigh and, although there is no clear attribution so I am unable to demonstrate a degree of consistency in accordance with the Istanbul Protocol, S4 is in keeping with her account of physical assault and rape.”

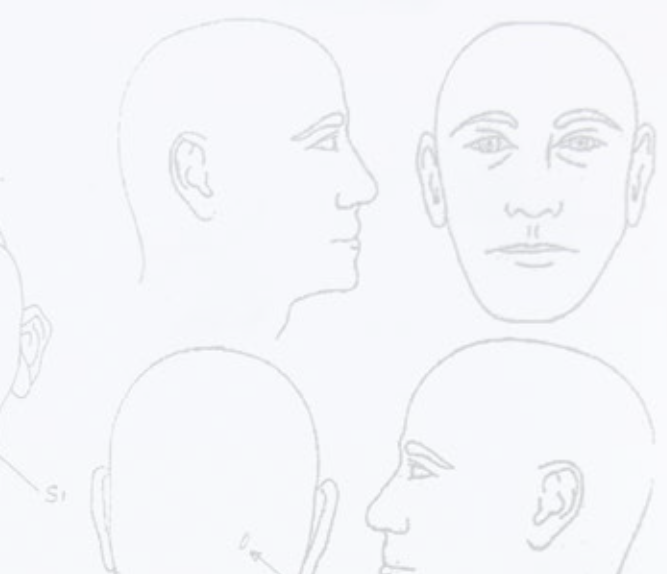
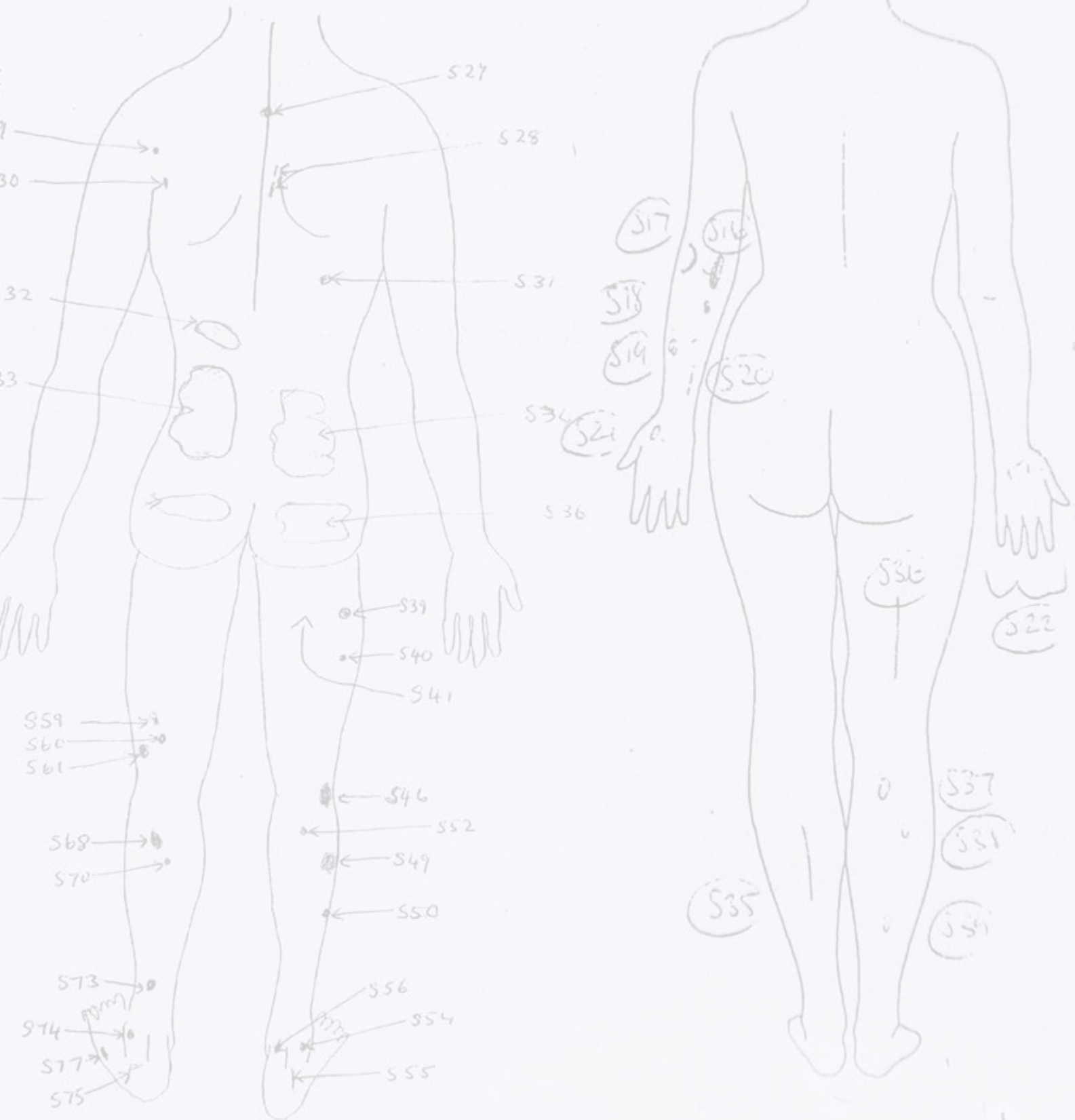
(Medico-legal report)

The Immigration Judge’s view of the medical evidence

On appeal the Judge was critical of the Home Office asylum caseworker’s handling of the medical evidence and found that Cesarine was detained and tortured in the DRC.

*As to the respondent’s criticisms of Dr **’s report, in my judgment they are misplaced.... The conclusion at paragraph 40 of the reasons for refusal letter that little weight should be placed on Dr **’s report is, in my judgment, wrong and based on a failure to correctly analyse her report... In my judgment, Dr **’s report is powerful, supportive and compelling evidence that the appellant was subject to physical and sexual violence and torture...*

(Determination)

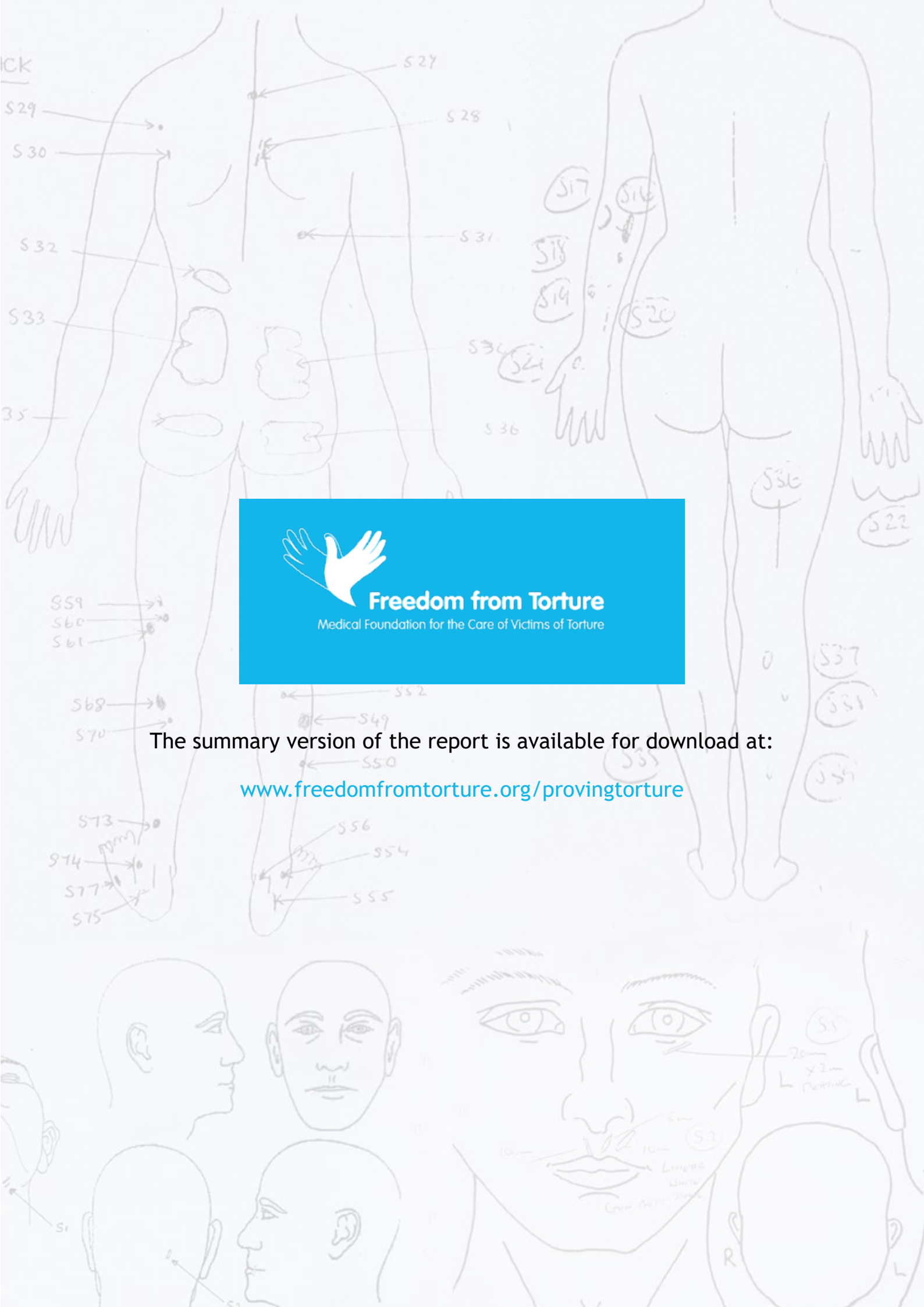


- 1 The Survivors Speak OUT (SSO) network is the UK's only torture survivor-led activist network and is actively engaged in speaking out against torture and about its impacts. Set up by survivors of torture, for survivors of torture, SSO uses first-hand experience to speak with authority for the rights of torture survivors. The network is supported and facilitated by Freedom from Torture and all network members are former Freedom from Torture clients.
- 2 UK Home Office, *Immigration Rules*, part 11: Asylum (paragraphs 326A to 352H): "339L. It is the duty of the person to substantiate the asylum claim or establish that he is a person eligible for humanitarian protection or substantiate his human rights claim...", available at: <https://www.gov.uk/guidance/immigration-rules/immigration-rules-part-11-asylum>, (last accessed 19/10/2016) (Home Office, *Immigration Rules*).
- 3 *R v SSHD ex p Sivakumaran [1988] Imm AR 147* established the relevant standard of proof as a "reasonable degree of likelihood" of persecution on return; *Kaja [1995] Imm AR 1 & Karanakaran v SSHD [2000] Imm AR 271* established that historical facts should be judged on the same standard of proof as future risk and there should be a "positive role for uncertainty" in asylum claims. This principle is extended to include cases that fall under the Human Rights Act 1998, regarding breaches of Article 3 of the European Convention on Human Rights (torture or inhuman or degrading treatment or punishment) in *Kacaj (01/TH/0634 19 July 2001)* starred).
- 4 Office of the United Nations High Commissioner for Human Rights, *Istanbul Protocol, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations, 2004, available at: <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>, (last accessed 19/10/2016) (United Nations, *Istanbul Protocol*, 2004).
- 5 In 2011 the charity Medical Foundation for the Victims of Torture changed its name to Freedom from Torture, but the Medico-Legal Report Service retained "Medical Foundation" in its title due to the high level of recognition of this name among specialist legal service providers and decision-makers at the Home Office and the Tribunal.
- 6 Freedom from Torture, *Body of Evidence: Treatment of Medico-Legal Reports for Survivors of Torture in the UK Asylum Tribunal*, May 2011, page 5: "... The higher than average overturn rate on appeal, which reaches 69% for cases where medical evidence was available to the UK [Home Office], indicates that there are serious deficiencies with the treatment of asylum claims which involve torture, at the initial decision stage", available at: <https://www.freedomfromtorture.org/sites/default/files/documents/body-of-evidence.pdf>. (last accessed 19/10/2016) (Freedom from Torture, *Body of Evidence*, 2011).
- 7 UK Home Office, Asylum Policy Instruction, *Medico-Legal Reports from the Helen Bamber Foundation and the Medical Foundation Medico-Legal Report Service*, Version 3.0, 17 January 2014. A revised version of this Policy Instruction (Version 4.0) was issued in July 2015 and is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444410/MLR_Foundation_Cases_External_v4_0.pdf (last accessed 19/10/2016) (Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015).
- 8 It should be noted that training was provided to a small group of caseworkers during a pilot of the Asylum Policy Instruction in 2011. However, this training was not rolled out to all caseworkers when the Asylum Policy Instruction was issued in January 2014.
- 9 Freedom from Torture, *The Poverty Barrier: The Right to Rehabilitation for Survivors of Torture in the UK*, July 2013, page 13, available at: <https://www.freedomfromtorture.org/sites/default/files/documents/Poverty%20report%20FINAL%20a4%20web.pdf>, (last accessed 19/10/2016) (Freedom from Torture, *The Poverty Barrier*, 2013).
- 10 Sigvardsson E, Marjan Vaez, Ann-Marie Rydholm Hedman, and Fredrik Saboonchi, *Prevalence of torture and other war-related traumatic events in forced migrants: A systematic review*, *Torture* 26 (2) 41-73, at page 47.
- 11 National Audit Office, *The Syrian Vulnerable Persons Resettlement Programme*, September 2016, page 4, available at <https://www.nao.org.uk/report/the-syrian-vulnerable-persons-resettlement-programme/> (last accessed 31/10/2016).
- 12 Freedom from Torture, *The Poverty Barrier: The Right to Rehabilitation for Survivors of Torture in the UK*, July 2013, page 13, available at: <https://www.freedomfromtorture.org/sites/default/files/documents/Poverty%20report%20FINAL%20a4%20web.pdf>, (last accessed 19/10/2016) (Freedom from Torture, *The Poverty Barrier*, 2013).
- 13 Freedom from Torture, *The Poverty Barrier*, 2013, Chapter 5: Impact of poverty on rehabilitation from torture.
- 14 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3.
- 15 Freedom from Torture, *Methodology Employed in The Preparation of Medico - Legal Reports on Behalf of the Medical Foundation*, June 2006, available at: <https://www.freedomfromtorture.org/sites/default/files/documents/methodology%20mlr.pdf>., (last accessed 19/10/2016).
- 16 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.1.
- 17 *SA (Somalia) V SSHD [2006] EWCA Civ 1302*, paras 28, 29, 32.

- 18 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; World Health Organisation, *ICD - 10 Classification of Mental and Behavioural Disorders (ICD-10)*; United Nations, *Istanbul Protocol*, 2004, para. 288.
- 19 For reasons explained in note 5 above, the medico-legal report service at Freedom from Torture is known as the Medical Foundation Medico-Legal Report Service.
- 20 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.1.
- 21 UK Home Office, Asylum Policy Instruction: *Assessing Credibility and Refugee Status*, V9.0 (January 2015), 5.5 Underlying factors, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/397778/ASSESSING_CREDIBILITY_AND_REFUGEE_STATUS_V9_0.pdf, (last accessed 19.10.2016) (Home Office, Asylum Policy Instruction, *Assessing Credibility*, 2015).
- 22 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3.
- 23 References to “Medical Foundation” in Home Office and judicial decision-letters have been replaced with “Freedom from Torture” to avoid confusion for the reader. Please see note 5.
- 24 See: UK Home Office, Visas and Immigration, “Candidate Information Pack Asylum Operations - Decision Maker”, available at <http://www.manpowergroup.co.uk/wp-content/uploads/2016/08/AsylumOperationsDecisionMaker-CandidateInformationPack.pdf> (last accessed 31/10/2016).
- 25 United Nations, *Istanbul Protocol*, 2004, para. 253.
- 26 United Nations, *Istanbul Protocol*, 2004, para. 99; Michael Peel Ed., *Rape as a Method of Torture*, Medical Foundation, 2004.
- 27 United Nations, *Istanbul Protocol*, 2004, para. 142; Cohen J., “Errors of recall and credibility. Can omissions and discrepancies in successive statements be reasonably said to undermine credibility of testimony?”, *Medico-Legal J* 69 (1), pages 25-34. 2001, *British Journal of Psychiatry* (2007), 191, pages 75-81; Bögnér D., Herlihy J., Brewin CR., “Impact of sexual violence on disclosure during Home Office interviews”, *The British Journal of Psychiatry*, 2007, 191 (1) pages 75-81.
- 28 United Nations, *Istanbul Protocol*, 2004, para. 253; The British Psychological Society, “Guidelines on Memory and the Law, Recommendations from the Scientific Study of Human Memory”, 2008, pages 26-27; Herlihy J., Scragg P., Turner S., “Discrepancies in autobiographical memories—implications for the assessment of asylum seekers: repeated interviews study”, *British Medical Journal*, 2002, pages 324-7; Van der Kolk, B., “Posttraumatic stress disorder and memory”, *Psychiatric Times*, 1997.
- 29 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3.
- 30 United Nations, *Istanbul Protocol*, paras 234, 236.
- 31 Home Office, *Immigration Rules*, paras 339J-339L.
- 32 Home Office, *Immigration Rules*, para. 339K.
- 33 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3; and Home Office, Asylum Policy Instruction, *Assessing Credibility*, 2015, 5.2.
- 34 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3: “... Caseworkers are required to consider all evidence in the round; including expert medical evidence and a conclusion on the overall credibility of an account of past events must not be reached without careful consideration of the contents of the Foundation’s [medico-legal report]”; and Home Office, Asylum Policy Instruction, *Assessing Credibility*, 2015, 5.2.
- 35 In January 2010 UNHCR signed a new Memorandum of Understanding with the UK Home Office and the Quality Initiative project became the Quality Integration Project.
- 36 Amnesty International and Still Human Still Here, *A Question of Credibility: why so many initial asylum decisions are overturned on appeal in the UK*, April 2013, page 8, available at: https://www.amnesty.org.uk/sites/default/files/a_question_of_credibility_final_0.pdf, (last accessed 19.10.2016).
- 37 Amnesty International and Still Human Still Here, *A Question of Credibility: why so many initial asylum decisions are overturned on appeal in the UK*, 2013, page 8.
- 38 Home Office, Asylum Policy Instruction, *Assessing Credibility*, 2015.
- 39 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3.
- 40 Caseworkers often focus on the personal credibility of the applicant as opposed to the claim, despite policy guidance that instructs them to avoid this: Home Office, Asylum Policy Instruction, *Assessing Credibility*, 2015, 5.4: “A structured approach to credibility assessment. The caseworker should focus first on the credibility of the claim rather than on the personal credibility of the claimant...”
- 41 The case *KV (Scarring - medical evidence) Sri Lanka [2014] UKUT 00230 (IAC) (23 May 2014)* states the following in the headnote: “... Where there is a presenting feature of the case that raises [self-infliction by proxy] as a more than

fanciful possibility of the explanation for scarring [...] a judicial fact-finder will be expected to address the matter, compatibly with procedural fairness, in deciding whether, on all the evidence, the claimant has discharged the burden of proving that he or she was reasonably likely to have been scarred by torturers against his or her will.” Note that this determination is currently on appeal in the Court of Appeal.

- 42 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015, 3.3.
- 43 *KV (Scarring - medical evidence) Sri Lanka [2014] UKUT 00230 (IAC) (23 May 2014)*, headnote.
- 44 *KV (Scarring - medical evidence) Sri Lanka [2014] UKUT 00230 (IAC) (23 May 2014)*, paras 286-287.
- 45 UK Home Office, National Statistics, Asylum, 5. Asylum Appeals, available at: <https://www.gov.uk/government/publications/immigration-statistics-april-to-june-2015/asylum#asylum-appeals> (last accessed 19/10/2016).
- 46 Freedom from Torture, *Body of Evidence*, 2011.
- 47 Freedom from Torture, *Body of Evidence*, 2011, page 5.
- 48 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015.
- 49 Freedom from Torture, *Body of Evidence*, 2011.
- 50 In further submissions cases there is no automatic appeal of a refusal letter. Further submissions must first be accepted as a fresh claim i.e. on the basis of substantial new evidence not previously considered, which could include a medico-legal report. If that is not met the case is refused without a right of appeal. If that is met but it is not accepted that the person is a refugee, the case is refused with a right of appeal, as in the 20 cases in this research. See *Immigration Rules* part 12: Procedure and rights of appeal, para. 353, available at: <https://www.gov.uk/guidance/immigration-rules/immigration-rules-part-12-procedure-and-rights-of-appeal> (last accessed 19/10/2016).
- 51 The large number of different teams in Liverpool named in refusal letters may reflect re-organization in the local office and re-naming of teams over the period since January 2014.
- 52 The name has been altered to protect the individual’s identity.
- 53 United Nations, *Istanbul Protocol*, 2004.
- 54 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015.
- 55 The name has been altered to protect the individual’s identity.
- 56 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015.
- 57 United Nations, *Istanbul Protocol*, 2004.
- 58 *KV (Scarring - medical evidence) Sri Lanka [2014] UKUT 00230 (IAC) (23 May 2014)*, paras 286-287.
- 59 The name has been altered to protect the individual’s identity.
- 60 United Nations, *Istanbul Protocol*, 2004.
- 61 Home Office, Asylum Policy Instruction, *Medico-Legal Reports*, 2015.



The summary version of the report is available for download at:

www.freedomfromtorture.org/provingtorture

Freedom from Torture

Freedom from Torture is the only UK-based human rights organisation dedicated to the treatment and rehabilitation of torture survivors. We do this by offering services across England and Scotland to around 1,000 torture survivors a year, including psychological and physical therapies, forensic documentation of torture, legal and welfare advice, and creative projects.

Since our establishment in 1985, more than 57,000 survivors of torture have been referred to us, and we are one of the world's largest torture treatment centres. Our expert clinicians prepare medico-legal reports (MLRs) that are used in connection with torture survivors' claims for international protection, and in research reports, such as this. We are the only human rights organisation in the UK that systematically uses evidence from in-house clinicians, and the torture survivors they work with, to hold torturing states accountable internationally; and to work towards a world free from torture.

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