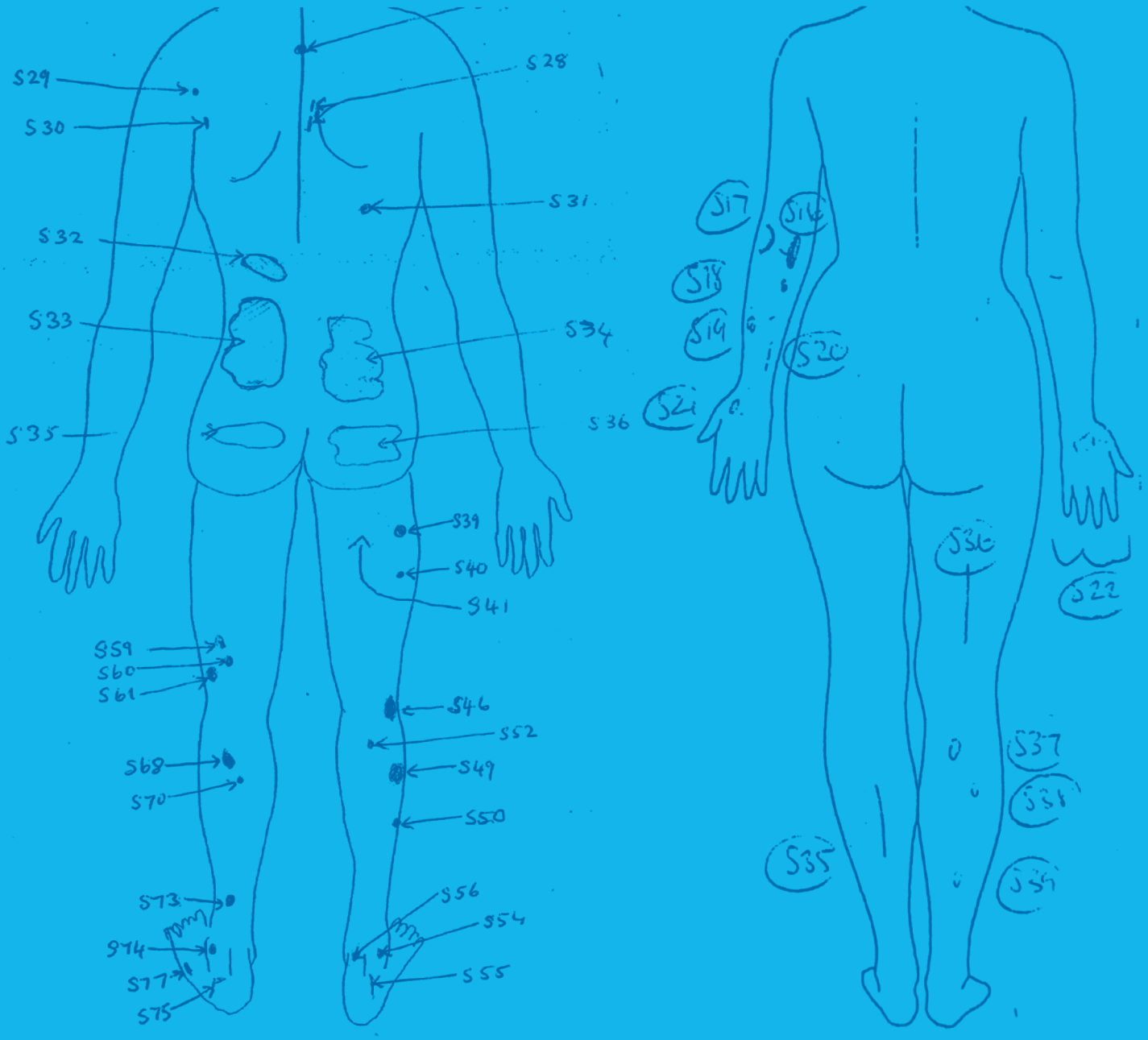
BODY OF EVIDENCE

Treatment of Medico-Legal Reports for Survivors of Torture in the UK Asylum Tribunal



FREEDOM FROM TORTURE
EMPOWERING SURVIVORS, REBUILDING LIVES

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Cover images are based on body maps used in medico-legal reports to document sequelae of torture and ill-treatment. All images have been anonymised.

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Freedom from Torture (Medical Foundation for the Care of Victims of Torture) is a human rights organisation that exists to enable survivors of torture and organised violence to engage in a healing process to assert their own human dignity and worth. Our concern for the health and well-being of torture survivors and their families is directed towards providing medical and social care, practical assistance, and psychological and physical therapy. It is also our mission to raise public awareness about torture and its consequences.

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BODY OF EVIDENCE:

Treatment of Medico-Legal Reports for Survivors of Torture in the UK Asylum Tribunal

ABBREVIATIONS

AIT	Asylum and Immigration Tribunal
API	Asylum Policy Instruction
DRC	Democratic Republic of Congo
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
ECHR	European Court of Human Rights
EWCA	England and Wales Court of Appeal
GP	General Practitioner
ICD-10	International Classification of Diseases
IARLJ	International Association of Refugee Law Judges
IJ	Immigration Judge
IP	Istanbul Protocol
MLR	Medico-Legal Report
NAM+	New Asylum Model
NASF	National Asylum Stakeholder Forum
PTSD	Post-Traumatic Stress Disorder
QADT	Quality Audit and Development Team
RFRL	Reasons for Refusal Letter
RSD	Refugee Status Determination
SSHD	Secretary of State for the Home Department
UKAIT	United Kingdom Asylum and Immigration Tribunal
UKIAT	United Kingdom Immigration Appeal Tribunal
UKBA	UK Border Agency
UKUT	United Kingdom Upper Tribunal
UNHCR	United Nations High Commissioner for Refugees

CONTENTS

EXECUTIVE SUMMARY

The aim of this report is to examine the treatment of Medical Foundation Medico-Legal Reports (MLRs) by Immigration Judges in the Tribunal (Asylum and Immigration Chambers) and to assess compliance with good practice standards and guidelines.[1]

The determinations assessed in this sample demonstrate that many Immigration Judges are familiar with and apply the guidance that is given, primarily in case law, on the treatment of expert medical evidence for cases involving a claim of torture, as well as the standards articulated in the Istanbul Protocol. In most of these cases the appeals are allowed and a grant of refugee status or humanitarian protection is made.

However, the evidence shows that there is a serious lack of consistency in the treatment of MLRs across the Tribunal and that in a significant number of cases the guidelines given in case law and good practice standards are not followed by Immigration Judges, leading to a dismissal of the appeal. Although an onward appeal may have been pursued in a number of these cases, depending on continuing access to legal aid and a diligent legal representative, a significant failure of protection could be the consequence for individual claimants who may be returned to a country in which they have been tortured.

This report does not suggest that all asylum claims for which there is an MLR documenting a claim of torture must be allowed on refugee convention or humanitarian protection grounds. It is, however, proposed that all such cases should be assessed according to clearly elaborated good practice standards that are applied with consistency by all Immigration Judges. For cases involving a claim of torture that has been assessed by a medical expert and documented in an MLR, this entails Immigration Judges taking a consistent and rigorous approach to the consideration of this evidence.

Although not the primary focus of this report, concerns that emerged from the evidence about the treatment by UK Border Agency (UKBA) case owners of claims involving torture are also elaborated and discussed. The higher than average overturn rate on appeal, which reaches 69% for cases where medical evidence was available to the UK Border Agency, indicates that there are serious deficiencies with the treatment of asylum claims which involve torture, at the initial decision stage.

The findings of this research have very serious resource and efficiency implications for the UK Border Agency and the Tribunal to consider, since poor decision making leads to an unnecessarily protracted legal process. However, there is also the very serious consequence of subjecting already vulnerable individuals to a legal process in which their integrity and credibility are repeatedly subject to question and doubt. Torture survivors should be able to focus on their rehabilitation, not on unnecessary legal proceedings.

KEY FINDINGS

Key findings elaborate the main concerns that emerge from this research about judicial practice and UK Border Agency decision-making in relation to expert medical evidence. The findings focus on the pattern of decision-making in cases where an MLR has been submitted in relation to a claim of torture and on the detailed treatment of the expert evidence by Immigration Judges.

Pattern of decisions

- Of the 37 cases in the sample, the appeals of 49% were allowed: significantly higher than the overall allowal rate of asylum cases in the Tribunal of 27% in the first three quarters of 2010.
- Of the 13 cases in the sample that had MLRs submitted to UK Border Agency at initial decision stage, 9 were allowed in the Tribunal: an overturn rate of 69%.
- In all the cases in the sample where the evidence of the MLR is accepted in full by the Tribunal; the appeal was allowed.
- Despite the acknowledged expertise of the Medical Foundation, in just over half the cases in the sample the evidence of the MLR is not accepted in full by the Tribunal.
- In 9 cases, although the clinical evidence of torture is accepted, the cause attributed by the claimant is not and the cases are dismissed on the grounds of lack of credibility.

Treatment of expert medical evidence

- For survivors of torture, expert evidence can play a key role in documenting the trauma resulting from an individual's experience of torture and placing this in the context of their particular history. Findings indicate a lack of consistency across the Tribunal in the willingness of Immigration Judges to be guided by the findings of MLRs in their consideration of the credibility of a case.
- The documentation and assessment of the subject's history in relation to injuries described and the examination findings is the key function of the MLR author. In some cases the Immigration Judge dismisses the claimant's history documented in the MLR as a 'recitation' or 'self-reported' account. The credibility of these claimants is not accepted and these cases are dismissed.
- Inconsistencies in testimony will often count against the overall credibility of an asylum claimant and may be fatal to their case. For survivors of torture, memory difficulties - an inability to give a coherent history or failure to disclose incidences of torture - are frequently observed and are well researched phenomena. In 8 of the 14 cases where the consistency of a claimant's account is at issue, the Immigration Judge dismisses the evidence presented in the MLR and dismisses the appeal on grounds of credibility.
- The integrated findings of MLRs, based on the documentation of clinical evidence of torture and an assessment of the consistency of this clinical evidence with the history (causation), are in some cases treated separately by Immigration Judges. In the 10 cases where the causation of the physical or psychological trauma documented in the MLR is at issue, the clinical evidence reported in the MLR is accepted and in some cases acknowledged to be evidence of torture. In 6 of these cases the appeal is dismissed on the basis that the claimant is not deemed to be credible and the causation they assert for the trauma that has been documented is not believed. In these cases, effectively no factual finding is made about the cause of their treatment and no alternative explanation for the injury and harm documented in the MLR is posited or examined.

RECOMMENDATIONS

Recommendations are made that address the key findings to the Presidents of the First-tier and Upper Tribunals (Asylum and Immigration Chambers) as well as to the Tribunals Procedures Committee and the Senior President of the Tribunals, in the interest of ensuring that the right to international protection for survivors of torture is secured.

Recommendations are also made to the UK Border Agency on the basis of relevant findings on the treatment of expert medical evidence for claims involving torture at first instance.

TO THE PRESIDENT OF THE UPPER TRIBUNAL AND THE PRESIDENT OF THE FIRST-TIER TRIBUNAL (IMMIGRATION AND ASYLUM CHAMBERS)

Guidance

1. Based on the findings of this research, and in accordance with the core duty to improve the quality of decision making described in the Tribunal's Customer Charter,[2] the President should **revise the Tribunal Practice Direction on expert evidence.**

   The revised Practice Direction should include specific guidelines on the treatment of expert medical evidence in relation to claims of torture and should reflect **case law** from the Tribunal and the Higher Courts on this issue, as well as the relevant **standards and guidelines** detailed in this report.

2. The following **standards** should be reflected in the Practice Direction:

   a. **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,

   b. **due consideration must be given to the medical expert's opinion** on the degree of consistency between the clinical findings and the account of torture, on the understanding that this does not impinge on the duty of the judge to make an overall finding on credibility,

   c. **the evidence of 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,

   d. **due consideration must be given to psychological research** in the area of trauma and memory and its relevance to an individual claim,

   e. **judicial 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,

   f. **evidence** given in an expert medical report **that gives a strong indication of torture,**
   according to the appropriate standard of proof, **must be accepted and acted upon.**

Training

3. The President of the Upper Tribunal should ensure that **facilitated training on torture** and the sequelae for survivors, the application of the Istanbul Protocol, and the revised Practice Direction is incorporated in the regular programme of training for Immigration Judges.[3] The training should be experiential, participatory and utilise proven teaching methods and include an appraisal of comprehension.

4. The Joint Training Committee (First Tier and Upper Tribunal) should work with relevant experts in the field (medical and legal) for the appropriate development and delivery of such training.

TO THE TRIBUNAL PROCEDURE COMMITTEE

Oversight and Monitoring

5. The Tribunal Procedure Committee, in accordance with its duty to make rules governing the practice and procedure in the First-tier and Upper Tribunal with a view to securing justice, fairness and efficiency,[4] should work with the Presidents of the Asylum and Immigration Chambers to improve the quality and consistency of decision making in cases involving a claim of torture.

6. The Tribunal Procedure Committee should **oversee** the revision of the Practice Direction on expert evidence to include guidance on the treatment of expert medical evidence in relation to claims of torture and should **monitor** its effective implementation.

TO THE SENIOR PRESIDENT OF THE TRIBUNALS

Oversight

7. In accordance with the duty of the Senior President of the Tribunals to 'maintain appropriate arrangements for training, guidance and welfare of judges and other members of the First-tier and Upper Tribunal', and to give Practice Directions and approve Practice Directions give by Chamber Presidents,[5] the Senior President should consult with the Presidents of the Immigration and Asylum Chamber to ensure:

    a. appropriate **guidance** is given to Immigration Judges on the treatment of expert medical evidence in cases involving a claim of torture in the form of a revised Practice Direction,

    b. appropriate **training** is given to Immigration Judges on the treatment of expert medical evidence in cases involving a claim of torture.

8. The Senior President should **report on progress** in relation to improved guidance and training for Immigration Judges on the treatment of expert medical evidence in cases involving a claim of torture in his 2012 Annual Report.

TO THE UK BORDER AGENCY

9. In view of the concerns about the quality of initial decision making - reflected in the high appeal overturn rate documented in this report for cases involving a claim of torture, in particular those cases where expert medical evidence was available - the UK Border Agency must urgently **revise** its **policy guidance** and its **training** programmes for case owners.

Policy Guidance

10. The **Asylum Policy Instruction (API) on the Medical Foundation** is currently under revision. Any new policy which replaces it must include significantly strengthened guidance for case owners on how to handle expert medical evidence in cases involving a claim of torture.

11. The **Asylum Instruction on Considering the Protection (Asylum) Claim and Assessing Credibility** must be amended so that: the 'Summary' and the section on 'Medical Evidence in support of the asylum claim' include references to the API on the Medical Foundation, any new policy which replaces this API and any other relevant policy guidance on medical evidence, so that case owners are clear that they must consult and comply with the more specific guidance that exists in this area.

12. The following **standards** identified in this research apply to first instance decision makers as well as to the judiciary and must therefore be incorporated into the relevant policy guidance:

    a. **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,

    b. **due consideration must be given to the medical expert's opinion** on the degree of consistency between the clinical findings and the account of torture, on the understanding that this does not impinge on the duty of the case owner to make an overall finding on credibility,

    c. **the evidence of General Practitioners** trained in the documentation of torture **must be accepted as expert medical opinion** on the clinical sequelae of torture, both physical and psychological,

    d. **due consideration must be given to psychological research** in the area of trauma and memory and its relevance to an individual claim,

    e. **the case owner'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,

    f. **evidence** given in an expert medical report **that gives a strong indication of torture,**
    according to the appropriate standard of proof, **must be accepted and acted upon**.

Training

13. The UK Border Agency must ensure that prior to the launch of any new policy guidance in this area, all case owners participate in **facilitated training** on: torture and the sequelae for survivors, the application of the Istanbul Protocol, and the requirements of the relevant policy guidance in this area. The training should be experiential, participatory and utilise proven teaching methods and include an appraisal of comprehension.

14. The UK Border Agency must also include training (at the standard described above) on torture and the sequelae for survivors, the application of the Istanbul Protocol and the requirements of the relevant policy guidance in both the foundation and consolidation training programmes for case owners.

15. The UKBA should work with independent, acknowledged torture experts in the medical and legal fields to develop and deliver such training.

Oversight and Monitoring

16. Drawing on the findings of this report, the UK Border Agency's New Asylum Model (NAM+) Quality Audit and Development Team (QADT) should undertake a **thematic review** of decision- making in cases involving a claim of torture.

17. The findings of this thematic review should be used to inform: UK Border Agency training on these issues, further revisions (if necessary) to the relevant policy guidance, and the QADT's own audit processes so that there is regular **monitoring** of the effectiveness of and compliance with the guidance.

18. The QADT should **map and report progress** to the National Asylum Stakeholder Forum (NASF) Quality Sub-group on the development and implementation of the policy guidance and training, and on the findings of the thematic review of decision-making in cases involving a claim of torture.

19. There should be an annual standing item on the agenda of the NASF Quality sub-group on the quality of decision-making in cases involving a claim of torture.

TO THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)

Oversight and Monitoring

20. As part of its Quality Integration Project, UNHCR should continue to closely monitor implementation of those recommendations from its previous Quality Initiative Project reports that relate to decision-making in cases involving a claim of torture.

TO THE INDEPENDENT CHIEF INSPECTOR OF THE UKBA

Accountability

21. On the basis of the concerns raised in this and other recent reports, the Independent Chief Inspector of the UKBA should conduct an **inspection** of decision-making in relation to vulnerable asylum claimants, and in particular those who have made a claim of torture.

INTRODUCTION

It is broadly accepted that asylum seekers will have some difficulty in providing evidence to substantiate their claim for international protection and that their fear of persecution is 'well founded'.[6] This is due to the nature of their flight from their country of origin and the journey to the country where they seek refuge. Often the journey will have been made in the hands of people smugglers who may have confiscated and retained documents that prove identity, nationality or other aspects of the individual's claim.

In these circumstances, the primary evidence to substantiate past treatment as well as future fear of persecution is the asylum seekers own testimony, which may be considered together with information about their country of origin. Information about the human rights record of the country and about the treatment of people with a similar profile to the claimant may be used to assess the plausibility of their claim and the credibility of their testimony. It may also be used to assess the potential future risk to them and whether to accept that they have suffered persecution in the past. However, this information is not often specific to the individual.

While the burden of proof falls on the claimant to establish why they need protection, given the gravity of getting a decision wrong, it is recognised that the standard of proof for asylum claims is relatively low when compared to the level of proof required in other civil proceedings.[7] This standard of proof has been well established in UK case law and applies to all aspects of the asylum claim, both establishing past persecution and future risk of persecution.[8]

In the case of survivors of torture, there is an additional 'body of evidence' that may be adduced in the form of a Medico-Legal Report (MLR). An MLR documents, in accordance with internationally accepted guidelines for the documentation of torture, the clinical evidence of torture of an individual asylum claimant and addresses the degree of consistency between this clinical evidence and the claimants' account of torture.[9] MLRs can carry significant evidentiary weight and may be of particular assistance to decision makers and torture survivors themselves, given the particular vulnerabilities which may affect their ability to give evidence.

An MLR may be submitted to the UK Border Agency by a claimant at the initial stage of the asylum decision making process or for a fresh claim, or at appeal, where it will be considered by the UK First Tier or Upper Tribunal (Asylum and Immigration Chamber).[10] It will form part of the evidence that may establish that the claimant has suffered torture or ill-treatment[11] in the past which, though not determinative, will have a significant bearing of the assessment of the risk they face in the future if returned to their country of origin. An MLR may have a significant impact on the outcome of an asylum claim, therefore it is imperative that it is given proper consideration and due weight.

This report examines how MLRs are treated by Immigration Judges at the Tribunal measured against accepted international standards and guidance, including that given in the Istanbul Protocol, the Tribunal Practice Direction and case law.

Part 1 of this Report provides an overview of the work of the Medical Foundation, of the practice of torture and context to the concerns about the treatment of MLRs in the Tribunal. The Methodology we have used is described in order to establish the extent to which our data can be said to be reasonably representative of current practice of the Tribunal concerning the treatment of MLRs prepared by the Medical Foundation.[12]

Part 2 sets out our findings in two main sections. The first section deals with the overall treatment of cases in the Tribunal for which a Medical Foundation MLR was submitted in evidence and looks at patterns of decisions on asylum claims. Patterns of decisions are considered in relation to MLRs; claimant profile - including county of origin, gender, age range and basis of claim and the availability of an MLR at first instance.

The second section looks in more detail at the judicial treatment of MLRs in the determination, including judicial comment on the expertise of the MLR author, on the quality of the MLR and findings on credibility in light of evidence in the MLR. Judicial comment on the issue of credibility is examined in three categories: 'history' – judicial comment on the taking of and assessment of the claimant's history by the MLR author; 'consistency'– judicial comment on inconsistency in testimony, evidence and late recall of and failure to disclose material facts; and 'causation' – judicial comment on the attributed cause of the injury and harm documented in the MLR.[13]

Part 3 examines the most relevant good practice standards and guidelines available for the documentation of torture and treatment of expert medical evidence in refugee status determination procedures. The standards and guidelines referred to include: the Istanbul Protocol,[14] the UNHCR Handbook;[15] the Tribunal Practice Directions on expert evidence;[16] the Tribunal Joint Presidential Guidance note on child and vulnerable adult appellants,[17] and the International Association of Refugee Law Judges guidelines on the evaluation of expert medical evidence.[18] In addition, relevant case law from the European Court of Human Rights, the Court of Appeal, the Upper Tribunal (Asylum and Immigration) and the former United Kingdom Asylum and Immigration Tribunal (UKAIT) is examined and summarised.

Part 4 sets out a framework to assess i) the extent to which Medical Foundation MLRs are compliant with the requirements of medical evidence and ii) the extent to which the practice of the Tribunal, as represented in this sample of determinations, is compliant with accepted good practice standards and judicial precedent.

Part 5 sets out conclusions and key findings in relation to the standards and guidance described in the Report.

Finally, **Part 6** makes recommendations to the Tribunal. Recommendations are also made to the UK Border Agency on the basis of relevant findings on the treatment of expert medical evidence at first instance.

PART 1

CONTEXT to the report

The Medical Foundation for the Care of Victims of Torture (Medical Foundation) has provided care and rehabilitation to survivors of torture and other forms of organised violence since 1985. It works to document evidence of torture, provide training for health professionals working with torture survivors, educate the public and decision-makers about torture and its consequences and ensure that governments honour their international obligation towards survivors of torture.

Those within the Medical Foundation remit for both its clinical and human rights work are survivors of torture and organised violence. This is understood to include both severe physical and mental suffering deliberately inflicted on a person in the custody, or under the control, of such organised bodies as police, security forces and other agencies of governments, military and paramilitary units, as well as organised non-state groups in situations where there is no effective state protection available. It includes rape and sexual abuse perpetrated by such agencies.

Torture has been described as the act of killing a person without their dying. It is the intentional infliction of severe pain or suffering for a specific purpose and is an attempt to destroy a person's physical and psychological integrity. The aim of torture is not to kill the victim, but to break down the victim's personality. Torture is often used to punish a person, to obtain information or a confession from a person, to take revenge on a person and to create terror and fear within a population.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which entered into force in 1987, defines torture in Article 1 (1) as follows:

> "... the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."

Torture is prohibited under international law, which places the responsibility on governments to prevent torture and to provide for the needs of survivors of torture, including as full rehabilitation as possible.

However, torture continues to be practised in over 111 countries,[19] including countries that are parties to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[20]

Use of torture

The use of torture and ill-treatment is integral to the institutional structure and practice of many states. During times of conflict and peace governments and security forces use torture to repress people. Torture is also used by opposition forces and by groups such as death squads acting with or without government approval.

Torture is not confined to regions of the world or to governments with particular political ideologies. Victims of torture include men and women from across social classes, age groups, religions, identities and professions.

The trauma and stress of torture arises from the total experience of incarceration and ill-treatment, as well as the specific acts of violence. While torture may be used to obtain information or signed confessions, it is also directed towards instilling and reinforcing a sense of powerlessness and terror in victims and the societies in which they live. It is a process which is designed to destroy the physical and psychological capabilities of survivors to function as viable individuals.

Torture Methods

Methods of physical and psychological torture are similar worldwide. Many torture techniques seek to prolong the victims' pain and fear for as long as possible without leaving long term visible evidence. Methods of torture and categories of abuse reported in the Istanbul Protocol include:

> Blunt trauma, positional torture, burns, electric shocks, asphyxiation, crush injuries, penetrating injuries, chemical exposure, sexual violence and rape, medical amputation of digits or limbs, surgical removal of organs, pharmacological torture, deprivation of normal sensory stimulation, humiliation, threats of death, threats of attack by animals, psychological techniques to break down the individual, violation of taboos, behavioural coercion, forcing the victim to witness torture or atrocities being inflicted on others.[21]

The consequences of torture reach far beyond immediate pain. Many victims suffer long lasting physical and psychological consequences from post-traumatic stress disorder (PTSD), which includes symptoms such as flashbacks (intrusive thoughts), severe anxiety, insomnia, nightmares, depression and memory lapses. [22] Torture victims often feel guilt and shame, triggered by the humiliation they have endured. Many feel that they have betrayed themselves or their friends and family. All such symptoms are normal human responses to abnormal and inhumane treatment.

Medical Foundation Medico-Legal Report service

The Medical Foundation prepares expert Medico-Legal Reports (MLRs) for around 600 torture survivors a year at the request of their legal representatives. The purpose of the MLR is to assess and document physical and psychological evidence of torture and place this within the context of the individual's history. The degree of consistency between the clinical evidence and the account of torture is assessed in accordance with the internationally accepted guidelines of the Istanbul Protocol.[23]

MLRs are submitted as expert reports[24] for asylum applications either to the UK Border Agency for first instance decisions or to the Tribunal for appeal cases. Around half the MLRs prepared by the

Medical Foundation are for appeal cases in the Tribunal.[25] The Medical Foundation has a rigorous intake and assessment procedure for MLRs and will only accept referral for those individuals who are deemed to be survivors of torture or organised violence. All clinicians who prepare MLRs are selected by the Medical Foundation as suitably qualified and are trained specifically in the methods of documentation of torture. Furthermore, all Medical Foundation MLRs are independently checked by clinical and legal specialists.

Critical concerns about the treatment of MLRs

Concerns have been expressed over a significant period of time about the treatment of MLRs by Immigration Judges at the Tribunal.[26]A study of determinations from the Immigration Appeal Tribunal in 2002,[27] found that in general MLRs are considered to be helpful as evidence in the determination of an asylum claim where an experienced doctor has found the history to be reliable and 'the pattern of physical/ psychological findings more likely to have been caused by the ill-treatment described by the individual than by other likely causes.'[28]

Most importantly, the study also found evidence of a lack of consistency in this approach to medical evidence and a lack of understanding in some cases of the way that MLRs are produced by the Medical Foundation, despite the fact that this is documented in a number of publications.[29] A number of specific concerns were identified in the 2002 study in relation to the treatment of medical evidence:

- the Adjudicator,[30] states a 'medical' opinion that contradicts the one expressed in the MLR, without reference to the appropriate medical expertise

This is of concern because the Medical Foundation takes the position that medical opinion must only be challenged by another professional with at least as much expertise.

- the Adjudicator questions the role of the doctor in assessing 'credibility'

While it is accepted that the Adjudicator is final arbiter in deciding credibility, it is nonetheless asserted in the study that medical evidence should be an important factor in that decision. History taking is part of normal medical practice and the purpose of the MLR is to 'establish degree of consistency between the history and the physical and psychological findings'. Detailed medical examination and examination of issues related to particular injuries are part of the process of establishing the accuracy of the history. The doctor would consider it unethical to produce a report in respect of someone who is deliberately giving a false account.

- the Adjudicator dismisses the doctor's findings that the scars are consistent with the history on the basis that possible causes beyond those given in the history have not been explored

The Medical Foundation argues that the doctor's reasoned argument of why a scar could have been caused in the manner described by the claimant should not be dismissed. If there are alternative credible scenarios that the doctor has not considered, they should be given the opportunity to do so.

These and further concerns are reiterated in a 2004 paper for the International Journal of Refugee Law.[31] The issues highlighted in the paper include:

- the assessment by Adjudicators of the credibility of asylum seekers who are torture survivors

Particular concern is expressed about the treatment by Immigration Judges of inconsistencies in testimony and difficulties in recall and disclosure of evidence by torture survivors, despite the growing body of evidence on the impact of trauma on memory and the ability to disclose traumatic events.

- the expertise of the Immigration Appeal Tribunal with regard to the consideration and evaluation of medical evidence

While it is acknowledged that the court possesses a level of expertise as a specialist Tribunal, it is argued that caution should be exercised in the consideration of medical evidence and that Adjudicators should not 'replace clinical with judicial judgement'. While acknowledging the tension between the judicial and expert witness roles, the paper states that "...It must be recognised that there are strictly medical areas upon which it is unsafe for the Tribunal to trespass."

- the interpretation of scars in relation to likely causation

Regarding the interpretation of scars, the paper states "...It is almost always true to say that a scar could have been caused in another way. However a doctor can only assess scars against those episodes which she knows are reasonably likely, given the patient's history ... the doctor cannot reasonably be expected to consider explanations for which there is no context according to the evidence before her." It is stated that should alternative causation be suggested by the UK Border Agency, the doctor should be given the opportunity to give evidence in this regard.

- the application of the correct, lower standard of proof for asylum claims

The MLR may provide corroboration of a claimant's assertion of torture, which in turn is supportive of the credibility of the claimant as a whole. Given that 'past torture is evidence of future risk' and that an asylum applicant is required to establish that there is a 'reasonable degree of likelihood' they would experience persecution for a Convention reason if returned to their country of origin, the lower standard of proof should be satisfied if the MLR corroborates the claimant's assertion of torture.

- order of reasoning with regard to credibility

The paper argues that the 'summary dismissal' of the opinion of the doctor is not acceptable and that medical evidence should be considered with the whole of the evidence and not after a decision on credibility has already been made.

- assessment of the claimant's account of their history

The authors do not agree that Medical Foundation doctors simply accept the history given by the MLR subject without question as is sometimes suggested by Adjudicators, since it is part of their professional expertise to make assessments about the truthfulness and consistency of a history in light of clinical findings and the presentation of the individual on examination.

All of the matters highlighted in these previous reports continue to be of concern. In a report written in 2009 monitoring the outcome of asylum applications where Medical Foundation MLRs had been submitted as evidence, a number of issues with the practice of decision makers were recorded as being worthy of further investigation. These include: handling discrepancies in testimony, memory problems and late disclosure of evidence; questioning the competence of General Practitioners to diagnose psychiatrics and the remit of doctors to express opinion on issues of credibility; inappropriately applying the Istanbul Protocol guidance in relation to the interpretation of scars.[32]

These and the following practice issues are regularly encountered at the Medical Foundation in the course of preparing letters of representation at the request of solicitors, where evidence from an MLR has been dismissed:[33]

- the disregard of medical evidence where credibility has been undermined in other areas,
- the dismissal of MLR evidence where torture has been clearly documented because of discrepancies in the claimant's account, with no alternative explanation proposed for the scars,
- the application of an inappropriately high standard of proof for asylum cases,
- the dismissal of evidence from GPs when they comment on psychiatric conditions or make a diagnosis of PTSD or depression, despite the fact that it is the doctor's duty to make a full mental state assessment,
- the dismissal of a claim due to the late disclosure of torture, particularly sexual torture, despite the existence of extensive research on the impact of trauma on memory and the ability of survivors to recall or articulate trauma,
- the dismissal of the MLR due to an inadequate investigation, the methodology used, or concerns about the qualification of the doctor/ professional to document torture.

This study was undertaken to address the many and longstanding concerns outlined above in a systematic manner on the basis of a representative sample of recent Tribunal decisions for asylum claimants where a Medical Foundation MLR had been submitted in evidence by:

- identifying patterns and trends in decision making and judicial reasoning in relation to expert medical evidence,
- assessing the treatment of expert medical evidence in the Tribunal in relation to good practice standards and guidance,
- gauging the extent to which the concerns of the Medical Foundation and others are reflected in current judicial practice.

It is expected that the findings will assist the Tribunal (Asylum and Immigration) in examining its own practice in relation to this particular form of expert evidence, and form the basis of a productive dialogue between all those interested in ensuring that the right to international protection for survivors of torture is secured.

METHODOLOGY

It was known that obtaining a truly random sample of relevant determinations would not be possible given the lack of direct access to Tribunal determinations for research purposes, and the difficulty in obtaining determinations from claimant's legal representatives.

A sample of 37 Tribunal determinations for asylum claimants where Medical Foundation MLRs had been submitted, dated between September 2009 and September 2010, was collected and subject to a detailed desk review. According to Medical Foundation records, the number of MLRs prepared for appeal cases, and therefore the potential number of relevant Tribunal decisions for the selected period, is approximately 300. The final sample of 37 determinations, obtained within the time allocated for this purpose, is therefore approximately 12% of the total number of MLRs produced annually by the Medical Foundation for appeal cases.

Regardless of the limitations of the sample described in Appendix 1 our view is that this sample provides a significant and sufficiently representative picture of current treatment of Medical Foundation MLRs for robust findings and recommendations to be made.

The investigation was conceived as a desk study and therefore did not involve direct interviews with the claimants whose decisions were the subject of the review. The Tribunal determinations and MLRs were obtained for the purpose of the research from the files held by legal representatives and the Medical Foundation respectively, with the permission of the individuals concerned. All the information presented in the report has been anonymised.

PART 2

FINDINGS - treatment of cases in the Tribunal for which a Medical Foundation MLR was submitted in evidence

Determinations[34]

Of the 37 cases in the sample, the appeals of 49% were allowed and 51% dismissed in the Tribunal. This is *significantly higher* than the overall allowal rate of asylum cases in the Tribunal, which was 28% in 2009, and 27% in the first three quarters of 2010 according to UK Border Agency statistics.[35]

Given that the MLR findings in all cases allowed were accepted in full, it could be concluded that those cases, where it is accepted by the Tribunal that the claimant is a victim of torture on the basis of expert evidence, have a significantly higher rate of success. It could also be concluded that the submission of expert evidence in the form of an MLR may have a significant bearing on the outcome of an appeal case of a survivor of torture in the Tribunal, though other significant factors may include the quality of the legal representation and the quality of the claimant's witness testimony.

Of the 37 cases in the sample, the appeals of 49% were allowed in the Tribunal: significantly higher than the overall allowal rate of asylum cases in the Tribunal of 27%.

Of the 13 cases in the sample that had MLRs submitted to UK Border Agency, 9 were allowed in the Tribunal.

These findings also indicate that the asylum claims of survivors of torture are particularly poorly considered by UK Border Agency case owners at the initial decision stage, even when expert medical evidence is available - as demonstrated by the rate of overturn on appeal.[36]

However, the findings also show that a significant number of people whom the Medical Foundation consider to be victims of torture are not successful in appealing a refusal of their asylum claim in the Tribunal, [37] even with supportive medical evidence. Furthermore, MLRs submitted as evidence to the Tribunal are dismissed in a considerable number of cases and have no bearing on the outcome of the appeal.

With regard to individual hearing centres, although the numbers in many cases are too small to subject to meaningful analysis, the Manchester Hearing Centre shows a significantly higher rate of dismissal of cases (6 out of 8). 4 out of the 6 cases heard at Taylor House on the other hand were allowed. Furthermore, 6 out of the 10 cases at Hatton Cross, and both cases heard at Field House (Upper Tribunal), were allowed. This means that for the London Hearing Centres, where 18 out of the 37 cases were heard, 12 cases were allowed, amounting to 67%, which is significantly above the average allowal rate in this sample and the average rate of 28% given in UK Border Agency statistics.[38]

Given the limited size of the sample from these centres, it is difficult to determine whether these findings reflect a significant difference in judicial practice in the London Hearing Centres, with regard to treatment of medical evidence, and with regard to the asylum claims of those who are accepted to be survivors of torture. On the basis of the evidence of this sample, however, this would certainly merit further investigation, since a lack of consistency of approach across the regional hearing

centres could considerably disadvantage claimants dispersed to those areas outside London in particular.

MLRs[39]

Of the 42 MLRs produced in respect of 37 clients (some clients will have more than one MLR from different clinicians or other professionals), the findings of 22 (52%) were accepted in full by the Tribunal and the findings of 20 (48%) were not. For the MLR to be accepted in full, this means that both the clinical evidence of torture and the attribution of torture given by the claimant and documented in the MLR, is accepted by the decision maker.[40]

In all of the 18 cases where the findings of the MLR(s) were accepted in full by the Immigration Judge, the appeals were allowed, and in all 19 cases where the findings of the MLRs were not accepted in full, the appeals were dismissed.[41] The sample therefore demonstrates a clear correlation between the acceptance of the medical evidence of torture and its sequelae as documented in the Medical Foundation MLRs, and a positive decision in the Tribunal.

In all cases where the evidence of the MLR was accepted in full by the Tribunal, the appeal was allowed.

Despite the expertise of the Medical Foundation, in just over half the cases the evidence of the MLR was not accepted by the Tribunal.

In 9 cases, although the clinical evidence of torture was accepted, the cause attributed by the claimant was not and the case was dismissed.

However, the sample also demonstrates that in a significant number of cases the findings of the MLR are not accepted in full by the Tribunal (48%), despite the acknowledged expertise of the Medical Foundation and the professional standards and methodology applied in the preparation of Medical Foundation MLRs.[42]

Some MLRs are dismissed in their entirety (19/27% of the cases in the sample) and in all these cases the appeals are dismissed. In a subset of this group of cases (9/24% of the cases in the sample) the clinical evidence of trauma documented in the MLR is accepted by the Immigration Judge, in some cases explicitly as evidence of torture, but the causation attributed by the claimant is not. The cases are dismissed on the basis that the claimant is not found to be credible and the overall findings of the MLR are therefore set aside.[43]

Claimant profile[44]

Gender

In this sample of 37 cases, 50% of female claimants and 48% of male claimants were successful in their appeals.

According to UK Border Agency statistics, the general grant rate of some form of protection on initial application is almost the same for female and male asylum applicants (28/27%),[45] although official gender disaggregated statistics are not available for decisions on appeal at the Tribunal. It is therefore difficult to compare the findings from this sample by gender, with findings for appeal applicants in general.

However, in a recent report published by Asylum Aid,[46] UK Border Agency internal management figures were cited (not published as official statistics and therefore 'need to be treated with a degree

of caution') which indicate that in the last 12 months there was an appeal allowal rate for women's asylum claims in the Tribunal of 35-41%.[47]

The allowal rate of 50% in this sample of claims from women torture survivors is significantly higher. This indicates that not only are women's claims treated significantly differently by Immigration Judges than UK Border Agency case owners, but that within this group the claims of women survivors of torture are particularly poorly considered at the initial decision level, judged by the rate of overturn.

Indeed, of the 16 women in the sample, 7 had submitted MLRs to the UK Border Agency for consideration at initial decision stage. The findings of all of these MLRs were dismissed according to the record in the determinations, while the Immigration Judge accepted the findings of 6 of these MLRs on appeal and allowed the cases.

These findings suggest that where women have an opportunity to give a proper account of their history for the preparation of an MLR and disclose in detail torture and ill-treatment, including incidences of sexual violence, in a non-adversarial and appropriately supportive setting, this has a very significant effect on their ability to establish their credibility, when such evidence is given proper consideration by the UK Border Agency or the Tribunal.

Half the female claimants in the sample were successful in their appeal, compared with a general allowal rate for women's appeals of 35% and a UKBA allowal rate of 28%.

8 women's claims for protection were dismissed despite it having been accepted by the Medical Foundation that they were survivors of torture.

It should be noted that of the women's cases in this study, 50% were dismissed on appeal. This means that of the 16 women whose cases were included in this sample, 8 were unable to establish a protection claim, despite the submission of the MLR and despite it having been accepted by the Medical Foundation that they were victims of torture.

Age range

With regard to age range, it is noticeable that the percentage dismissal rate for two largest age groups is significantly higher than that of other age groups, although it is noted that the numbers involved in the other groups are small. Although the 26-45 year age group is much larger in size, it has a similar dismissal rate to the 19-25 year olds.

These findings suggest that it may be harder for a torture survivor to establish a claim for asylum in the largest overall age cohort of 26-45.

Basis for protection claim

The percentage of cases allowed that are based on the ground of political opinion (32%, the largest group in the sample), is significantly lower than the overall allowal rate for this sample (49%).[48]

As statistics disaggregated according to Refugee Convention ground are not available from the UK Border Agency or the Tribunal, it is not possible to compare the findings from this sample with the general trend. It would be interesting to know, for example, whether the majority of asylum applications are made on the basis of political opinion (or imputed political opinion), and whether

the allowal rate for this category of claimant is significantly lower than the average, as in this sample. This might indicate a more sceptical view taken by decision makers of claims based on political opinion or a higher threshold of 'proof' required for such cases to be made out.

It is possible to say that in this sample, in a significant number of cases based on political opinion, whilst it may have been accepted that torture or harm has occurred as evidenced in the MLR, it is not accepted that the cause is that claimed by the claimant or that there is a future risk.

In 9 of the 13 cases where an MLR had been submitted to the UKBA for the initial decision, the Immigration Judge allowed the case.

This represents an overturn rate of 69% for this group of cases.

Country of Origin

No obviously discernible pattern emerges from the treatment of individual cases and the respective MLRs according to the country of origin of the claimant, because of the small number of cases for each country.

However, it is interesting to note that all 4 cases in the sample from the Democratic Republic of Congo (DRC) are dismissed and the MLR evidence rejected. Three of the cases were heard in the Manchester Hearing Centre: all female claimants with claims based on imputed political opinion and all dismissed on grounds of credibility.

By contrast, 4 of the 5 cases of claimants from Afghanistan were allowed on appeal, with the MLR evidence being fully accepted. All 5 cases were heard in London, 4 in Hatton Cross.

2 of the 4 allowed cases are minors, one of whom had been forcibly recruited to the Taliban, while the other two were male and female claimants who were deemed at risk due to perceived connections with the Taliban and forced marriage with a Taliban commander respectively.

UK Border Agency Treatment of MLRs[49]

UK Border Agency Reasons for Refusal Letters (RFRLs) were not read for the purpose of this study. However, judicial determinations routinely consider the UK Border Agency's RFRLs and where it was recorded that the initial decision by the UK Border Agency included consideration of an MLR, this was noted.

Bearing in mind that all the cases in the sample had been dismissed by the UK Border Agency, and that not all cases in the sample had MLRs submitted at the initial decision stage, the treatment of medical evidence in the sample cases by the UK Border Agency (as noted in the determination) was also recorded. This was with a view to comparing the treatment of the same medical evidence by the Tribunal.

It was found that 13 of the 37 cases in the sample (35%) had MLRs submitted at the initial decision stage and in all cases this medical evidence had been rejected, accorded little weight or treated negatively by the UK Border Agency according to the record in the determination.

At appeal stage, the Immigration Judge in 9 of the 13 cases (69% of the sample of 13 cases) overturned this assessment and accepted the findings of the MLRs in full. All the appeals were allowed.

This overturn rate on appeal is clearly a great deal higher than the average overturn rate of 28%, according to UK Border Agency statistics.[50] It suggests a significant discrepancy in the treatment of medical evidence in cases involving survivors of torture by the UK Border Agency and by the Tribunal, which should be of serious concern to the UK Border Agency, particularly given their express commitment in the Asylum Improvement Project to achieving 'better, more sustainable decisions (i.e. not lost at appeal)'.[51]

Detailed findings indicate that the reasons given by UK Border Agency case owners for the refusal of cases and dismissal of evidence from the Medical Foundation include: late disclosure and inconsistencies in testimony between MLR and initial account; uncritical acceptance in the MLR of the history and account given by the claimant (cause of harm); lack of or inadequate exploration in the MLR of alterative causation of harm, including self-harm; and the GP not being qualified to diagnose psychiatrics and particularly PTSD.

Interestingly, these are all significant issues highlighted in this report with regard to the negative treatment of MLRs in the Tribunal. This suggests that a significant number of decision makers both at first instance and in the Tribunal have a similarly sceptical approach to the consideration of medical evidence in relation to survivors of torture. Indeed, the 4 cases where the Tribunal did not overturn the UK Border Agency assessment of medical evidence illustrate this point. In these cases the Immigration Judges give the following reasons for dismissal of the case: the claimant's account and history was accepted uncritically in the MLR; the claimant is not found to be credible; the Immigration Judge is unable to reach a 'firm conclusion' about the causation of injuries, which was found to be 'diagnostic' of torture in the MLR; and there are inconsistencies in the claimant's account.

In one case, the Immigration Judge states: "... I am satisfied that the appellant has suffered torture in the past ... I am also satisfied having regard to Dr X's opinion that the appellant is suffering from PTSD, depression and memory loss". He then dismissed the case on the basis that the claimant was not credible and that there were inconsistencies in the history, despite this having been specifically addressed in the MLR.

The 9 cases that were allowed in this group of 13, on the other hand, are good examples of positive and considered treatment by Immigration Judges of Medical Foundation MLRs, even where the UK Border Agency has taken a negative or sceptical view:

> *Case 3: "...it is perhaps right to start by saying that the respondent's approach to these applications has I think been significantly flawed from the very beginning. The refusal letter is written on the basis of a total refusal to believe a word the husband in particular has told ... I found both appellants entirely credible in the evidence that they gave, not least because what they said was significantly supported by the quality of the expert reports that had clearly examined their cases very closely, conscientiously and with considerable expertise."*
>
> *Case 6: "...The medical evidence shows that the appellant is in a fragile mental state and is a particularly vulnerable individual *an acute suicide risk+ ... terrified of being returned to x..."*
>
> *Case 14:"...the physical scarring is highly consistent with the attributions she gives, and there is no discrepancy between the causations and approximate timescale she describes ... Dr x also states that the appellant has clear features of PTSD ... In the reason for refusal letter at paragraph 37 the respondent considers that this diagnosis of PTSD 'cannot be considered reliable when a doctor does*

not have the appropriate psychiatric qualifications'. That attack on Dr x's qualifications in my view is amply dealt with in the letter of Dr Juliet Cohen, the Head of Medical Services at the Medical Foundation, in which attention is drawn to Dr x's qualifications in psychiatry."
Case 18:"...In the absence of any contra medical evidence from the respondent I see no reason to reject the expert report by Dr x and therefore adopt his conclusions".

Case 19: "...The respondent has stated that they do not accept that the injuries were sustained in the manner she has described, however given that the respondent does accept that the appellant has been detained by the authorities in x, I find that the evidence from the Medical Foundation satisfies me to the relevant standard of proof that these scars are indeed as a result of having been beaten in detention".

Case 28: "...Dr x set out at paragraph 20 of the MLR 'other possible causes of these clinical signs could be arthritis or inflammatory changes in the connecting tissue of the feet, but x does not give history of such problems' ... Dr x has noted that there are some inconsistencies given in his account and has also given a reason as to why they may have occurred..."

Case 32: "... I have noted that Dr x has assessed over 130 alleged torture victims for the Medical Foundation ... I find that the medical and counselling evidence is compelling ... whilst it would be completely unrealistic to state that that the organisation (MF) cannot reach erroneous conclusions, nevertheless I must take into account that they frequently refuse to prepare reports ... The authors of the medical reports have properly assessed their findings against the WHO diagnostic criteria for research, the ICD-10 classification of mental and behaviour disorders...and I find that Miss x is suffering from PTSD..."

Of particular note in Case 32 is the Immigration Judge's comment about the claimant's negative experience of the UK Border Agency screening process, in relation to discussion of discrepancies in her account. The Immigration Judge makes the following observation on the basis of a recording of the interview:

Case 32 "... The interviewers constantly tried to persuade her to admit that her real name was not x. One of them even said to her 'you are lying through your teeth'. The tone was very intimidating and I was shocked to hear these words. In spite of this persistent pressure, she continued to insist on her real name. She wept uncontrollably for long stretches of time "

FINDINGS - treatment of MLRs in the determination

Expertise of the MLR author[52]

The weight given to expert evidence will depend to a great extent on the expert's 'expertise, experience or opportunity to investigate'.[53] While it may be considered an error of law to ignore relevant evidence from a reliable source, it may be set aside if it has been given 'due consideration' and reasons are given. These reasons should include consideration of the areas of expertise and experience of the expert and how these were acquired, as well as 'consideration of whether the expert's opinion is based on a full knowledge of all established and relevant facts, using reliable methods.'[54]

In 10 of the 37 cases in the sample, the Immigration Judge specifically comments in their determination on the expertise and credentials of the MLR author. In 7 of the 10 cases the comments were positive, accepting the expertise of the author and their qualification to make the relevant diagnosis. All of these cases resulted in the appeal being allowed. It is interesting to note that in 2 cases the Immigration Judge specifically mentions their disagreement with the negative opinion of the UK Border Agency on the matter of the expertise of the MLR author, while in 1 case the Immigration Judge agrees with this assessment.

Some Immigration Judges question the expertise of Medical Foundation doctors despite their qualifications and experience, their specific training and the guidelines and quality assurance procedures that are in place at the Medical Foundation.

In all 3 of the cases where expertise was not accepted, the MLR author was a General Practitioner. In 2 of these cases the Immigration Judge did not accept the General Practitioner's qualification to diagnose psychiatrics and specifically PTSD, while in 1 their qualification to assess scars is questioned and in another, their objectivity is questioned.

While the majority of Immigration Judges whose determinations are in this sample therefore accept the credentials of the authors of Medical Foundation MLRs, this is not a position that is consistently adopted.

It is noted that the number of cases where the qualification and expertise of the doctor is not accepted is small (3). However, given that the acceptance or otherwise of the expertise of the MLR author has an important bearing on the acceptance of the overall findings of the MLR, and given that this in turn has a bearing on the outcome of the appeal, it is significant and of overwhelming importance to the individual claimant.

Moreover, whatever the numbers involved, it is a matter of concern that the qualification of Medical Foundation doctors to present expert medical reports and specifically to make a psychological evaluations, is subject to question at the Tribunal.

All the doctors and other professionals who write MLRs are selected by the Medical Foundation as suitably qualified and are trained specifically in the methods of documentation of torture, in accordance with the standards of the Istanbul Protocol.[55] Furthermore, all Medical Foundation MLRs

are prepared in accordance with strict guidelines and are independently checked by clinical and legal specialists.[56]

Quality of MLR[57]

The Immigration Judges in the sample specifically comment in their determinations on the quality of the MLR in 6 cases. In 4 of these cases the comments are positive, mentioning the reputation of the Medical Foundation, the experience and expertise of the authors, the lengthy assessments that have been carried out, the careful preparation of the reports and the useful content, including medical assessments made with reference to the relevant diagnostic criteria. In 3 of the 4 cases the appeals were allowed. The 6th case was criticised for not considering 'in detail' alternative possible causation for the injuries documented in the report.

These positive findings as well as the general lack of comment on the quality of MLRs indicate that in general the Immigration Judges in this sample have not taken a negative view of the quality of the MLRs before them.

Credibility

Given that corroborative evidence is very often lacking in asylum claims, 'credibility assessments' based on the internal coherence of the claimant's testimony, its external consistency with objective evidence and its inherent plausibility, are used throughout the decision-making process to filter out 'false' claims.[58] Indeed, in a recent report on decision-making in women's asylum claims, Asylum Aid observes that 'the assessment of credibility forms the core of the refugee status determination process in the UK'.[59]

However, serious concerns about the assessment of credibility in asylum cases have been highlighted in a number of previous reports.[60] According to Catriona Jarvis, an Immigration Judge cited in a recent study of the Tribunal, since credibility findings '... go to the heart of the identity of asylum applicants, to get it wrong is to add insult to injury...to inflict yet further damage upon a human being who has already undergone experiences incomprehensible to most of us.'[61]

The assessment of credibility forms the core of the refugee status determination process - it requires an assessment of the essential 'truthfulness' of a claimant's history.

For survivors of torture an MLR can play a key role in documenting the trauma resulting from torture and placing this in the context of their particular history.

Findings indicate a lack of consistency in the willingness of Immigration Judges to be guided by the findings of MLRs in their consideration of the credibility of a case.

The detailed examination of the cases in this sample demonstrates that a finding on credibility is the core element of a decision in an asylum claim at appeal level, as well as at the initial decision stage. Furthermore, it is evident that decision making on the issue of credibility is inherently problematic and complex in asylum claims. It requires that an assessment of the essential 'truthfulness' of a claimant's testimony and history is made in light of such evidence as is available. In the cases of survivors of torture, expert evidence in the form of an MLR can play a key role in documenting the trauma resulting from an individual's experience of torture and placing this in the context of their particular history.

While it is the absolute prerogative of the Tribunal and the Immigration Judge to make a finding of fact on the overall credibility of an asylum claimant,[62] in the case of survivors of torture in particular, they may benefit from the assistance of doctors experienced in the documentation of torture. Findings of this investigation indicate that while many Immigration Judges are willing to be guided by the findings of an MLR in their consideration of the credibility of a case, a significant number are not.

The position taken by Immigration Judges in some cases appears to call into question the authority and purpose of expert medical evidence in asylum appeals, if the doctor is merely required to record the physical or psychological sequelae of torture and is criticised for giving a professional opinion about the relationship of this evidence to the likely cause. The Istanbul Protocol states the following with respect to the purpose of medical expert opinion in the investigation of torture:

The documentation and assessment of the subject's history in relation to injuries described and the examination findings is the key function of the MLR author.

In some cases the Immigration Judge dismisses the claimant's history documented in the MLR as a 'recitation' or 'self-reported' account.

The credibility of these claimants is not accepted and these cases are dismissed.

"... A. Purpose of inquiry, examination and documentation

... 122. 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."[63]

Taking a history[64]

As detailed in the Medical Foundation Methodology, Medical Foundation doctors and other professionals are required to exercise their skill, experience and training in taking and assessing a history from the subject of an MLR. The assessment of the subject's history in relation to the injuries described and the examination findings is the key function of the MLR author, who is guided by Medical Foundation Methodology guidelines,[65] and the standards set out in the Istanbul Protocol.[66]

With respect to medical evidence required for the investigation of torture, the Istanbul Protocol provides the following guidance:

" 4. Medical Evidence
...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?"[67]

Taking the history is understood to be a complex process and in accepting the history given, the doctor (or other MLR author) is exercising their professional judgement as an independent expert or professional witness whose duty is to the court. The Medical Foundation Methodology describes the process as follows:

" The doctor sees the subject of the report on a minimum of two occasions, more if needed. A full history and examination are undertaken and physical and psychological findings documented. Photographs or body diagrams of scars may be made if they would assist (e.g., where recent bruising might fade).

Before taking the detailed history and conducting the examination, the doctor will familiarise herself with the papers provided to the Medical Foundation, (usually) by the subject's legal representative ... However, it is important to note that the testimony of the subject given elsewhere does not form the basis for the doctor's history taking, which is always done independently.

The whole of the subject's testimony is assessed in the light of, among other things: health reported prior to and after torture, the history and detail given of the torture and the subject's affect and behaviour... There is no 'normal' behaviour of a torture victim, but the doctor assesses their observations within her consideration of the person's mental state in the overall context of the person's speech content, culture of origin, family history, employment, levels of education, current state of health and apparent personality...

The specificity of the detail in an account, particularly sensory and geographical detail, as well as medical details of injuries received and the healing process of those injuries (e.g. how medically plausible is the account given of the healing process?) - all add to the often complex and detailed picture ...

It is not the role of the report writing doctor to assess credibility. However, doctors do not, even in their everyday practice, accept at face value everything they are told by their patients...

During the examination Medical Foundation doctors critically assess the account given in relation to the injuries described and the examination findings, in the light of their own experience and the collective experience of colleagues at the Medical Foundation, and may decline to write a report if the account and findings do not correlate....

> ...A senior doctor then reviews the report and a legal officer to check that all relevant aspects have been addressed appropriately before it is signed off.
>
> All Medical Foundation doctors understand and sign a declaration to the effect that the MLR is an expert witness report and that their duties to the court are those of an expert witness ..."[68]

In the majority of the cases in the sample, while issue may be taken with regard to the credibility of the claimant, the Immigration Judge does not comment on the process of history taking specifically. However, in 4 of the 6 cases in the sample where reference is made to this process, the Immigration Judge appears to make the assumption that the doctor has merely listened to the account and assumed its veracity. In one case the Immigration Judge states that the MLR author has 'recited' the account of the claimant; in another, that the diagnosis is 'founded on a pre-existing acceptance of the account'. A further example states that the MLR was 'based largely on self-reporting'.[69]

Given that many asylum claims rest on an acceptance of the core credibility of the claimant, central to which is the claimant's account of their history, the dismissal of the findings of the medical expert in regard to this history will have serious consequences for the claimant. All 4 of the cases where the expert's assessment of the history given in the MLR is explicitly rejected by the Immigration Judge were dismissed on grounds of credibility.

It is of concern that this sample demonstrates a lack of consistency in the view of Immigration Judges about the role of the MLR author in assessing the veracity of a claimant's account of their history. As is noted in the Medical Foundation MLR Methodology guidelines,[70] it is not the role of the expert to make a finding of fact about the overall credibility of the claimant. However, it is central to their task to assess the degree to which the account is consistent with the findings before them. Their findings on this, which are informed by their professional duties and their duty to the court, should therefore be taken into account in the assessment of the claimant's core credibility in relation to which the Immigration Judge will be required to make a finding of fact.

Inconsistencies in testimony will often count against the overall credibility of an asylum claimant and may be fatal to their case.

For survivors of torture, memory difficulties - an inability to give a coherent history or failure to disclose incidences of torture - are frequently observed and are well researched phenomena.

Consistency, recall & late disclosure[71]

The issue of inconsistency in the claimant's account of their history is commented on in 14 of the 37 cases in the sample (38%). This is in a context where inconsistencies in testimony, whether given on separate occasions or on a single occasion, will be often counted against the overall credibility of an asylum claimant and may be fatal to their case.

With regard to the assessment of inconsistencies in the testimony of a survivor of torture, it is acknowledged that particular conditions apply. Memory difficulties - an inability to give a coherent history or failure to disclose incidences of torture and ill-treatment in non-conducive circumstances, such as an interview with a Home Office official - are frequently observed and well researched phenomena.[72] For example:

"... Current research on memory shows that stories can change for many reasons and the changes do not necessarily indicate that the narrator is lying. In the real world, we know that the most rigidly reproduced accounts may be so because they have been memorised from a script. Conversely, those with certain discrepancies may be genuinely reconstructed from autobiographical memories. Yet we encourage consistency in all testimony because it "keeps it simple".

Motivation to be consistent is only present if the subject first knows that consistency is valued above everything. If not, it is "accidental" rather than intended. In Britain we give witnesses their statements to read before going into court, to ensure they are happy to swear to them on oath and to make sure they do not then depart from the "established" story. Presumably this is based on the assumption that they are likely to do so. This does not mean we are suggesting they lie, just that experience in the courts has shown it is almost impossible to maintain absolute consistency, especially if it is a long time since the events to be recalled. Yet this latitude is not given to asylum seekers who are repeatedly judged and found not credible on this very issue. This application of dual standards is iniquitous.

There are strong grounds for arguing that lack of consistency per se cannot be used to give any negative weight to the assessment of credibility. In addition, it needs to be acknowledged that judgments about credibility are extremely fallible...

The findings of this review have wider implications for any witness evidence presented in court. In the case of asylum seekers, especially, it is clear that great caution needs to be exercised in denying credibility. The normal variability of memory is likely to be exacerbated by the medical factors reviewed above and a general impairment of recall is to be expected as a result of their traumatic experiences and physical and mental state..."[73]

The Istanbul Protocol, while recognising that false allegations or exaggerated accounts of torture are sometimes made, states:

"...Inconsistencies in testimony can occur for a number of valid reasons, such as memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time or fragmentation and repression of traumatic memories.
Effective documentation of psychological evidence of torture requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report."[74]

The Medical Foundation MLR guidelines address this issue in the excerpt below:

"... Methodology of Medical Foundation Reports

... It is our experience that, because doctors take their histories in ways quite different from lawyers or government officials, and because of the setting of a doctor's examination room compared to, say, the lawyer's busy offices or an interview room at the Home Office, a more detailed disclosure often results. Disclosure is sometimes significantly enhanced merely by the fact that the questions are put by a doctor, especially, we believe, if the doctor has had a level of specialist clinical training on interviewing survivors of torture and has gained experience from other such interviews of the immediate and long term impact of torture.

Memory difficulties are explored in detail and with reference to established psychology research in this field.[75] Further resources such as psychometric testing by a clinical psychologist are available if needed. An opinion is given on the examination in its entirety and not on isolated findings.

... Each report is read back to the subject to confirm details of the history have been accurately recorded. This process sometimes triggers further recall of details of the events as well as serving as a check that interpreter and doctor have understood the subject correctly ..."[76]

In 6 of the determinations examined in this sample the Immigration Judge makes reference to either the late disclosure of traumatic incidences such as rape, or inconsistencies in testimony around material facts, and accepts the explanation for this given in the MLR. In all of these 6 cases the Immigration Judge, having given due consideration to the evidence of the MLR, accepts the core credibility of the claimant's case and the cases are allowed. For example:

Case 4: the Immigration Judge accepts that the inconsistencies in testimony of the claimant could be attributed to his age (16, though younger when the trauma occurred), as suggested by the MLR but denied by the UK Border Agency, who disputed his age.

Case 6: the Immigration Judge accepts that a woman was unable to disclose the fact that she had been raped when interviewed by a UK Border Agency case owner due to the presence of a male interpreter.

Case 7: the Immigration Judge accepts that the claimant had been unable to give a coherent description of her history to the UK Border Agency interviewer due to the high level of trauma that she had suffered. It was noted that after the lengthy involvement of a counsellor at the Medical Foundation with whom she had built up a relationship of trust, she was eventually able to give a clear and coherent history.

Case 32: the Immigration Judge comments on the intimidating tone and questioning style of the UK Border Agency screening officer in connection with the failure to disclose relevant information. The judge, who had listened to a recording of the interview, states that he was shocked to hear this tone and the claimant being accused of 'lying through her teeth'.

Cases demonstrate that evidence about the negative impact of torture on memory and the ability to disclose information is not accepted by some of the Immigration Judges in the Tribunal.

This has a very significant impact on the assessment of credibility in these cases, all of which are dismissed.

However, in 8 of the 14 cases (22% of the whole sample) in which consistency of testimony is at issue, the Immigration Judges take a negative view of the evidence presented in the MLR and the cases are all dismissed.

For example:

Case 10: the MLR doctor diagnoses PTSD and severe depression according to DSM-IV criteria[77] and refers to a "complex trauma picture" and the difficulty in assessing the claimant in the usual way due to the severity of ill health. The doctor recommends an adjournment of the case so that a full assessment could be carried out following a period of treatment or that "there is an understanding of the possible psychological reasons for discrepancies in her history." The Immigration Judge remarks in the determination, "The defects of the account go beyond inconsistency and include implausibility" and states that the MLR does not have significant evidential weight.

Case 11: the Immigration Judge does not accept that the client's mental state as documented in the MLR affected her ability to give evidence at the relevant hearing; "I therefore find that there was no good reason for the appellant to fail to disclose evidence on which she now seeks to rely...namely the claimed multiple rapes in prison, to reinforce her claim of detention..."

The MLR doctor gives the opinion that the late disclosure of rape and pregnancy as result of rape in this case, are due to the psychological condition of the claimant and the male dominated environment she experienced at all stages of the legal process. This included a male interpreter from her community, with the concomitant issues of stigma and shame.

The Immigration Judge dismissed these reasons on the basis that her legal representative had not requested an all female court for the current hearing and that during screening and asylum interviews the claimant had not stated that she was not fit to conduct interviews. Furthermore the Immigration Judge states that she did not disclose rape despite being asked one open question: "...You were in prison...what happened during that time".

In the same case, the Immigration Judge states that as the claimant is intelligent and educated "...had she been detained as claimed, and raped repeatedly as she claimed, then she would have disclosed this at the earliest opportunity, regardless of the sex or nationality of the interviewing officer or interpreter." In making this assertion, the Immigration Judge completely ignores the opinion of the MLR doctor, who states that "x manages her psychological difficulties by avoiding dwelling on her past traumatic experiences as much as she can" and that she demonstrates strong avoidance strategies common among rape victims.

*Case 37: the Immigration Judge finds, in relation to a claimant who had been detained on a number of occasions and repeatedly tortured, that "If the appellant were recounting events *from each of the torture sessions] which had actually taken place, it is highly probable his evidence would be consistent". The claimant was found not to be credible despite the fact that the MLR documents evidence of all the torture methods described by the claimant in their various interviews and statements, albeit that not all were disclosed to the UK Border Agency on one occasion.*

In 15 cases the cause of the torture documented in the MLR is at issue and discussed in the determination.

In 12 of these cases the clinical evidence of trauma reported in the MLR is accepted.

In 8 of the 12 cases the cause of torture given by the claimant and documented in the MLR as part of the overall findings, is not accepted. All of these cases are dismissed.

These examples, as well as the others in the sample, demonstrate that evidence about the negative impact of trauma on memory and the ability to disclose, based in clinical psychology, other research and explained by the MLR doctors in individual cases, is clearly not accepted with consistency in the Tribunal. Findings on the issue of the consistency of the history and testimony given by a claimant bear heavily on the overall credibility finding in asylum cases. It is a matter of concern therefore that an apparently contradictory position is adopted by different Immigration Judges in relation to consistency and recall in cases involving survivors of torture.

Causation[78]

In 15 of the 37 cases in the sample (41%), the question of causation or attribution of the physical or psychological sequelae of torture reported in the MLR is at issue and explicitly discussed in the determination. The question of the competence of the MLR doctor to take the claimant's history and their authority to assess the veracity of the account in relation to medical evidence is discussed in the sections on 'Expertise' and 'History' above.

Of interest here is the way in which the integrated or holistic findings of MLRs, which are focused on the documentation of evidence of torture and an assessment of the consistency of these findings

with the history, are often artificially separately by Immigration Judges. The question of 'causation' is then treated distinctly, often in light of an existing negative finding on credibility.

The standard text Asylum Law and Practice makes comment on this issue as follows:

> "... Medical experts, like any other, should not stray into the area of decision-making reserved for an adjudicator, and hence should normally steer clear of giving an opinion on the credibility of an account, for their reports can at their highest suggest a consistency between physical features of the appellant and their own account of their genesis rather than independently confirming the account's veracity. This is not to say high quality reports may not win the day... and to criticise a medical report on the basis of credibility findings made without reference to it is to approach the matter from the wrong direction."[79]

Medical Foundation Methodology describes the process involved in the preparation of an MLR as follows:

> "... The doctor sees the subject of the report on a minimum of two occasions, more if needed. A full history and examination are undertaken and physical and psychological findings documented. Photographs or body diagrams of scars may be made if they would assist (e.g., where recent bruising might fade).
>
> Before taking the detailed history and conducting the examination, the doctor will familiarise herself with the papers provided to the Medical Foundation, (usually) by the subject's legal representative. These papers guide our doctors as to the areas on which they should concentrate. However, it is important to note that the testimony of the subject given elsewhere does not form the basis for the doctor's history taking, which is always done independently.
>
> The whole of the subject's testimony is assessed in the light of, among other things: health reported prior to and after torture, the history and detail given of the torture and the subject's affect and behaviour. Affect means the objective observation of their mood. Behaviour in this context means the manner of giving their account, the facial expressions, body language and forms of speech as assessed by the doctor. There is no 'normal' behaviour of a torture victim, but the doctor assesses their observations within her consideration of the person's mental state in the overall context of the person's speech content, culture of origin, family history, employment, levels of education, current state of health and apparent personality. For example, culture of origin and social background as well as severity of depressive illness can affect the level of eye contact made. During an assessment some cry a lot, some cry a little or not at all. It is not the number of tears shed but the total picture of the person gained during two different meetings that gives the doctor their impression of 'behaviour'.
>
> The specificity of the detail in an account, particularly sensory and geographical detail, as well as medical details of injuries received and the healing process of those injuries (e.g. how medically plausible is the account given of the healing process?) - all add to the often complex and detailed picture...
>
> Memory difficulties are explored in detail and with reference to established psychology research in this field. Further resources such as psychometric testing by a clinical psychologist are available if needed. An opinion is given on the examination in its entirety and not on isolated findings...[80]

Where the Immigration Judge has already made a judgement in relation to the credibility of the claimant, evidence from this sample demonstrates that the assessment given by the doctor is simply dismissed. In some cases the Immigration Judge may simply assert their own conclusion as to the

consistency of the evidence of torture and its claimed causation. In others, the Immigration Judge even suggests an alternative causation without providing an explanation as to how this is related to the specific signs of physical or psychological trauma, as a doctor would be required to do.

The Istanbul Protocol gives detailed guidance on the documentation and evaluation of specific forms of torture, which Medical Foundation doctors are required to follow. It is recommended 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.'[81] The following terms are recommended for use in this regard:

> (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. [82]

Importantly, the following paragraph 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.'[83]

Of the 15 cases in the sample where the question of causation is at issue, the Immigration Judge accepts the evidence and findings in the MLR of physical or psychological trauma in 12 of them. However, in 8 of these 12 cases (22% of the sample) the attributed cause of torture, documented in the MLR as part of the overall findings, is treated separately and not accepted. All of these cases are dismissed.

Indeed of this group of cases, only the 4 where the clinical findings of trauma and cause are treated in an integrated way are allowed. The Immigration Judge in one of these cases states: "...The Appellant husband has clearly been diagnosed as suffering from PTSD as a result of ...his own later detention and ill-treatment. Of course it can always have arisen in other ways but it is perverse to ignore the obvious, which is that his state of health has arisen from the experiences he has claimed." Examples of those cases where the attributed cause is not accepted by the Immigration Judge are as follows:

> *Case 2: The Immigration Judge accepts "entirely" the MLR evidence as to the nature of scarring and the claimant's general mental health but takes issue with the conclusions of the report in which it is stated that the findings are "diagnostic" of torture. The Immigration Judge states "... the finding simply does not fit in with my conclusions as to the credibility of the Appellant's account. After careful consideration I conclude that the medical report does not persuade me that my findings on credibility must be wrong... I conclude that although the scars on the Appellant's body do present as evidence of torture I am not satisfied that they were incurred in the manner claimed by the Appellant." The Immigration Judge further comments "...whilst it is pointless to speculate how the Appellant's scarring may have occurred I am satisfied on the totality of the evidence before me that they did not occur in the manner claimed by the Appellant." It is also stated that the claimant has "set out to provide evidence" to support their asylum claim.*

Case 5: The Immigration Judge comments that although the professional view presented in the MLR is that the claimant has suffered trauma "...I am not persuaded by the conclusions of the medical specialists that the Appellant suffered trauma for the reasons he gave. Indeed I specifically find to the contrary." The Immigration Judge suggests "It is in my view entirely possible that the general country circumstances in x may well have caused trauma "No specific evidence is adduced or referred to in support of this assertion.

Case 8: The Immigration Judge accepts clinical evidence of rape and ill treatment but does not accept that this occurred in detention as claimed. The case was reviewed in the First and Upper Tier Tribunals and the decision sustained. The Immigration Judge states in the Reason for Decision (First Tier Tribunal review): "It is simply unarguable that the medical report compelled a finding that the Appellant was raped and beaten over a period of time in detention, as claimed by the Appellant, as opposed to the ill-treatment having been sustained in other circumstances." The MLR doctor accepts the claimant's account based on the compatibility of clinical findings with it and no obvious alternative explanation, having considered alternatives from life history. No alternative medical or other opinion is adduced to provide opinion about other possible causes of the reported findings.

Case 13: The Immigration Judge does not accept the MLR finding that the appellant suffers from PTSD on the basis that the General Practitioner is not qualified to diagnose PTSD though accepts the same diagnosis from an alternative expert. However, the Immigration Judge does not accept the basic credibility of the account and states: "There must therefore be another explanation why the Appellant is suffering from PTSD."

Furthermore, despite the fact that the MLR reports that 17 scars are 'diagnostic' of torture and 11 are 'highly consistent' with the claimant's attribution to injuries, the Immigration Judge finds that "I have rejected her claim of having those scars inflicted by others in x and am unable to reach a firm conclusion whether the scars were self-inflicted (or applied voluntarily) in the UK or against the appellant's will but in different circumstances from what she has claimed ". The MLR doctor states explicitly that self-infliction or voluntary infliction would be unlikely due to the location/nature and totality of scarring.

Case 20: The Immigration Judge accepts that the doctor is 'an expert'. He mentions the fact that there is one scar which is 'diagnostic' and a further 8 scars which are 'typical' and 4 which are 'highly consistent' with the appellant's attribution. But he then says 'Given my adverse findings of credibility. I find the scars were not attributed to the torture as claimed by the appellant'.

Case 22: The Immigration Judge states there was little to support the doctor's conclusion that she did not doubt the history given by the claimant. "Although she uses the words 'consistent' and 'highly consistent', she does not consider other possible causes by which the scars could have been caused. In particular the scar on the appellant's right upper thigh is 'highly consistent' with her description of a burn from the tip of a cigarette there could be many other reasons for her having such a scar. What I take from the report is that the appellant has two scars that could have happened in the way the appellant describes'".

In the MLR the Doctor states" . this is consistent bearing in mind that such injuries are unusual on the inner aspect of the upper arm ..This lesion is highly consistent with the alleged cause on an area of the body that is usually protected by clothing. Only a heated object of the same diameter as a cigarette could cause such an injury".

Case 26: The Immigration Judge rejects the entire MLR evidence, agreeing with the UK Border Agency that the doctor has 'assessed credibility'. The MLR states '...the man described his arrest, detention, and severe ill treatment at the hands of the x ... For five days he was confined, punched, beaten with gun butts and kicked. During this period he was not fed, and was kept in his underclothes. His hands and fingers were deliberately burnt and before he was released he was rendered unconscious by a blow or blows to the head ... on examination he has scarring on the face consistent with his story of being beaten with a gun butt and evidence of marked burns of the hands and fingers that are unlikely to be self inflicted'. The two scars are referenced and described according to the correct Istanbul Protocol standards. The Immigration Judge appears to conflate the assessment of the credibility and the assessment of the consistency of the evidence of trauma with the claimant's attribution.

Case 37: The Immigration Judge states "... I am not persuaded the medical report provided by the appellant establishes there is a reasonable likelihood he has been tortured as claimed and find it is probable that his scars have been occasioned by another cause such as a traffic accident." The Immigration Judge states that the appellant only mentions having hot water poured over him when he is with the Doctor "...Given my credibility findings in relation to this appellant's account, I find it probable that the hyper pigmentation observed by the doctor was caused by another trauma such as a domestic accident, perhaps spilling a hot cup of tea".

Of particular note in these examples are the cases (2, 13, 20) where the MLR documents evidence of scarring that is 'diagnostic' of torture in the language of the Istanbul Protocol (where the injuries could not have been caused any other way), and the Immigration Judge simply dismisses the findings, substituting their own 'findings'.

If these findings are representative of a general pattern, then there is a potentially significant number of cases where it is accepted by the Immigration Judge that the claimant has suffered significant harm and in some cases to have been tortured, but is not deemed at risk because no factual finding was made about the cause of their mistreatment. A potentially dangerous failure to protect a person in need could be the consequence.

PART 3

STANDARDS for torture documentation and for the treatment of evidence in refugee status determination

One of the objectives of this Report was to assess Tribunal practice and guidance against established good practice standards in relation to the documentation of torture and the treatment of expert evidence in refugee status determination (RSD) procedures. These standards include the Istanbul Protocol and the UNHCR Handbook on Procedures and Criteria for Determining Refugee Status. [84] [85]

The Istanbul Protocol

The Istanbul Protocol (IP) contains the first set of internationally recognised standards for the effective examination, investigation and reporting of allegations of torture and ill-treatment.[86] It was drafted by more than 75 experts in law, health and human rights during three years of collective effort involving more than 40 different organisations. Since its inception in 1999 the IP has been endorsed and promoted by the UN and other key human rights bodies.[87] It was primarily developed with a view to the prevention of torture by providing states with a tool to carry out effective documentation of torture in order to hold perpetrators to account. The methods were also developed with a view to their application in other contexts, such as RSD procedures.

The IP deals with the legal investigation of torture and notes that procedures for the investigation of torture occur in a number of different contexts, including those which may result in the trial of an alleged perpetrator. Such proceedings require the 'highest level of proof'. However, it also sets out the standard for reports supporting an application for asylum in a third country, which 'need provide only a relatively low level of proof of torture.'[88]

The IP standard for medical evidence is that in formulating a clinical impression for the purpose of reporting physical and psychological evidence of torture, the doctor (or other report writer) should question whether 'the physical and psychological findings are consistent with the alleged report of torture', taking into account the overall clinical picture, the cultural and social context of the individual, the time frame of the alleged events and other stress factors potentially affecting the individual.[89] A medical evaluation for legal purposes 'should be conducted with objectivity and impartiality' and be based on the doctor's clinical expertise and professional experience.[90] Furthermore, 'clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse.'[91]

In terms of the documentation and evaluation of specific forms of torture, the IP gives detailed guidance. It is recommended 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.' The following terms are recommended:

> (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. [92]

Importantly, the IP states that '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.'[93]

The IP further sets out that since psychological symptoms are so prevalent among survivors of torture the documentation process should include a psychological evaluation, including a psychiatric diagnosis if appropriate. The goal of the 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.[94] Relevant to this assessment would be 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 should be described.' Additional factors such as the difficulties endured by the individual due to their forced migration and resettlement should be described and taken into account,[95] and a relevant Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or International Classification of Diseases (ICD-10) psychiatric diagnosis should be made if the individual has symptom levels consistent with it. [96] However, 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.

The UNHCR Handbook

The UNHCR Handbook establishes that it is the responsibility of the applicant themselves to supply the relevant facts of their case. It is then up to the person charged with determining their status to assess the validity of any evidence and the credibility of the applicant's statements.[97] While the burden of proof in principle rests on the person submitting the claim, the Handbook also states that the duty to ascertain and evaluate all the relevant facts is shared between the applicant and the examiner.[98]

If the applicant's account appears credible, it is recommended that they should be given the benefit of the doubt, 'unless there are good reasons to the contrary'. Furthermore, the guidance states that it is the duty of the decision maker to clarify any apparent inconsistencies and to resolve any contradictions in the applicant's account, and to find an explanation for any misrepresentation or concealment of material facts.[99]

The Handbook notes that the benefit of the doubt should only be given when all available evidence has been obtained and checked and when the examiner is satisfied as to the applicant's general credibility.[100] However, in view of the difficulty of proof inherent in the situation in which asylum seekers find themselves, the guidance recommends that the usual requirements of evidence should 'not be too strictly applied'.[101]

The Handbook also acknowledges that individuals who have fled their country as a result of negative experiences of their own state authorities may be fearful and apprehensive around any authority, and may be unable to give a full and accurate account of their case.[102] It cautions the decision-maker about taking isolated incidents in an applicant's case out of context and advises that the 'cumulative effect of the applicant's experience must be taken into account' in deciding their claim.[103]

GUIDELINES on the treatment of expert medical evidence, on vulnerable appellants and on the preparation of MLRs

One of the objectives of this Report is to assess the current practice of the Tribunal in relation to the adherence or otherwise of Immigration Judges to guidelines on the treatment of expert medical evidence. These include:

- Practice Direction: Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal – Part 4 10 Expert evidence
- Joint Presidential Guidance Note 2 of 2010: Child, vulnerable adult and sensitive appellant guidance
- International Association of Refugee Law Judges (IARLJ): Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence, June 2010
- Medical Foundation for the Care of Victims of Torture, Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation, June 2006

Tribunal Practice Direction: Expert evidence

The guidance given in the Practice Direction is directed to the expert in preparing and presenting their evidence.[104] It sets out that it is the duty of the expert to help the Tribunal on matters within their expertise, and that this duty 'is paramount and overrides any other obligations'.[105] Expert evidence 'should be the independent product of the expert and should provide objective, unbiased opinion on matters within their area of expertise' and the expert is warned against taking on the role of advocate.[106]

The expert is instructed to consider all material facts, including those that might detract from their opinion, and to make it clear if an issue falls outside their area of expertise or if they are unable to reach a definite opinion because of lack of information or for other reasons.[107] An expert report is furthermore required to give details of the expert's qualifications and all material relied upon in producing the report. It should also contain a statement of all the facts and information which are relied on and make clear which facts are 'within the experts own knowledge'.[108]

Where there is a range of opinion on matters dealt with, this should be summarised and the reasons for the experts own opinion should be stated. The report should give a summary of conclusions reached and any qualifications to the opinions stated, and lastly should contain a statement that the expert understands their duty to the Tribunal and has complied with this duty (Statement of Truth).[109]

Joint Presidential Guidance Note: Child, vulnerable adult and sensitive appellant

The guidance note recognises that applicants who have undergone traumatic experiences, such as torture survivors, may be vulnerable and describes what measures Immigration Judges may consider implementing to avoid re-traumatising them, and to ensure that evidence provided by them is admissible and reliable.[110]

The guidance note recognises that the way in which evidence is given may be affected by trauma and that where there are discrepancies in evidence, the extent to which the vulnerability of the individual is an element of this should be considered.[111]

International Association of Refugee Law Judges Guidelines: Evaluation of Expert Medical Evidence

The International Association of Refugee Law Judges (IARLJ) Guidelines are the product of five years' work by an Expert Working Party of Immigration Judges and other experts, and two world conferences of refugee law judges.[112] They are presented as 'aspirational best practice' and are regarded as a 'tool to facilitate the decision making process'. The Guidelines differ from the UK Tribunal Practice Direction on Expert Evidence in that they are addressed to both the expert and decision-maker.

With regard to the duty of the decision-maker, the Guidelines affirm that any medical or psychiatric report deserves 'careful and specific consideration', bearing in mind particularly that there may be psychological consequences from ill-treatment which may affect the evidence which is given by the applicant. However, the Guidelines note that the consideration given to a report will depend on the quality of the report and the standing and qualifications of the doctor.[113]

Attention should be given to each and every aspect of medical reports and medical evidence should be treated as 'an integral part of all evidence considered in establishing the facts'.[114] Furthermore, medical evidence 'should form an integral part of any findings of credibility and should not be separated from other evidence'.[115] The Guidelines note that while expert medical evidence may not prove conclusively whether someone was tortured, it provides 'expert opinion on the degree to which the injuries or behaviour presented correlate with the allegations of torture/ill-treatment'.[116]

In relation to the requirements of expert medical evidence, the Guidelines state that it should:

- include the credentials of the author,
- deal with the individual claimant's particular case,
- be restricted to the author's area(s) of competence and expertise,
- demonstrate a critical and objective analysis of the injuries and/or symptoms displayed,
- address the relative likelihood of any other possible cause for the injury in question,
- provide an overall evaluation of all lesions and note the consistency of each lesion with a particular form of torture,
- remain impartial and refrain from giving any opinion as to the overall credibility of the claimant or of the merits of the claimant's case.[117]

An expert report should advise on the contact of the author with the claimant, the nature of the examination, diagnostic tests and methodology employed, suggested prescribed treatment and long term prognosis.[118] It should demonstrate a critical and objective analysis of the injuries and/or

symptoms displayed, rather than an unquestioning acceptance of the claimant's account of how any injuries were sustained.[119]

On the documentation of injury, the Guidelines provide that expert medical evidence should address the relative likelihood of any other possible cause for the injury in question as well as an overall evaluation of all lesions, noting the consistency of each lesion with a particular form of torture. The overall conclusion should not go further than the findings as detailed by the expert.[120] On the issue of causation the Guidelines state that it is not necessary to include 'speculation and enumeration' about a range of other possible causes; 'it is enough for the expert to state that there are other possible causes for the injury, and how likely they are considering what is known about the claimant's life history and experiences.'[121] On the assessment of credibility the Guidelines state that expert medical evidence should 'remain impartial and refrain from giving any opinion as to the overall credibility of the claimant or of the merits of the claimant's case'.[122] The Guidelines include extracts from the Istanbul Protocol which set out best practice with regard to the documentation of 'visible injuries' and 'non-visible scarring' (psychological sequelae).[123]

On the documentation of psychological findings, doctors should comment on the consistency of the findings with the alleged abuse. The Guidelines note that the emotional state and expression of the person during the interview, the symptoms, the history of detention and torture and the personal history prior to torture, should all be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should also be noted.[124]

For overall consideration of expert medical evidence, the Guidelines state that if the judge decides to reject a report 'there is a positive obligation to do more than merely state that it had been considered'. Moreover '*T]he decision maker must provide some meaningful discussion as to how he or she had taken account of the applicant's serious medical condition before making a negative credibility finding'.[125]If expert medical evidence is dismissed by a decision-maker as being of little evidential value, this should be stated accompanied by appropriate reasoning. The Guidelines note that this obligation particularly applies where 'the expert evidence has been submitted by an organisation which has established itself as an objective and reliable provider of medico-legal reports in asylum or asylum related cases'.[126] Lastly, the Guidelines state that a decision-maker 'should not attempt to substitute his or her own opinion in preference to that of a reliable expert'.[127]

Medical Foundation Methodology Guidelines

The guidelines used by the Medical Foundation in the preparation of MLRs, and which are appended to all MLRs for the reference of decision-makers, contain a number of important provisions. Foremost is the Medical Foundation's duty to the Tribunal.[128] All Medical Foundation doctors understand and sign a declaration to the effect that the MLR is an expert witness report and that their duties to the Tribunal are those of an expert witness.

Medical Foundation reports are commissioned and produced through a series of intake and quality control measures; the Medical Foundation does not produce an MLR every time one is requested. Each case is processed through an intake panel involving legal staff and clinicians, by which it is established whether a report might make a material difference to the case and whether the case is within the remit of the Medical Foundation.

Many cases are referred for an assessment interview by a non-clinical caseworker, usually with legal training, to establish what (if anything) can be documented in a medico-legal report, for example to find whether scars are present, whether there are significant psychological sequelae and to establish a more detailed history of events if necessary. This assessment is carried out in line with Istanbul Protocol guidelines.[129] If the multi-disciplinary panel then determines that case falls within the Medical Foundation's remit,[130] the panel will refer the case to an appropriate doctor. The doctor makes the final decision on whether or not a report can be written, and may decline to write a report after seeing and assessing the patient.

Medical Foundation doctors

Medical Foundation doctors are mainly General Practitioners, so their prior training and practice give them a breadth of experience in all medical fields. Some have additional specialist qualifications and experience in fields such as paediatrics, dermatology, gynaecology and psychiatry. The majority of GPs have extensive experience in psychiatry, both as a result of time spent during GP training working in psychiatry departments, and as GPs, where over 60% of consultations have a psychological component and 80% of psychiatric patients are managed by GPs.

Medical Foundation doctors undergo specialised training in the clinical conditions of asylum seekers and refugees generally and the more technical aspects of the documentation of scars and medico-legal report writing, with particular reference to the Istanbul Protocol. New doctors are supervised initially by more experienced doctors, and all Medical Foundation doctors have an annual appraisal and attend one-day specialist academic meetings twice yearly as well as monthly lunchtime clinical meetings. All Medical Foundation doctors are actively encouraged to consult their colleagues on particular cases and more generally to share their thoughts and experiences with colleagues.

While most Medical Foundation Reports are prepared by independent doctors who see the subject only for the purpose of preparing a report, some are prepared by a treating clinician or other professional such as a counsellor, psychotherapist or social worker. The report may be based on a number of treatment/contact sessions over a prolonged period. This type of 'professional' report may be considered more appropriate where the subject has already been in treatment for some time, or where it becomes apparent that a full picture of the impact of the trauma on them can emerge only during therapy. However, in preparing the MLR, the professional is aware at all times of their duty to the court.

Clinical Assessment process

The doctor sees the subject of the report on a minimum of two occasions, more if needed.[131] A full history and examination are undertaken and physical and psychological findings documented. Photographs or body diagrams of scars may be made if they would assist (e.g. where recent bruising might fade). Before taking the detailed history and conducting the examination, the doctor will familiarise themselves with the relevant papers provided by the subject's legal representative. However, the subject's testimony given elsewhere does not form the basis for the doctor's history taking, which is always done independently.

The whole of the subject's testimony is assessed in the light of, among other things: health reported prior to and after torture; the history and detail given of the torture; and the subject's affect and behaviour. The doctor assesses their observations within their consideration of the person's mental state in the overall context of the person's speech content, culture of origin, family history, employment, levels of education, current state of health and apparent personality. The specificity of the detail in an account, particularly sensory and geographical detail, as well as medical details of injuries received and the healing process of those injuries (e.g. how medically plausible is the account given of the healing process?), are all taken in to account.

Memory difficulties are explored in detail and with reference to established psychology research in this field. Further resources such as psychometric testing by a clinical psychologist are available if needed. An opinion is given on the examination in its entirety and not on isolated findings.

Each report is read back to the subject to confirm details of the history have been accurately recorded. A senior doctor and a legal officer then review the report to check that all relevant aspects have been addressed appropriately before it is signed off.

Assessment of consistency

Medical Foundation doctors understand their duty to the court as expert witnesses and understand that it is not the role of the report writing doctor to assess the overall credibility of the subject of the MLR. However, as in their everyday practice, the doctors do not accept at face value everything they are told by the subject of the MLR. During the examination Medical Foundation doctors critically assess the account given in relation to the injuries described and the examination findings, in the light of their own experience and the collective experience of colleagues at the Medical Foundation. They may decline to write a report if the account and findings do not correlate.

CASE LAW related to expert medical evidence

One of the objectives of this Report was to assess the current practice of the Tribunal in relation to the adherence or otherwise of Immigration Judges to case law on the treatment of expert evidence, and expert medical evidence in particular. Case law from the UK jurisdiction and from the European Court of Human Rights has been accessed and the relevant findings and guidance summarised below.[132]

European Court of Human Rights (ECHR)
R.C. v. SWEDEN 2010 (application no. 41827/07)

England and Wales Court of Appeal (EWCA)
Y (Sri Lanka) v SSHD [2009] EWCA Civ 362
HH (Ethiopia) [2007] EWCA Civ 306
SA SOMALIA [2006] EWCA Civ 1302
MIBANGA v SSHD [2005] EWCA Civ 367

United Kingdom Upper Tribunal (UKUT)

RR (Challenging evidence) Sri Lanka [2010] UKUT 000274 (IAC)
BN (psychiatric evidence – discrepancies) Albania [2010] UKUT 279 (IAC)

United Kingdom Asylum and Immigration Tribunal (UKAIT)
RT (medical reports, causation of scarring) Sri Lanka [2008] UKAIT 00009
AJ (Assessment of medical evidence -examination of scars) Cameroon [2005] UKIAT 00060
XS (Kosovo- Adjudicator's conduct - psychiatric report) Serbia and Montenegro [2005] UKIAT 00093
HE (DRC - credibility and psychiatric reports) Democratic Republic of Congo [2004] UKIAT 00321

EUROPEAN COURT OF HUMAN RIGHTS

R.C. v. SWEDEN 2010 (application no. 41827/07)

- The medical report 'gave a strong indication' that the claimant's injuries had been caused by torture. In these circumstances (a 'prima facie' case had been made out) the government should have obtained expert opinion if they doubted the cause of the scarring.
- "...the State has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture."

England and Wales COURT OF APPEAL

Y (Sri Lanka) v SSHD [200] EWCA Civ 362

- Where there is medical evidence that is 'uncontradicted', the judge must have and must give acceptable reasons for rejecting it. This obligation is particularly strong when it directly relates to the claimant's fundamental human rights.
- Where two experts are thought to have contradicted each other the judge may have to choose between them, but may not for that reason alone reject both. The judge must still carefully decide whether the evidence of one or other of the doctors is cogent.
- The judge must respect uncontradicted expert evidence as to reasons why the claimant should not give evidence.
- When considering the factual basis of psychiatric findings and whether a claimant has exaggerated their symptoms when examined by a doctor, it is a matter for the expert in the first instance to evaluate the patient's account of their symptoms and '... it is only if the tribunal has good and objective reason for discounting that evaluation that it can be modified or - even more radically – disregarded'.
- If the judge has concerns about an aspect of an expert's evidence they should be put directly to the expert when they are giving their evidence and not reserved until the written judgement.

- When the expert evidence is all one way and not materially shaken in terms of "either authorship or content" the judge must accept and act on it.

HH (Ethiopia) [2007] EWCA Civ 306

- The most that any doctor can say is that the physical and psychological condition of an appellant is consistent with her story; it is not for the doctor to reach an overall conclusion on the credibility or otherwise of the account. It is the task of the Immigration Judge to look at all the evidence including the medical report and arrive at a conclusion on credibility.

- The judge was in this case entitled to attach little weight to the doctor's diagnosis of PTSD due to the lack of a specialist psychiatric qualification. The doctor should have considered other possible causes of the appellant's depression 'especially since the diagnosis was very largely dependent on assuming that the account given by the appellant was to be believed.'

SA SOMALIA [2006] EWCA Civ 1302

- A medical report should address the question of consistency of scars with the history given if it is to lend weight to or corroborate the account of the claimant.

- It should contain "...a clear statement of the doctor's opinion as to consistency, directed to the particular injuries said to have occurred as a result of the torture or other ill treatment relied on as evidence of persecution. It is also desirable that, in the case of marks of injury which are inherently susceptible of a number of alternative or "everyday" explanations, reference should be made to such fact, together with any physical features or "pointers" found which may make the particular explanation for the injury advanced by the complainant more or less likely."

- Where an account of torture is challenged, close attention should be paid to the Istanbul Protocol, which states that the physician should indicate the degree of consistency between each lesion and the attribution, as well as an overall evaluation of all lesions, as follows:

  "186... (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 anyway other than that described.

- Following MIBANGA, medical evidence that is corroborative or potentially corroborative of an appellant's account of torture and/or fear of persecution should be considered as part of the entire package of evidence to be taken into account on the issue of credibility.

MIBANGA v SSHD [2005] EWCA Civ 367

- The Court of Appeal criticised the decision maker who had conclusively rejected the central features of the appellant's account of events before considering highly relevant medical evidence.
- Lord Justice Buxton emphasised the artificial separation of the medical evidence from the rest of the evidence in this case and the reaching of a conclusion on credibility before dealing with the medical evidence, which was then found to be of no assistance.
- This was described as a "structural failing" which demonstrated a departure from HE (DRC – credibility and psychiatric reports).

UNITED KINGDOM UPPER TRIBUNAL (ASYLUM AND IMMIGRATION CHAMBER)

RR (Challenging evidence) Sri Lanka [2010] UKUT 000274 (IAC)

- Independent expert evidence may assist the Tribunal where there are 'difficulties' (inconsistencies) with the claimant's evidence and if the Secretary of State for the Home Department (SSHD) wants to challenge the expert evidence, this should be supported by their own evidence.
- The SSHD should question the claimant or expert directly during oral evidence (if given) about the cause of injury, if it is suggested that it was not caused in the way the claimant has asserted.
- If the claimant has not been given the opportunity to respond to questions about the cause of injury then the Tribunal may find it difficult to find against them.
- If there is no basis for such a challenge to the evidence to be made, then it should probably be abandoned.

BN (psychiatric evidence – discrepancies) Albania [2010] UKUT 279 (IAC)

- The Tribunal should give clear reasons "... which engage adequately with a medical opinion representing the judgment of a professional psychiatrist ..." if they intend to reject a clinical diagnosis that a claimant suffers a depressive illness.
- Psychiatric evidence that may provide an explanation for inconsistencies in a claimant's account may not deal with all aspects of the claim found to be incredible, in which case the claim may still be dismissed.

UNITED KINGDOM ASYLUM & IMMIGRATION TRIBUNAL

RT (medical reports, causation of scarring) Sri Lanka [2008] UKAIT 00009

- Medical reports dealing with injuries or scarring attributed to torture should "pay close attention" to the guidance in SA (Somalia).

- This states that where a doctor finds that there is a degree of consistency between injuries/scarring and the claimed cause which allows for other possible causes, these should be explored in relation to the claimant's life history and experiences.

AJ (Assessment of medical evidence –examination of scars) Cameroon [2005] UKIAT 00060

- Even if it is the case that evidence regarding injuries could have been provided by a report from another source but was not, it is not a basis for rejecting or diminishing the value of the evidence that has been provided which should be properly considered.
- The Adjudicator should not carry out their own "medical examination and diagnosis" at a hearing or afterwards. If they have particular skills in this area this should be made known during the hearing.

XS (Kosovo- Adjudicator's conduct – psychiatric report) Serbia and Montenegro [2005] UKIAT 00093

- It is important to distinguish where the relevance of psychiatric or other medical evidence is wholly or in part to support the truthfulness of the account given by the claimant, and where its relevance is that the illness or condition exists, regardless of its cause. One medical report may be relied on for both arguments.
- Where a medical report seeks to: 'identify the extent to which the diagnosis is dependent on the Appellant's account of what had happened', and reach a conclusion, based on experience and expertise which is 'objectively supportable rather than one which simply accepted symptoms which could be described but which could not be verified', these 'material facts' should not be ignored.

HE (DRC – credibility and psychiatric reports) Democratic Republic of Congo [2004] UKIAT 00321

- It would be wrong to ignore a medical report if it offers some corroboration for what a claimant is saying, though there is no necessary obligation to give a report weight.
- The consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor.
- A doctor does not usually assess the credibility of an applicant; it is the task of the fact-finder "who will have often more material than the doctor, and will have heard the evidence tested."
- The report may be able to offer a description of physical conditions and an opinion as to the degree of consistency of what has been observed with what has been said by the claimant. "Rather than offering significant separate support for the claim, a conclusion as to mere consistency generally only has the effect of not negating the claim."
- "Where the report is specifically relied on as a factor relevant to credibility, the Adjudicator should deal with it as an integral part of the findings on credibility rather than just as an add-on, which does not undermine the conclusions to which he would otherwise come."

- Where a medical report is used to support credibility findings, the advocate"...must identify what about it affords support to what the claimant has said and which is not dependant on what the claimant has said."

PART 4

COMPLIANCE with good practice standards and guidelines

The following two tables bring together the findings described in Part 2 and the standards, guidelines and case law described in Part 3, in order to assess the extent to which Medical Foundation MLRs are compliant with the requirements of medical evidence and the extent to which the practice of the Tribunal, as represented in this sample of determinations, is in accordance with or departs from accepted good practice standards and judicial precedent.

Figure 1 sets the requirements of medical evidence described in good practice standards, guidelines and case law against the methodology of the Medical Foundation for the production of MLRs in order to assess the extent to which these reports may be said to be compliant.

Figure 2 sets the standards, guidelines and case law against the treatment of expert medical evidence by Immigration Judges identified in the sample set of determinations.

Figure 1: Application of Standards, Guidelines and Case Law to expert medical evidence (Medical Foundation MLRs)

Guidance	Source	Medical Foundation procedure & methodology
Duty of the Expert and Expertise The duty of the expert to help the Tribunal on matters within their expertise is paramount and overrides any other obligations. Expert medical evidence should be independent, objective, unbiased, and impartial. It should not be advocacy. Expert medical evidence should deal with the individual claimants' case and all material facts should be considered, even those that might detract from the expert's opinion. Expert medical evidence should be restricted to the author's area of expertise and competence which should be stated; issues outside the expert's competence should be identified.	Tribunal Practice Direction Istanbul Protocol Tribunal Practice Direction IARLJ Guidelines Tribunal Practice Direction IARLJ Guidelines Istanbul Protocol Tribunal Practice Direction IARLJ Guidelines	All doctors sign a declaration that the MLR is an expert witness report and that their duties to the court are those of an expert witness There is a detailed intake and quality control process for MLRs; the MF does not produce an MLR every time one is requested. The doctor sees the subject on a minimum of two occasions. A full history and examination are undertaken and physical and psychological findings documented. Before taking the detailed history and conducting the examination, the doctor will familiarise themselves with the relevant legal papers. Medical Foundation MLR doctors are mainly General Practitioners; their prior training and practice gives them relevant experience in all medical fields, including psychiatry. Where

		appropriate, specialist clinical or other professionals will prepare the MLR. All doctors undergo specialised training in the documentation of scars and medico-legal report writing, in line with the Istanbul Protocol. All doctors include a CV stating their qualifications, expertise and training.
Content of the Expert report The expert report should state all facts & information relied on and which facts are within the experts own knowledge. Expert medical evidence should give a summary of conclusions reached and any qualifications to opinions stated.	Tribunal Practice Direction IARLJ Guidelines	A full history and examination are undertaken and physical and psychological findings documented. During the examination Medical Foundation doctors critically assess the account given in relation to the injuries described and the examination findings, in the light of their own experience and the collective experience of colleagues at the Medical Foundation. An opinion is given on the examination in its entirety and not on isolated findings.
Assessment of credibility Expert medical evidence should not give opinion as to the overall credibility of the claimant or of the merits of the claimant's case. It is the task of the Immigration Judge to look at all the evidence and come to a conclusion on credibility.	IARLJ Guidelines Case Law (HH Ethiopia EWCA; HE DRC UKAIT)	Medical Foundation doctors know and understand that it is not the role of the report writing doctor to assess the overall credibility of the MLR subject or of their asylum claim. This is distinguished from the task of assessing the consistency of their clinical findings with the history given.
Assessment of consistency (clinical evidence with history) Expert evidence reporting on the physical & psychological evidence of torture should address the consistency of the findings with the report of torture, taking into account the overall history and circumstances	Istanbul Protocol Case Law (SA Somalia EWCA) IARLJ Guidelines	The whole of the subject's testimony is assessed in the light of, among other things: health reported prior to and after torture; the history and detail given of the torture; and the subject's affect and behaviour. The doctor assesses their observations within their consideration of the person's mental state in the overall context of the

of the individual.		person's speech content, culture of origin, family history, employment, levels of education, current state of health and apparent personality. The specificity of the detail in an account, particularly sensory and geographical detail, as well as medical details of injuries received and the healing process of those injuries (e.g. how medically plausible is the account given of the healing process?) are all taken in to account. Memory difficulties are explored in detail and with reference to established psychology research in this field.
Assessment of physical evidence For each lesion and for the overall pattern of lesions, the expert should indicate the degree of consistency between it and the attribution given using Istanbul Protocol terms: 'not consistent with', 'consistent with', 'highly consistent', 'typical of' & 'diagnostic of'. Where marks of injury could have a number of alternative explanations, reference should be made to evidence which makes the claimant's attribution more or less likely.	Istanbul Protocol Case Law (SA Somalia EWCA & RT Sri Lanka UKAIT) IARLJ Guidelines IARLJ Guidelines Case Law (SA Somalia EWCA)	Medical Foundation doctors undergo specialised training the documentation of scars and medico-legal report writing, with particular reference to the Istanbul Protocol. A full history and examination are undertaken and physical and psychological findings documented. Photographs or body diagrams of scars may be made if they would assist. Medical Foundation doctors follow the direction in RT that where there is a finding of a degree of consistency between the injuries/scarring and the appellant's claimed cause and there are other possible causes, these will be examined 'to gauge how likely they are, bearing in mind what is known about the individual's life history and experiences.' (RT Sri Lanka)
Assessment of psychological evidence Expert evidence should include a psychological assessment to assess the degree of consistency between the account of torture and the	Istanbul Protocol IARLJ Guidelines	A full history and examination are undertaken and physical and psychological findings documented. The doctor assesses their observations within their consideration of the person's mental state in the overall

findings during the course of the evaluation. This should include a history, mental state examination, assessment of social functioning and formulation of clinical impressions. Where relevant this should include a DSM-IV or ICD-10 psychiatric diagnosis. Alternative explanations for psychological symptoms should be explored.	HH Ethiopia EWCA	context of the person's speech content, culture of origin, family history, employment, levels of education, current state of health and apparent personality. Where relevant DSM IV or ICD 10 criteria are discussed and appended to the MLR. Memory difficulties are explored in detail and with reference to established psychology research in this field. Further resources such as psychometric testing by a clinical psychologist are available if needed. An opinion is given on the examination in its entirety and not on isolated findings.

Figure 2: Application of Standards, Guidelines and Case Law to the treatment of expert medical evidence in the Tribunal

Guidance	Source	Practice of the Tribunal
Duty to consider medical evidence The duty to ascertain and evaluate all the relevant facts is shared between the applicant and the decision maker. A medical or psychiatric report deserves careful and specific consideration. Attention should be given to each and every aspect of medical reports. The state authority has a duty to ascertain all the relevant facts and if necessary obtain medical opinion if they doubt the causation given in a medical report that gives a strong indication of torture.	UNHCR handbook IARLJ Guidelines Case Law (RC Sweden ECHR)	MLRs are not consistently given 'careful and specific consideration' in all the cases in this sample. 19 MLRs in the sample are entirely dismissed. 9 MLRs in the sample are dismissed in part; each part is not given due consideration in these cases.
Quality of report & expertise of author Consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor.	IARLJ Guidelines Case Law (HE DRC UKAIT)	Generally expertise and quality of Medical Foundation MLRs is accepted where commented on. Consideration of the standing and qualifications of the doctor is not consistent though all MLRs are produced by the same

		methodology. The authority of General Practitioners to diagnose psychiatrics is not consistently accepted.
Assessment of credibility An assessment of credibility is indispensable in RSD. It is not for the doctor to reach an overall conclusion on credibility. It is the task of the decision maker to look at all the evidence, including the medical report, and arrive at a conclusion on credibility. Medical evidence that is corroborative or potentially corroborative of an appellant's account of torture and/or fear of persecution should be treated as an integral part of all evidence considered in establishing the facts, and should form an integral part of any findings of credibility. It should not be artificially separated from the rest of the evidence or treated as an 'add on'.	UNHCR Handbook UNHCR Handbook Case Law (HH Ethiopia EWCA, HE DRC UKAIT) IARLJ Guidelines Case Law (SA Somalia EWCA, Mibanga EWCA, HE DRC UKAIT)	Many Immigration Judges are willing to be guided by the findings of an MLR in their consideration of credibility; a significant number are not. Many Immigration Judges comment that the doctor has given opinion on credibility when they have commented on consistency. Some Immigration Judges arrive at a decision on credibility before considering medical evidence and then dismiss the medical evidence.
Assessment of consistency (clinical evidence with history) Expert medical evidence must provide a clear statement of opinion on the degree to which injuries or psychological behaviour presented are consistent with the history of torture or ill-treatment given. The absence of physical or psychological evidence does not suggest that torture has not occurred. Claimants who have undergone traumatic experiences such as torture may be vulnerable. The way in which evidence is given may be affected by trauma; where there are discrepancies in evidence, the extent to which the vulnerability of the individual is an element of this should be considered. Expert evidence that explains inconsistency may not explain all aspects of the claim found to be incredible and the case may still be	Istanbul Protocol IARLJ Guidelines Case Law (SA Somalia EWCA HH Ethiopia EWCA, HE DRC UKAIT) Istanbul Protocol Joint Presidential Guidelines UNHCR Handbook Case Law (BN Albania UKUT)	Some Immigration Judges conflate opinion on credibility with opinion on consistency. They criticise doctors for giving an opinion about consistency of findings with the history stating either that the history was accepted uncritically or that the doctor is giving an opinion about credibility. A significant number of Immigration Judges separate findings on clinical evidence and likely cause; some accept evidence of torture but not torture as cause due to an overall credibility finding. An inconsistent approach between Immigration Judges

dismissed.		regarding inconsistency in testimony and late recall is observed in the sample. Some Immigration Judges accept expert opinion and evidence on the impact of torture/trauma on memory, others do not. A significant number of cases are dismissed for inconsistency in testimony and a negative credibility finding.
Assessment of physical evidence The Istanbul Protocol should be regarded as the best aspirational practice for the assessment of injuries. For each lesion and for the overall pattern of lesions, the expert should indicate the degree of consistency between it and the attribution given using Istanbul Protocol terms: 'not consistent with', 'consistent with', 'highly consistent', 'typical of' & 'diagnostic of', defined in the Istanbul Protocol.	IARLJ Guidelines Istanbul Protocol Case Law (SA Somalia EWCA & RT Sri Lanka UKAIT)	The assessment of 'consistent' or 'highly consistent' given by the doctor is simply dismissed in some cases even where alternative possible causes from the history are considered. Findings of 'consistent' are sometimes given no weight at all. In some cases Immigration Judges assert their own conclusion as to the consistency of evidence of torture and claimed causation. Immigration Judges suggest alternative causation with no explanation or support from alternative medical opinion. In some cases MLRs document evidence of scarring that is 'diagnostic' of torture and the Immigration Judges dismisses the findings, substituting their own.
Assessment of psychological evidence/ diagnosis Expert evidence should include a psychological assessment to assess the degree of consistency between the account of torture and the findings during the course of the evaluation. This should include a history, mental state examination, assessment of social functioning and formulation of clinical impressions. Where relevant this should include a DSM-IV or ICD-10	Istanbul Protocol	Medical Foundation MLRs (except for non-medical) all have psychological assessment as per Istanbul Protocol standards.

psychiatric diagnosis. When considering the factual basis of psychiatric findings, it is a matter in the first instance for the medical expert to evaluate the claimant's account of their symptoms, and only if the judge has 'good and objective reason' for discounting that evaluation should it be modified or disregarded. The Tribunal should give clear reasons '... which engage adequately with a medical opinion representing the judgment of a professional psychiatrist on what he has seen of the appellant...' if they intend to reject a clinical diagnosis that a claimant suffers a depressive illness. If the medical report seeks to examine the extent to which the diagnosis is dependent on the claimant's account and reaches a conclusion, based on the experience and expertise of the doctor, which is 'objectively supportable rather than one which simply accepted symptoms which could be described but which could not be verified', these 'material facts' should not be ignored. The judge may be entitled to attach little weight to a doctor's diagnosis of PTSD due to the lack of a specialist psychiatric qualification. The doctor should consider other possible causes of psychological symptoms and not reach a diagnosis that is 'dependent on assuming that the account given by the appellant [is] to be believed.'	Case Law (Y Sri Lanka EWCA) Case Law (BN Albania UKUT) Case Law (XS Kosovo UKAIT) Case Law (HH Ethiopia EWCA)	The qualification of General Practitioners to comment on and diagnose psychiatric conditions such as PTSD and depression is not consistently accepted by Immigration Judges. Some Immigration Judges substitute clinical opinion for their own without reference to alternative medical opinion. Some Immigration Judges state that a diagnosis is dependent on an uncritical acceptance of a history (a 'recited' account), despite Medical Foundation methodology which clearly states that doctors do not accept history at face value but exercise their professional judgement and critically assess the history in light of overall clinical findings. Medical Foundation Methodology clearly explains how General Practitioners are qualified to assess PTSD & depression. This is accepted by some Immigration Judges, not others.
Treatment of medical evidence by decision maker The state authority has a duty to ascertain all the relevant facts and if necessary obtain medical opinion if they doubt the causation given in a medical report that gives a strong indication of torture When the expert evidence is 'all one way and not materially shaken' in terms of its	(RC Sweden ECHR) Case Law (Y Sri Lanka EWCA)	The Tribunal does not independently commission medical opinion if medical evidence is doubted. The UK Border Agency does not provide expert medical opinion. There is a wide variation in the interpretation of the guidance in

'authorship or content', the judge must accept and act on it. If expert medical evidence is uncontradicted and is dismissed by a decision-maker as being of little evidential value, this should be stated accompanied by appropriate reasoning (especially if from an organisation which has established itself as an objective and reliable provider of medico-legal reports) If there is no basis for a challenge to the evidence, then it should probably be abandoned. (RR Sri Lanka UKUT) A decision-maker should not attempt to substitute his or her own opinion in preference to that of a reliable expert. If the SSHD wants to challenge the expert evidence, this should be supported by alternative expert evidence. If there are concerns about an aspect of an expert's/claimant's evidence this should be put directly to the expert/claimant (when giving evidence) and not reserved for the written judgement/decision (Y Sri Lanka EWCA/RR Sri Lanka UKUT)	IARLJ Guidelines Case Law (Y Sri Lanka EWCA) Case Law (Y Sri Lanka EWCA) IARLJ Guidelines (RR Sri Lanka UKUT) Case Law (Y Sri Lanka EWCA/RR Sri Lanka UKUT)	Y Sri Lanka on the evidence of this sample; i.e. on what ground is the evidence considered 'materially shaken'? The dismissal of expert evidence is not always clearly articulated with reasons. Medical evidence is not contradicted by alternative medical opinion. The challenge to expert medical opinion is the substitution of the Immigration Judge's own opinion in some cases.
Standard of proof Reports supporting an application for asylum in a third country 'need provide only a relatively low level of proof of torture.' If the applicant's account appears credible, he should, unless there are good reasons to the contrary, be given the benefit of the doubt. The benefit of the doubt should only be given when all available evidence has been obtained and checked and when the decision maker is satisfied as to the applicant's general credibility. The requirement of evidence should not be too strictly applied in view of the difficulty of proof inherent in the special situation in which an applicant for refugee status finds himself. The relevant standard of proof for asylum claims is a 'reasonable degree of likelihood' of persecution if the claimant is returned to the	Istanbul Protocol UNHCR Handbook Case Law (R v SSHD ex p Sivakumaran [1988] Imm AR 147)	The benefit of the doubt does not appear to be exercised in a number of cases in this sample. In some cases a very sceptical view of the evidence and of the credibility of the claimant is taken. Determinations state that the lower standard of proof applies. Not all seem to assess medical

place for which they assert a 'well founded fear' of persecution. Historical facts (such as a claim to have been tortured in the past) 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 (inhuman or degrading treatment or punishment).	 Kaja [1995] Imm AR 1 & Karanakaran v SSHD [2000] Imm AR 271 Kacaj (01/TH/0634 19 July 2001 starred)	evidence and overall credibility on this standard of proof. In some cases Immigration Judges seem to apply a high standard of proof for assessing historical facts such as a claim of torture and expect an unrealistically high level of certainty from the expert evidence in order to give it weight.

PART 5

CONCLUSIO

NS

The aim of this report is to examine the treatment of Medical Foundation MLRs by Immigration Judges in the Tribunal and to assess compliance with good practice standards and guidelines.

The determinations assessed in this sample demonstrate that many Immigration Judges are familiar with and apply the guidance that is given, primarily in case law, on the treatment of expert medical evidence for cases involving a claim of torture, as well as the standards articulated in the Istanbul Protocol. In most of these cases the appeals are allowed and a grant of refugee status or humanitarian protection is made.

However, the evidence shows that there is a serious lack of consistency in the treatment of MLRs across the Tribunal and that in a significant number of cases the guidelines given in case law and good practice standards are not followed by Immigration Judges, leading to a dismissal of the appeal. Although an onward appeal may have been pursued in a number of these cases, depending on continuing access to legal aid and a diligent legal representative, a significant failure of protection could be the consequence for individual claimants who may be returned to a country in which they have been tortured.

This report does not suggest that all asylum claims for which there is an MLR documenting a claim of torture must be allowed on refugee convention or humanitarian protection grounds. It is, however, proposed that all such cases should be assessed according to clearly elaborated good practice standards that are applied with consistency by all Immigration Judges. For cases involving a claim of torture that has been assessed by a medical expert and documented in an MLR, this entails Immigration Judges taking a consistent and rigorous approach to the consideration of this evidence.

Although not the primary focus of this report, concerns that emerged from the evidence about the treatment by UK Border Agency case owners of claims involving torture are also elaborated and discussed. The higher than average overturn rate on appeal, which reaches 69% for cases where medical evidence was available to the UK Border Agency, indicates that there are serious deficiencies with the treatment of asylum claims which involve torture, at the initial decision stage.

The findings of this research have very serious resource and efficiency implications for the UK Border Agency and the Tribunal to consider, since poor decision making leads to an unnecessarily protracted legal process. However, there is also the very serious consequence of subjecting already vulnerable individuals to a legal process in which their integrity and credibility are repeatedly subject to question and doubt. Torture survivors should be able to focus on their rehabilitation, not on unnecessary legal proceedings.

KEY FINDINGS

The key findings elaborate the main concerns that emerge from this research about judicial practice and UK Border Agency decision-making in relation to expert medical evidence. The findings focus on

the pattern of decision-making in cases where an MLR has been submitted in relation to a claim of torture and on the detailed treatment of the expert evidence by Immigration Judges.

Overturn rate on appeal: UK Border Agency decision- making

The finding that nearly half the cases were allowed at the appeal stage indicates that there are serious deficiencies with the treatment of asylum claims which involve torture, at the initial decision stage.

Despite guidelines and case law that give direction to decision makers on these issues, the overturn rate for those cases in the sample where medical evidence was available to the UK Border Agency at initial decision stage is even higher, at more than two-thirds of the cases. This indicates a significant discrepancy in the way that such cases are treated, and in particular the way expert medical evidence is treated by UK Border Agency case owners and Immigration Judges at the Tribunal.

These findings have very serious resource and efficiency implications for the UK Border Agency and the Tribunal to consider. However, there is also the very serious consequence of subjecting already vulnerable individuals to a protracted legal process in which their integrity and credibility are repeatedly subject to question and doubt. Torture survivors should be able to focus on their rehabilitation, not on unnecessary legal proceedings.

In a context where it may be increasingly difficult to secure legal representation, it is far from certain that the asylum claims of survivors of torture that have not been properly assessed in the first instance, will reach the appeal stage and the opportunity for review, whether or not medical evidence has been submitted. A serious or fatal failure of protection for these individuals could be the consequence, with those needing and deserving of international protection being returned to the country in which they have been tortured and in which they are at continuing risk.

Appeal allowal rate: the weight of medical evidence

The research demonstrates a 100% correlation between the acceptance by the Immigration Judge of the expert medical evidence in relation to a claim of torture, in full and according to the relevant standard of proof, and the case being allowed. However findings also demonstrate that, on the basis of this sample, more than half the cases in which expert medical evidence is submitted are refused at the appeal level. Although the numbers involved in this sample are relatively small, if the findings are considered to be reasonably representative of current practice in judicial decision-making, the trend is very significant and of overwhelming importance to the individuals involved.

Detailed findings indicate that while the submission of expert medical evidence in the form of an MLR may have a significant bearing on the outcome of an appeal involving a claim of torture in the Tribunal, this is found to depend on the treatment of that evidence by the particular Immigration Judge. There is in fact a demonstrable lack of consistency between the different Immigration Judges whose decisions are represented in this sample, in relation to their adherence to and interpretation of the relevant standards, guidelines and case law on the treatment of medical evidence in asylum applications involving a claim of torture.

It is notable in this regard that the current Tribunal 'Practice Directions on Expert Evidence', while giving some guidance to Immigration Judges on what is required of expert evidence, are silent on

how that evidence is to be treated by the Tribunal. Furthermore, the guidance does not relate specifically to expert medical evidence in asylum claims involving torture and therefore only has the most general application to such cases. This may go some way to explaining the inconsistency of practice among Immigration Judges in this area.

Case law deals directly with the treatment of expert medical evidence in cases where there is an allegation of torture and with the required standards for the documentation of torture elaborated in the Istanbul Protocol. However, the interpretation of this case law in relation to particular cases represented in this sample appears to be quite variable and at times plainly contradictory.

Further guidance is potentially available in the form of the 'Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence' produced by the International Association of Refugee Law Judges in 2010. These guidelines, the product of several years work and extensive discussion, are presented to Refugee Law Judges as 'aspirational best practice' and 'a tool to facilitate the decision-making process' rather than an attempt to 'restrict judicial independence.'[133] They are not binding on Immigration Judges within the UK jurisdiction and have not been adopted by the UK Tribunal, or incorporated into their own guidelines.

The guidelines represent the combined knowledge and expertise of a working party of Judges who are experts in this field, as well as a number of non-judicial expert members.[134] They cover the relevant aspects of the requirements of expert medical evidence as well as the treatment of that evidence in the context of asylum claims involving torture, incorporating case law and the standards described in the Istanbul Protocol. As such they represent the most current and complete guidance on these matters and a consensus of international judicial opinion, and could be used to good effect in developing consistency in decision-making in this area.

Standing and authority of the Medical Foundation

There is some evidence that Immigration Judges are in general satisfied with the quality of Medical Foundation MLRs and the expertise of Medical Foundation doctors and other professionals. However this is not a consistently held position and in a significant though small number of cases in this sample, the qualification and expertise of the doctor is questioned, with negative consequences for the evaluation of the evidence and for the individual case.

As demonstrated in the Medical Foundation Methodology guidelines and elaborated in this report in relation to specific case examples, MLRs are produced by the Medical Foundation in accordance with and in cognisance of: relevant case law; good practice standards for the documentation of torture elaborated in the Istanbul Protocol; requirements of expert medical evidence described in the IARLJ Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence; as well as the Tribunal Practice Direction on expert evidence.

No evidence was found in this research that would suggest that the production methods and quality control measures in place at the Medical Foundation are not working consistently and effectively. It would therefore seem appropriate for the matter of the authority and expertise of Medical Foundation doctors and other professionals to give expert opinion in relation to a claim of torture to be approached in a manner that brings consistency across the Tribunal.

Expertise of Medical Foundation doctors to comment on and diagnose PTSD & depression

In general it was found that the expertise of Medical Foundation doctors and other professionals was accepted positively or was not commented upon. The majority of Medical Foundation MLRs are expert witness reports produced by General Practitioners. In a small number of cases in this sample their expertise was found to be at issue, and in particular their qualification to comment on and diagnose psychiatric conditions such as PTSD and depression was questioned. It is noted that according to the Istanbul Protocol, any evaluation of torture should include a psychological evaluation including a mental status examination and a psychiatric diagnosis where relevant.

The Medical Foundation methodology guidelines state that a General Practitioner is extremely well qualified by both training and experience to assess psychological symptoms and diagnose conditions such as depression and PTSD in the context of a Medico-Legal Report, as they are expected to do in their general practice. It should be noted that the Royal College of Psychiatrists, the Royal College of General Practitioners and the General Medical Council have never pronounced to the contrary.[135] Indeed it is expected that General Practitioners will be able to assess and make psychiatric diagnoses, and nowhere in the medical literature of the Royal Colleges, or any other bodies that maintain medical standards, is it stated that General Practitioners should not do so or that they are unable to do so.[136] In preparing an MLR the examining doctor is required to make a declaration of their understanding of their duty to the court, which includes the undertaking not to give opinion outside their expertise. To suggest that a doctor has made a psychiatric diagnosis that is outside their expertise is therefore to make a very serious allegation of professional misconduct.

Medical Foundation doctors are trained specifically in the clinical and technical aspects of the documentation of torture, including psychological sequelae, with reference to the Istanbul Protocol. Doctors make their assessment of a person's mental state in the overall context of their speech content, culture of origin, family history, employment, level of education, current state of health and other current circumstances, as well as their apparent personality and their account of torture. All clinical findings and opinions are also checked by a second doctor before a report is signed off.

The Court of Appeal gave guidance in 2009 on the factual basis of psychiatric findings, stating that it is a matter in the first instance for the medical expert to evaluate the claimant's account of their symptoms, and only if the judge has 'good and objective reason' for discounting that evaluation should it be modified or disregarded, (Y Sri Lanka). The Tribunal gave further guidance in 2010 that clear reasons should be given by a Judge, 'which engage adequately with a medical opinion representing the judgment of a professional psychiatrist on what he has seen of the appellant', if they intend to reject a clinical diagnosis that a claimant suffers a depressive illness, (BN Albania UKUT).

Although a 2007 Court of Appeal case, (HH Ethiopia EWCA), states that a judge may be entitled to attach little weight to a doctor's diagnosis of PTSD due to the lack of 'a specialist psychiatric qualification', concern had been expressed in this case that the doctor had not considered other possible causes of psychological symptoms and had reached a diagnosis that was 'dependent on assuming that the account given by the appellant was to be believed'

The Court of Appeal and the Upper Tribunal give clear guidance that the Tribunal should not assume an expertise in medical matters that it does not have and that Immigration Judges should not

override expert medical opinion without good reason, which should be clearly articulated and preferably based on well qualified alternative medical opinion. However, case law does not appear to give specific guidance on the qualification of a General Practitioner to assess psychological symptoms and to make a diagnosis of depression or PTSD. This may contribute to the inconsistency of approach and outcome in individual cases observed in this sample.

It would be preferable, therefore, if clear guidance could be given by the Tribunal that suitably trained General Practitioners are indeed qualified to give expert opinion on the psychological sequelae of torture, and that General Practitioners are professionally trained and qualified to make psychiatric diagnoses, including PTSD and depression.

Assessment of Credibility and Consistency

It is accepted that an assessment of the overall credibility of the claimant is an indispensable part of deciding an asylum claim, and it is understood by all parties that this is ultimately the task of the decision maker, looking at all the evidence in the round and applying the appropriate standard of proof. However, it is emphasised in case law from the Court of Appeal and the Tribunal, (SA Somalia EWCA, Mibanga EWCA, HE DRC UKAIT), that expert evidence, such as medical evidence, should be treated as an integral part of all the evidence considered and should not be considered as an 'add-on' once the overall credibility of the claimant has been decided.

Findings of this Report indicate that while many Immigration Judges are willing to be guided by and include the findings of an MLR in their consideration of credibility, a significant number demonstrably are not. In a significant number of cases a decision has explicitly or implicitly already been made on credibility before the medical evidence has been considered. In such cases the evidence is invariably dismissed and the case not allowed.

The reasons given by Immigration Judges for the refusal to consider medical evidence, or to give it significant weight in relation to the assessment of credibility, are considered in detail in this report and are summarised in Part 4 Figure 2.

They include criticism of the doctor for:

- giving an opinion on the judicial area of credibility, when an opinion has in fact been given on the consistency of the clinical evidence and the account of torture as required by the Istanbul Protocol, case law and judicial guidelines,
- accepting an account and history of torture without question, despite the clear statement in every MLR of the doctor's methodology and professional duty to critically assess all aspects of the subject's presentation, as well as their duty to report to the court impartially and objectively,
- failing to consider alternative causation for the physical and psychological harm documented in the MLR, when the doctor has found the clinical evidence and cause given to be consistent, to varying degrees of certainty, having considered all relevant aspects of the claimant's history and circumstances as required by the Istanbul Protocol, case law and judicial guidelines,

- accepting inconsistencies in testimony or believing at face value a late disclosure of torture, despite significant research on the impact of trauma on memory and the explanation of this research in relation to the individual case.

Some Immigration Judges in this sample are found to have simply preferred their own opinion on matters in which the expert has been required to give opinion, without providing either alternative evidence from an equally qualified expert or 'appropriate reasoning', (Y Sri Lanka EWCA).

Treatment of expert evidence: standard of proof

The recent judgement from the European Court of Human Rights, (RC Sweden), finds that the state authority has a duty to ascertain all the relevant facts of an asylum claim, and if necessary obtain medical opinion if they doubt the causation given in an expert medical report that gives a strong indication of torture. UK case law, cited in Part 3 of this report and summarised in Part 4 Figure 2, directs that expert medical evidence if not 'materially shaken' in terms of the expertise of the author or the quality of their evidence, should be accepted and acted upon, (Y Sri Lanka EWCA). Furthermore, if the decision-maker intends to dismiss expert evidence that is uncontradicted, case law directs that this should be on the basis of appropriate reasoning, (Y Sri Lanka), supported by alternative expert evidence, (RR Sri Lanka UKUT), and that the concerns about the expert medical evidence should first be put to the expert and not reserved for the written decision, (Y Sri Lanka, RR Sri Lanka).

The findings of this investigation indicate a serious lack of consistency in the way that this guidance is interpreted by Immigration Judges in the Tribunal. Independent expert evidence is not commissioned by either the UK Border Agency or the Tribunal if the findings of an expert medical report are in doubt. Moreover, according to the evidence of the written determinations in this sample, concerns about expert medical evidence are not put to the expert, or to the Medical Foundation, in order to provide an opportunity for clarification or further explanation before a decision is made.

While in many cases in this sample medical evidence that is uncontradicted and which gives a strong indication of torture is accepted by Immigration Judges, in a significant number of other cases it is not. Furthermore, some Immigration Judges appear content to substitute their own opinion in preference to that of the expert, in some cases without appropriate reasoning and in all cases without the support of alternative expert opinion.

As stated in the introduction, it is recognised that the standard of proof for asylum claims is relatively low, and that there is a 'reasonable degree of likelihood' of persecution if the claimant is returned to the place for which they assert a 'well founded fear' of persecution, (R v SSHD ex p Sivakumaran [1988] Imm AR 147). It is also recognised that historical facts, such as a claim to have been tortured in the past, should be judged on the same standard of proof as future risk and that there should be a 'positive role for uncertainty' in asylum claims, (Kaja [1995] Imm AR 1 & Karanakaran v SSHD [2000] Imm AR 271).

Although all the determinations in this sample state at the outset that the lower standard of proof applies, there is evidence to suggest that not all Immigration Judges assess expert medical evidence according to this standard of proof. In dismissing or giving little evidential weight to the findings of

an MLR, some Immigration Judges appear to demand an unrealistically high level of certainty and ‘proof’ before accepting a claim of torture and giving this finding due consideration in the assessment of the credibility of the claimant.

PART 6

RECOMMENDATI

ONS

Recommendations are made that address the key findings to the Presidents of the First-tier and Upper Tribunals (Asylum and Immigration Chambers) as well as to the Tribunals Procedures Committee and the Senior President of the Tribunals, in the interest of ensuring that the right to international protection for survivors of torture is secured.

Recommendations are also made to the UK Border Agency on the basis of relevant findings on the treatment of expert medical evidence for claims involving torture at first instance.

TO THE PRESIDENT OF THE UPPER TRIBUNAL AND THE PRESIDENT OF THE FIRST-TIER TRIBUNAL (IMMIGRATION AND ASYLUM CHAMBERS)

Guidance

1. Based on the findings of this research and in accordance with the core duty to improve the quality of decision making described in the Tribunal's Customer Charter,[137] the President should **revise the Tribunal Practice Direction on expert evidence**.

   The revised Practice Direction should include specific guidelines on the treatment of expert medical evidence in relation to claims of torture and should reflect **case law** from the Tribunal and the Higher Courts on this issue, as well as the relevant **standards and guidelines** detailed in this report.

2. The following **standards** should be reflected in the Practice Direction:

   a. **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,

   b. **due consideration must be given to the medical expert's opinion** on the degree of consistency between the clinical findings and the account of torture, on the understanding that this does not impinge on the duty of the judge to make an overall finding on credibility,

   c. **the evidence of General Practitioners** trained in the documentation of torture **must be accepted as expert medical opinion** on the clinical sequelae of torture, both physical and psychological,

   d. **due consideration must be given to psychological research** in the area of trauma and memory and its relevance to an individual claim,

   e. **judicial 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,

f. **evidence** given in an expert medical report **that gives a strong indication of torture,**
according to the appropriate standard of proof, **must be accepted and acted upon**.

Training

3. The President of the Upper Tribunal should ensure that **facilitated training on torture** and the sequelae for survivors, the application of the Istanbul Protocol, and the revised Practice Direction is incorporated in the regular programme of training for Immigration Judges.[138] The training should be experiential, participatory and utilise proven teaching methods and include an appraisal of comprehension.

4. The Joint Training Committee (First Tier and Upper Tribunal) should work with relevant experts in the field (medical and legal) for the appropriate development and delivery of such training.

TO THE TRIBUNAL PROCEDURE COMMITTEE

Oversight and Monitoring

5. The Tribunal Procedure Committee, in accordance with its duty to make rules governing the practice and procedure in the First-tier and Upper Tribunal with a view to securing justice, fairness and efficiency,[139] should work with the Presidents of the Asylum and Immigration Chambers to improve the quality and consistency of decision making in cases involving a claim of torture.

6. The Tribunal Procedure Committee should **oversee** the revision of the Practice Direction on expert evidence to include guidance on the treatment of expert medical evidence in relation to claims of torture and should **monitor** its effective implementation.

TO THE SENIOR PRESIDENT OF THE TRIBUNALS

Oversight

7. In accordance with the duty of the Senior President of the Tribunals to 'maintain appropriate arrangements for training, guidance and welfare of judges and other members of the First-tier and Upper Tribunal', and to give Practice Directions and approve Practice Directions give by Chamber Presidents,[140] the Senior President should consult with the Presidents of the Immigration and Asylum Chamber to ensure:

    a. appropriate **guidance** is given to Immigration Judges on the treatment of expert medical evidence in cases involving a claim of torture in the form of a revised Practice Direction,

    b. appropriate **training** is given to Immigration Judges on the treatment of expert medical evidence in cases involving a claim of torture.

8. The Senior President should **report on progress** in relation to improved guidance and training for Immigration Judges on the treatment of expert medical evidence in cases involving a claim of torture in his 2012 Annual Report.

TO THE UK BORDER AGENCY

9. In view of the concerns about the quality of initial decision making reflected in the high appeal overturn rate documented in this report for cases involving a claim of torture, in particular those cases where expert medical evidence was available, the UK Border Agency must urgently **revise** its **policy guidance** and its **training** programmes for case owners.

Policy Guidance

10. The **Asylum Policy Instruction (API) on the Medical Foundation** is currently under revision. Any new policy which replaces it must include significantly strengthened guidance for case owners on how to handle expert medical evidence in cases involving a claim of torture.

11. The **Asylum Instruction on Considering the Protection (Asylum) Claim and Assessing Credibility** must be amended so that: the 'Summary' and the section on 'Medical Evidence in support of the asylum claim' include references to the API on the Medical Foundation, any new policy which replaces this API and any other relevant policy guidance on medical evidence, so that case owners are clear that they must consult and comply with the more specific guidance that exists in this area.

12. The following **standards** identified in this research apply to first instance decision makers as well as to the judiciary and must therefore be incorporated into the relevant policy guidance:

    g. **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,

    h. **due consideration must be given to the medical expert's opinion** on the degree of consistency between the clinical findings and the account of torture, on the understanding that this does not impinge on the duty of the case owner to make an overall finding on credibility,

    i. **the evidence of General Practitioners** trained in the documentation of torture **must be accepted as expert medical opinion** on the clinical sequelae of torture, both physical and psychological,

    j. **due consideration must be given to psychological research** in the area of trauma and memory and its relevance to an individual claim,

    k. **the case owner'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,

    l. **evidence** given in an expert medical report **that gives a strong indication of torture,**
    according to the appropriate standard of proof, **must be accepted and acted upon**.

Training

13. The UK Border Agency must ensure that prior to the launch of any new policy guidance in this

area, all case owners participate in **facilitated training** on: torture and the sequelae for

survivors, the application of the Istanbul Protocol, and the requirements of the relevant policy guidance in this area. The training should be experiential, participatory and utilise proven teaching methods and include an appraisal of comprehension.

14. The UK Border Agency must also include training (at the standard described above) on torture and the sequelae for survivors, the application of the Istanbul Protocol and the requirements of the relevant policy guidance in both the foundation and consolidation training programmes for case owners.

15. The UKBA should work with independent, acknowledged torture experts in the medical and legal fields to develop and deliver such training.

Oversight and Monitoring

16. Drawing on the findings of this report, the UK Border Agency's NAM+ Quality Audit and Development Team (QADT) should undertake a **thematic review** of decision-making in cases involving a claim of torture.

17. The findings of this thematic review should be used to inform: UK Border Agency training on these issues, further revisions (if necessary) to the relevant policy guidance, and the QADT's own audit processes so that there is regular **monitoring** of the effectiveness of and compliance with the guidance.

18. The QADT should **map and report progress** to the NASF Quality Sub-group on the development and implementation of the policy guidance and training ,and on the findings of the thematic review of decision-making in cases involving a claim of torture.

19. There should be an annual standing item on the agenda of the NASF Quality sub-group on the quality of decision-making in cases involving a claim of torture.

TO THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)

Oversight and Monitoring

20. As part of its Quality Integration Project, UNHCR should continue to closely monitor implementation of those recommendations from its previous Quality Initiative Project reports that relate to decision-making in cases involving a claim of torture.

TO THE INDEPENDENT CHIEF INSPECTOR OF THE UKBA

Accountability

21. On the basis of the concerns raised in this and other recent reports, the Independent Chief Inspector of the UKBA should conduct an **inspection** of decision-making in relation to vulnerable asylum claimants, and in particular those who have made a claim of torture.

APPENDIX 1

METHODOLOGY

Obtaining a sample of Tribunal determinations

The objective was to collect a sample of determinations from the Tribunal that could be considered sufficiently representative of current practice, in order to investigate the concerns of the Medical Foundation and underpin recommendations to the Tribunal. It was known that obtaining a truly random sample of relevant determinations would not be possible given the lack of direct access to Tribunal determinations for research purposes, and the difficulty in obtaining determinations from claimant's legal representatives.[141]

The sample consists only of decisions involving Medical Foundation MLRs and not those where MLRs from other organisations or independent clinicians had been submitted. The findings cannot therefore be said to be representative of judicial treatment of MLR medical evidence per se, although perhaps indicative of current practice, particularly given the standing of the Medical Foundation as a specialist centre for the care and treatment of torture survivors, and the experience of Medical Foundation doctors and other professional staff who prepare MLRs on a regular basis.

A sample of 37 Tribunal determinations for asylum claimants where Medical Foundation MLRs had been submitted, spanning a 12 month period from September 2009 to September 2010, was collected and subject to a desk review. The date range included decisions from the former AIT and decisions from both the First Tier and Upper Tier Tribunal (Asylum & Immigration Chamber).

According to Medical Foundation MLR records, the number of MLRs produced in a 12 month period is around 600. The potential number of MLRs prepared for submission to the Tribunal on appeal, and therefore the potential number of relevant Tribunal decisions for this period, is approximately 300.[142] The final sample of 37 determinations obtained within the time allocated for this purpose is therefore approximately 12% of the total number of MLRs produced annually by the Medical Foundation for appeal cases.

Sourcing the sample

Of these 37 cases, 20 were identified via Medical Foundation clinical staff and 17 were identified through MLR administrative records. Most of the determinations were then obtained from the legal representatives of the asylum claimants, with appropriate permissions; though in a small number of cases determinations were on file in the Medical Foundation.[143] Copies of MLRs were retrieved from the Medical Foundation files for the claimant's whose determinations were included in the sample, also with appropriate permissions.

It should be noted that over 100 potential cases for the sample were identified through MLR administrative records, more than 50 of whose legal representatives were contacted requesting determinations.[144] While many expressed a willingness to send the documents, in the majority of cases they did not do so due to time and resource constraints.[145]

Given that a significant number of the cases were sourced internally via Medical Foundation clinicians, as well as the MLR Service, it should be noted that the sample may contain a higher than

average number of 'professional' as opposed to 'expert' MLRs, although not all the cases identified in this way were professional reports.[146] In general, the majority of MLRs produced by the Medical Foundation are 'expert' reports prepared by General Practitioners working for the MLR Service.

Furthermore, although it was made clear that the purpose of the study was to examine the treatment of MLRs in the Tribunal, both positive and negative, there may have been a selective process involved in the decision of individuals to put forward cases for which they had authored an MLR. Given that it was not possible to collect a truly random sample, it is not possible to say the sample is entirely free of such 'biases'.

Nonetheless, it is considered that both the number and the variety of cases represented in this sample, as well as the variation in treatment of MLRs by Immigration Judges represented in the determinations, provide a significant and sufficiently representative picture of current treatment of Medical Foundation MLRs for robust findings and recommendations to be made.[147]

Establishing the concerns of the relevant medical professionals

In order to identify the concerns of the medical professionals about the treatment of Medical Foundation MLRs in the Tribunal, a literature search for previously published material on this subject was conducted and the relevant reports and papers reviewed.

In addition, informal interviews were conducted with the relevant members of the Medical Foundation MLR Service, including the doctors and legal staff. Cases where letters of representation had been prepared for submission to the UK Border Agency or the Tribunal responding to the dismissal of an MLR were also reviewed with a view to identifying the persistent issues of concern.

Establishing the relevant guidelines and standards

In order to assess the current practice of the Tribunal in relation to the adherence, or otherwise, to current guidance regarding the treatment of medical evidence, the following guidance was accessed and reviewed:

- Practice Direction: Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal – Part 4 10 Expert evidence
- Joint Presidential Guidance Note 2 of 2010: Child, vulnerable adult and sensitive appellant guidance
- International Association of Refugee Law Judges: Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence

In order to measure the Tribunal guidance and practice against established best practice standards on judicial treatment of medical evidence relating to torture survivors in the RSD process, the following documents were accessed and reviewed:

- Istanbul Protocol, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN High Commission for Human Right, 2004
- Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees, Reedited, Geneva, January 1992, UNHCR 1979

In order to assess the methodology of the Medical Foundation for the preparation of MLRs in relation to the established guidelines for torture documentation (the Istanbul Protocol), the Methodology Employed in the Preparation of Medico-Legal Reports on behalf of the Medical Foundation was reviewed.

Data sample Analysis

In order to review and analyse the sample of determinations, a data spreadsheet was prepared which recorded information in 4 sections: Client Profile; MLR; Determination and Treatment of the MLR in the written decision.

Client Profile:

Country of Origin, Gender, Age, Basis for claim

MLR:

Date, Doctor/ Professional, Type of MLR

Determination:

Date of decision, Hearing Centre, Immigration Judge, UKBA MLR issues, Decision, MLR findings accepted in full, MLR clinical findings accepted, MLR causation not accepted

Treatment of MLR in the written decision:

Expertise of MLR author, MLR quality
Credibility: history taking, interpretation of medical & psychological findings, causation, consistency of memory & recall, & late disclosure

Basic information was recorded in sections 1-3, while in the 4th section more detailed information was recorded including quoted excerpts from determinations and, where relevant, from the respective MLR.

The information recorded on the data sheet was then extracted and the findings were analysed in two parts; the first considered the overall treatment of cases in the Tribunal for which a Medical Foundation MLR was submitted in evidence and the second considered in detail the treatment of MLRs in the written determination.

The findings were recorded in tables as follows (see APPENDIX 2 for the tables in full) and analysed.

FINDINGS Part 1: Treatment of cases in the Tribunal for which a Medical Foundation MLR was submitted in evidence

1. Determinations
   - Table 1a Determinations: number and date of decision
   - Table 1b Determinations: hearing centre
2. MLR Evidence
   - Table 2a Summary allowal rate/ treatment of MLRs
3. Claimant profile
   - Table 3a Claimant profile: country of origin
   - Table 3b Claimant profile: gender
   - Table 3c Claimant profile: age

Ethics

The investigation was conceived as a desk study and therefore did not involve direct interviews with the claimants whose decisions were the subject of the review.

The Tribunal determinations and MLRs were obtained for the purpose of the research from the files held by legal representatives and the Medical Foundation respectively, with the permission of the individuals concerned.

All the information presented in the report has been anonymised. All information recorded on the data spreadsheet refers to individuals by their Medical Foundation client ID number and not by name. The information recorded on the data spreadsheet will not be made available to the public but retained as a confidential record by the Medical Foundation.

SAMPLE

Determinations[1]

[48] **Number**

The total number of Tribunal determinations in the sample for asylum claimants for whom Medical Foundation MLRs were submitted in evidence is 37. This represents approximately 12% of the potential number for the selected period of a year, on the basis of an estimated annual total number of MLRs (prepared by the Medical Foundation for submission to the Tribunal for an appeal hearing) of 300.

Date range

The date range of the sample of determinations was September 2009 – September 2010. It was hoped that this sample would yield information about current practice in the Tribunal over a reasonably sustained period. It was also hoped that the sample would include determinations from the former AIT as well as the Tribunal (Asylum and Immigration).

However, given the difficulties with access to Tribunal determinations for research purposes, the sample contains no determinations from 2009, with the majority being from June-September 2010 (21/37). A small number of determinations from October 2010 have been included on the basis that they had been forwarded by legal representatives and could compensate in a small way for the lack of determinations from the first 4 months of the sample date range.

In the event there are no determinations from the former AIT, which means that the findings and analysis will represent practice in the new Tribunal alone.

Hearing Centre

The Tribunal (Asylum and Immigration) lists the following 18 hearing centres on its website: Belfast, Birmingham, Bradford, Bromley, Field House, Glasgow, Harmondsworth, Hatton Cross, Manchester, Newport, North Shields, Nottingham x2, Stoke-on-Trent, Sutton, Taylor House, Walsall and Yarl's Wood.

The sample of 37 determinations considered were from 10 hearing centres, 1 of which, it should be noted, is not listed on the Tribunal website (Liverpool). The Hearing Centres represented in the sample are: Birmingham (1), Bradford (3), Field House Upper Tribunal (2), Glasgow (1), Hatton Cross (10), Manchester (8), North Shields (2), Sutton (1), Taylor House(6) & Liverpool (3).

18 of the cases were heard in London hearing centres (Taylor House, Field House and Hatton Cross); the remaining 19 are spread throughout the country with the largest number coming from the north of England and Manchester in particular.

MLRS[149]

The 42 MLRs in this sample were produced by 26 different doctors/professionals, ranging from GPs to psychiatrists, clinical psychologists, psychotherapists, family therapists, counsellors and social workers, working for the Medical Foundation. [150]

General Practitioners produced 28 of the 42 MLRs, all of which are medical/psychological reports containing an assessment of the client's physical and psychological presentation in relation to their account of ill-treatment/torture and other factors which may impact on their physical and mental health. These are 'expert witness' reports in the sense that they are prepared by an 'impartial, experienced practitioner who sees the subject only for the purpose of preparing a report.'[151]

A smaller number of 'professional witness' reports were produced by the other medical and non-medical professionals mentioned above. These are reports produced by a professional treating, or in other ways working with, a Medical Foundation client and although not 'independent', the professional is nonetheless aware of their duties to the court.[152]

Claimant profile[153]

Gender

57% of the claimants in the sample were male, and 43% female. According to the 2009 Medical Foundation 2009 Clinical Audit, 72.9% of those clients assessed by the Medical Foundation were male, and 27.1% were female.[154] This figure does not distinguish clients for whom MLRs have been prepared from other clients of the Medical Foundation, as this information is not recorded. However, the proportionate number of female clients in this sample seems to be higher than the average for Medical Foundation clients.

According to UKBA Immigration Statistics for 2009, 67% of asylum applicants for that year were male, and 33% female.[155] The sample therefore also contains a higher proportion of female claimants than is the average for asylum applicants in general.

UKBA statistics for 2009 also record that 28% of female applicants, and 27% of male applicants, were granted either asylum or some form of subsidiary protection. The statistics do not record numbers of appeals allowed or dismissed by the Tribunal according to gender at present.

Age range

The majority of claimants represented in the sample were aged between 25-45 (65%), the next largest group being 19-25 year olds (19%), whilst 3 were under 18, and 3 over 45.

According to the 2009 Medical Foundation Clinical Audit, the age of new clients ranged from 13-74 years and the majority of the clients were aged 18-40 (78%).[156] This sample is therefore in accordance with the general age ratio of Medical Foundation clients, as it is with the age ratio of UK asylum applicants.[157]

Basis for protection claim

The basis for the protection claim of the majority of claimants in the sample is political opinion or imputed political opinion (76% of the sample). Of the 37 cases in the sample, 28 were in this category, although some of these had further bases for their claim, such as ethnicity. Claims based on ethnicity formed a significant group, as did those based on fear of non-state actors and a failure of state protection. Many women's asylum claims fall into this category, although many women's claims in this sample were based on imputed political/political opinion.

Country of Origin

There are 16 countries of origin of claimants represented in this sample: Afghanistan (5), Armenia (1), Burkina Faso (1), Cameroon (3), DRC (4), Iran (5), Iraq (2), Lebanon (1), Nigeria (1), Palestine OPTs (1), Somalia (2), Sri Lanka (4), Sudan (1), Turkey (2), Uganda (3) and Zimbabwe (1).

The 'top ten' countries of origin of those referred to the Medical Foundation (not necessarily for an MLR) in 2009 were: Iran, Sri Lanka, Afghanistan, Democratic Republic of Congo, Zimbabwe, Iraq, Turkey, Eritrea, Cameroon, and Sudan.[158] The only country not included in the sample from this list is Eritrea; the sample could therefore in general be said to be reflective of client referrals to the Medical Foundation.

'Top ten' countries for asylum applicants to the UK in the 3rd quarter of 2010, according to UKBA statistics, were Iran, Sri Lanka, China, Afghanistan, Pakistan, Zimbabwe, Eritrea, Nigeria, Sudan and Somalia. The only country not included in the sample from this list is China. [159]

APPENDIX 2

FINDINGS -

TABLES

INDEX of tables

FINDINGS Part 1

Treatment of cases in the Tribunal for which a Medical Foundation MLR was submitted in evidence

1. Determinations

Table 1a Determinations: number and date of decision

Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	TOTAL
3	5	1	2	2	8	5	4	4	3	**37**

Table 1b Determinations: hearing centre

Hearing Centre	Total	% of total	Appeal Allowed	%	Appeal Dismissed	%
Birmingham	1	3%	0	0%	1	100%
Bradford	3	8%	0	0%	3	100%
Field House	2	5%	2	100%	0	0%
Glasgow	1	3%	0	0%	1	100%
Hatton Cross	10	27%	6	60%	4	40%
Manchester	8	22%	2	25%	6	75%
North Shields	2	5%	2	100%	0	0%
Sutton	1	3%	1	100%	0	0%
Taylor House	6	16%	4	67%	2	33%
Liverpool	3	8%	1	33%	2	66%
TOTAL	**37**		**18**		**19**	

2. MLR Evidence

Table 2a Summary allowal rate/ treatment of MLRs

Total number of cases	Appeal Allowed	Appeal Dismissed	MLR findings accepted in full	MLR dismissed	MLR clinical evidence accepted, causation not accepted	MLR clinical evidence accepted/ case dismissed
37	**18** **49%**	**19** **51%**	**18** **49%**	**19** **51%**	**27** **73%**	**9** **24%**

3. Claimant profile

Table 3a Claimant profile: country of origin

Country	Case Allowed	Case Dismissed	Total	MLR accepted
Afghanistan	4	1	5	4

Armenia	1	0	1	1
Burkina Faso	1	0	1	1
Cameroon	2	1	3	2
DRC	0	4	4	0
Iran	2	3	5	2
Iraq	1	1	2	1
Lebanon	0	1	1	0
Nigeria	0	1	1	0
Palestine OPTs	0	1	1	0
Somalia	2	0	2	2
Sri Lanka	2	2	4	2
Sudan	1	0	1	1
Turkey	2	0	2	2
Uganda	1	2	3	0
Zimbabwe	0	1	1	1

Table 3b Claimant profile: gender

	Total	**%**	**Allowed**	**%**	**Dismissed**	**%**
Male	21	57%	10	48%	11	52%
Female	16	43%	8	50%	8	50%
Total	37		18		19	

Table 3c Claimant profile: age

Age	**0-18**	**%**	**19-25**	**%**	**26-45**	**%**	**46+**	**%**
Total	**3**	**8% of sample**	**7**	**19% of sample**	**24**	**65% of sample**	**3**	**8% of sample**
Allowed	2	67%	3	43%	11	46%	2	67%
Dismissed	1	33%	4	57%	13	54%	1	33%

Table 3d Claimant profile: basis for claim

Ground for protection	**political opinion**	**%**	**ethnicity**	**%**	**religion**	**%**	**PSG; persecution by non-state**	**%**

claim – cases may have more than one ground	**& imputed political opinion**						**actor/family members - failure of state protection (forced recruitment child soldier; forced marriage; sex/relationship outside marriage)**	
Total	**28**	**76% of sample**	**10**	**27% of sample**	**1**	**3% of sample**	**7**	**19% of sample**
Allowed	9	32%	5	50%	1	100%	5	71%
Dismissed	19	68%	5	50%			2	29%

4. UKBA treatment of MLRs

Table 4a UKBA/ Tribunal treatment of MLR

Treatment of MLR	Total	%
MLR submitted to UKBA: negative finding, case refused	13	35% of whole sample
Tribunal overturns UKBA assessment of MLR: case allowed	9	**69% of sample of 13 (rate of overturn)**
Tribunal concurs with UKBA assessment of MLR: case dismissed	4	31% of sample of 13

Table 4b UKBA/ Tribunal treatment of MLR – detailed findings

Case No.	UKBA treatment of MLR	Tribunal Treatment	Decision
Case 3	Refused due to discrepancies between asylum application & MLR - late disclosure of rape. RFRL states the claimant "... had ample opportunity prior to his referral to the MF to disclose what had happened to him and the fact that he had not done so significantly damaged his credibility". The MF Doctor diagnosed PTSD and severe depressive episodes but RFRL finds"... it was accepted that the doctor was qualified to diagnose this condition but was not in a position to assess his credibility. He may have been suffering from these conditions but it was not accepted that he was suffering from them for the reasons he had claimed."	The IJ states"...it is perhaps right to start by saying that the respondent's approach to these applications has I think been significantly flawed from the very beginning. The refusal letter is written on the basis of a total refusal to believe a word the husband in particular has told..." "...I found both appellants entirely credible in the evidence that they gave, not least because what they said was significantly supported by the quality of the expert reports that had clearly examined their cases very closely, conscientiously and with considerable expertise."	**Allowed**

Case 5	MLR - trauma diagnosed; RFRL "... an assessment of trauma, and the prescription of anti-depressant tablets did not ... entail an uncritical acceptance of..." the claimant's account. Drugs and facilities are available in DRC.	IJ accepts that the MLR presents evidence of trauma but does not accept the cause attributed; MLR 'recited' account of the appellant.	Dismissed
Case 6	RFRL - MLR "... added little to the Appellant's claim as a whole." Due to "large inconsistencies" throughout her claim, RFRL does not accept that the claimant's scars were caused as claimed, nor that she was ill-treated or tortured in the way she described.	The IJ accepts MLR assessment of future risk and vulnerability if returned. "The medical evidence shows that the appellant is in a fragile mental state and is a particularly vulnerable individual ... terrified of being returned to x..." and an acute suicide risk. The IJ accepts MLR evidence of scarring and rape and attribution, detention and torture by x security forces.	**Allowed**
Case 7	RFRL - credibility not accepted. MLR "considered" but does not accept that case "...reached the high threshold required by Article 3".	IJ accepts MLR explanation of difficulty in giving coherent testimony due to high level of trauma; claimant would not have "been able to dupe the MF given their careful assessment". The centrepiece of the testimony has remained constant and consistent. The claimant was able to give testimony to counsellor who she trusted.	**Allowed**
Case 11	RFRL - the MLRs were "largely based on self-reporting, and the fact that the experts concluded that her symptoms and injuries were broadly consistent with the accounts the appellant had provided were in no way conclusive evidence that the events had occurred as claimed".	Decision essentially upholds UKBA position, totally rejecting credibility of claimant. The Psych MLR - is "just one part of the evidence" based on self-reporting and the Medical MLR "only had effect of not negating appellant's claim."	Dismissed
Case 13	UKBA refusal on basis of credibility: adverse inference drawn from unwillingness of claimant to undergo intimate examination. Use of language by the client leads UKBA to conclude account is inconsistent (words such as 'arm' and 'hand' and 'broken' and 'dislocated'.) Criticised a 'lack of opinion' by the MLR doctor on how the injuries were inflicted and when they might have occurred. RFRL states opinion re whether claimant could make a journey from x to UK with stated injuries without 'going into shock' and whether or not she could have hidden her injuries at the UK border. RFRL also states opinion 'it was not impossible' that the appellant was a 'willing participant' in the infliction of her injuries.	IJ concurs re credibility of claimant. Despite the fact that the MLR reports that 17 scars are 'diagnostic' of torture and 11 are 'highly consistent' with her attribution to injuries, IJ states 'I have rejected her claim of having those scars inflicted by others in x and am unable to reach a firm conclusion whether the scars were self-inflicted (or applied voluntarily) in the UK or against the appellants will but in different circumstances from what she has claimed'. MLR Doctor suggests this would be unlikely due to the location / nature and totality of scarring.	Dismissed
Case 14	Evidence of MLR is rejected on basis that the doctor is not qualified to assess psychiatrics.	IJ notes MLR finding that "...the physical scarring is highly consistent with the attributions she gives, and there is no discrepancy between the causations and approximate timescale she describes..." IJ states '"Dr x also states that the appellant has clear features of PTSD ... In the reason	**Allowed**

		for refusal letter at paragraph 37 the respondent considers that this diagnosis of PTSD 'cannot be considered reliable when a doctor does not have the appropriate psychiatric qualifications'. That attack on Dr x's qualifications in my view is amply dealt with in the letter of Dr Juliet Cohen, the Head of Medical services at the Medical Foundation, in which attention is drawn to Dr x's qualifications in psychiatry."	
Case 18	RFRL states MLR doctor had not listed his methodology.	MF rebuts this assertion, provides evidence that methodology was stated. The IJ states "...In the absence of any contra medical evidence from the respondent I see no reason to reject the expert report by Dr x and therefore adopt his conclusions".	**Allowed**
Case 19	RFRL asserts MLR doctor is not qualified to assess psychiatrics. RFRL does not accept injuries were sustained in the way described by the claimant although accepts that she was detained.	IJ states "...I find that during appellant's time in detention she was interrogated and beaten by both male and female officers. I note that the appellant has marks on her body that are consistent with being beaten by a belt, as confirmed in the report from the Medical Foundation ... The respondent has stated that they do not accept that the injuries were sustained in the manner she has described, however given that the respondent does accept that the appellant has been detained by the authorities in x, I find that the evidence from the Medical Foundation satisfies me to the relevant standard of proof that these scars are indeed as a result of having been beaten in detention".	**Allowed**
Case 25	RFRL does not accept the scars, depression & PTSD diagnosed by the MLR doctor are attributable to torture. Finds scars all attributed to motor cycle accident recorded in MLR (which finds that a number of scars were caused by this) despite MLR opinion that specific injuries to the claimant's neck and abdomen were typical of torture.	The IJ does not accept the credibility of the claimant's account in key areas and mentions inconsistencies in the claimant's evidence. BUT the IJ also states as "...Dr x is employed by the Medical Foundation then I find that her opinion must carry considerable weight". The MLR mentions the issue of memory and recall in terms of PTSD, which may explain inconsistencies in testimony. IJ also states "...I am satisfied that the appellant has suffered torture in the past ... I am also satisfied having regard to Dr x's opinion that the appellant is suffering from PTSD, depression and memory loss".	Dismissed
Case 28	UKBA had appealed original First tier decision to allow on the basis that the IJ had found the claimant not credible and then changed this finding on reading the MLR without stating which aspects of the MLR he was relying on.	The IJ (in fresh claim) notes that reports from the Medical Foundation are given special status according to the UKBA API (2.6). IJ also states "I find the report as a whole, well balanced". IJ disagrees with UKBA that MLR did not	**Allowed**

	UKBA states MLR doctor did not explore alternative cause of injuries and account of claimant inconsistent.	explore alternative causes; "...Dr x set out at paragraph 20 of the MLR 'other possible causes of these clinical signs could be arthritis or inflammatory changes in the connecting tissue of the feet, but x does not give history of such problems' ..." IJ also states "Dr x has noted that there are some inconsistencies given in his account and has also given a reason as to why they may have occurred..."	
Case 32	UKBA states the MLR doctor is a GP with no experience to diagnose PTSD.	IJ states "... I have noted that Dr x has assessed over 130 alleged torture victims for the Medical Foundation ... I find that the medical and counselling evidence is compelling ... whilst it would be completely unrealistic to state that that the organisation (MF) cannot reach erroneous conclusions, nevertheless I must take into account that they frequently refuse to prepare reports ... The authors of the medical reports have properly assessed their findings against the WHO diagnostic criteria for research, the ICD-10 classification of mental and behaviour disorders...and I find that Miss x is suffering from PTSD". IJ comments re reasons for late disclosure: and re the claimant's experience of the UKBA screening process: "... The interviewers constantly tried to persuade her to admit that her real name was not x. One of them even said to her' you are lying through your teeth'. The tone was very intimidating and I was shocked to hear these words. In spite of this persistent pressure, she continued to insist on her real name. She wept uncontrollably for long stretches of time ."	**Allowed**
Case 34	UKBA appealed First Tier decision on basis that the IJ failed to give adequate reasons for his conclusions. IJ in First Tier appeal had found "...there is a reasonable degree of likelihood that he was subjected to torture as alleged. The medical evidence is cogent. Each injury sustained has been commented upon in detail with the events said to have caused those injuries"	IJ states that the findings "...were made by the Immigration Judge after hearing oral evidence and after receipt of medical evidence and obviously submissions. The Immigration Judge gave very full and comprehensive reasons for accepting the appellant had been tortured and in short the Immigration Judge found that the appellant was telling the truth".	**Allowed**
Total: 13 cases		**9 Allowed** **4 dismissed**	

FINDINGS Part 2

Treatment of MLRs in the determination

5. Expertise of MLR author

Table 5: Expertise of MLR author

Expertise of MLR author/ qualified to diagnose?	Clinical field	+ve	-ve	Decision	Immigration Judge (IJ) comments
Case 1	GP	x		allowed	Expertise is accepted as is the assessment of the veracity of the claimant's account
Case 3	Psych.	x		allowed	IJ accepts that the expert was "...well able to assess the material in front of them and take an independent view"
Case 4	Counsellor & Social Worker	x		allowed	Credentials and expertise of both authors are accepted
Case 6	GP & Psychiatric Social Worker	x	x	allowed	IJ accepts general qualifications of the 2 MLR authors in this case. However, **in agreement with UKBA**, he does not accept that the GP is entitled to diagnose PTSD as she "has no psychiatric qualifications or experience". He does accept the diagnosis of PTSD & depression from the psychiatric social worker
Case 7	Counsellor	x		allowed	IJ **disagrees with UKBA** that the MLR author is not qualified to give expert opinion. He states that since she is Lead Counsellor at the MF, she is experienced and due to the reputation of MF (a "highly respected organisation"), he can accept her opinion
Case 9	Psych.	x		allowed	IJ comments that "the competency of the *Medical+ Foundation cannot be questioned".
Case 13	GP		x	dismissed	IJ comments that while he accepts the positive diagnosis of PTSD given by another doctor in another medical report (qualifications unknown) "He is better qualified to make the assessment he has than Dr x who is a G.P'" The IJ also questions the MLR author's expertise and experience in assessing scars on the basis that "none of her training appears to have been particularly in the field of scar tissue and its analysis."
Case 14	GP	x		allowed	IJ **disagrees with UKBA** that the MLR author is not qualified to diagnose PTSD. Accepts MF rebuttal letter which makes note of the GPs qualifications in psychiatry.

Case 22	GP		x	dismissed	IJ finds that MLR author has "overstepped their objective role" by accepting the claimant's history. MLR states: "'In my professional opinion the marked psychological distress Mrs N presents coupled with the scars I note, are compatible with her account of torture whilst in detention. I have no reason to doubt that history"

6. MLR Quality

Table 6: MLR Quality

MLR quality: methodology & adequacy of investigation	+ve	-ve	Decision	Immigration Judge (IJ) comments
Case 2	x		dismissed	"...A carefully prepared report and very thorough" "...I accept entirely the evidence of the medical report as to the nature and extent of the scarring on the Appellant's body ... the medical report does not persuade me that my findings on credibility must be wrong."
Case 3	x		allowed	The doctor spent considerable time with the appellant; a supplemental report deals with late disclosure of rape The doctors "...rationalise and develop their reasons very clearly..."
Case 7	x		allowed	The report is based on 8 assessments and 16 counselling sessions over an extended period. It explains the counselling process in full.
Case 12	x		allowed	Detailed account of detention given in the MLR, client history accepted
Case 28	x		allowed	-' consequently reports from the medical foundation are given special status' As noted by the Secretary of State API (2.6) Paragraph 68" find the report as a whole, well balanced'
Case 32	x		allowed	'I have noted that Dr x has assessed over 130 alleged torture victims for the Medical Foundation ... I find that the medical and counselling evidence is compelling. .. whilst it would be completely unrealistic to state that that the organisation (MF) cannot reach erroneous conclusions, nevertheless I must take into account that they frequently refuse to prepare reports .. The authors of the medical reports have properly assessed their findings against the WHO diagnostic criteria for research, the ICD-10 classification of mental and behaviour disorders .and I find that Miss x is suffering from PTSD'.
Case 33		x	dismissed	"I think it fair to say that Dr x does not look in detail at possible alternative causes for certain of the injuries which have been attributed to physical ill-treatment."

7. Credibility: history – consistency - causation

Table 7a Credibility: taking a history

	Decision	History taking

Case 5	dismissed	The IJ states "...I note that the medical professionals have recited the accounts which the Appellant set out as to past circumstances. That does not mean that they have made their own medical findings as to the truth of the past accounts".
Case 8	dismissed	The MLR doctor accepts the account is credible based on compatibility of clinical findings with it and no obvious alternative explanation; IJ does not. The MLR states in conclusion "x's physical and psychological findings are compatible with the account of her experiences, as they were given to me". The Dr explicitly attributes scars to a period in detention having considered alternatives from life history. The IJ states "...Although the appellant's description of the events in late February 2008 is consistent with the reports in the background material before me, her description of what happened to her personally is fraught with significant elements that are not credible .I do not accept the appellant's account of her detention and escape as credible. I do not accept to the requisite standard of proof that the appellant was detained in the circumstances she claimed . Although I accept that the appellant has been raped and beaten I do not accept that it occurred in the circumstances she has claimed."
Case 9	allowed Art 3	"...Clearly the story recounted is that told by the Appellant to the doctors and not tested by cross-examination, but I am aware of the special expertise of this Foundation in dealing with trauma victims..."
Case 10	dismissed	The IJ states that the doctor makes a diagnosis of PTSD "but it is founded upon a pre-existing acceptance of the account, and whilst the report points out that the Appellant was inconsistent within the description of the events given, it only considers an explanation of PTSD and not the possibility of a false story..." However, in an appendix to the MLR the doctor writes: "All MF doctors are trained to take a new history from each client and the process of medical examination is one of continual reassessment of the likelihood and clinical plausibility of the events described. No history is accepted 'without question'." In addition the introduction to the MLR states: "...This medical report should be considered as an interim report pending further assessment after x has received some medical and therapeutic treatment for post-traumatic stress disorder...Her mental condition is so severe that she is unable to give a complete or reliable account of her experiences in the DRC. Furthermore it is not clinically justifiable, at this point in time, to push her for detailed description of her torture experiences..."
Case 11	dismissed	"As with all expert reports. Ms x's report forms just one part of the evidence which has to be considered along with the remainder. I agree with the respondent that it was based largely on self-reporting. "
Case 12	allowed	The IJ accepts the doctor's assessment of the history as credible; "...there is no suggestion in the medical report that he might have been lying".

Table 7b Credibility: consistency, recall & late disclosure

	Decision	Consistency, recall & late disclosure
Case 3	allowed	IJ accepts explanation in MLR of late disclosure of rape.
Case 4	allowed	IJ takes positive account of MLR support of age assessment as 16 and accepts that inconsistencies in testimony could be attributed to age
Case 6	allowed	Accepts explanation of late disclosure of rape - male interpreter at UKBA
Case 7	allowed	IJ accepts MLR explanation of difficulty in giving coherent testimony due to high level of trauma, would not have "been able to dupe the MF given their careful assessment" and given costs involved they would not have offered such lengthy involvement to someone who was not a VOT. The centrepiece of the testimony has remained constant and consistent. The claimant was able to give testimony to counsellor who she trusted.
Case 10	dismissed	MLR doctor diagnoses PTSD & severe depression according to DSM-IV criteria. The MLR refers to a "complex trauma picture" and the difficulty in assessing the claimant in the usual way due to the severity of ill health. Doctor recommends adjournment so that full assessment could be carried out following a period of treatment or that "there is an

		understanding of the possible psychological reasons for discrepancies in her history." IJ remarks "The defects of the account go beyond inconsistency and include implausibility" and states that the MLR does not have significant evidential weight.
Case 11	dismissed	The IJ does not accept that client's mental state, as reported in the psych MLR, affected her ability to give evidence at recon hearing (assessment began after appeal process) - "I therefore find that there was no good reason for the appellant to fail to disclose evidence on which she now seeks to rely...namely the claimed multiple rapes in prison, to reinforce her claim of detention, and an effort to explain why x should help her to escape." MLR explains late disclosure of rape & pregnancy as result of rape, due to psychological condition and male dominated environment at all stages of the legal process, including male interpreter from own community & shame & stigma issues; also interpreter - claimant believed interpreter at hearing same as at UKBA screening - affected ability to give testimony as i)lost confidence in impartiality of court ii) shame issue re disclosure of rape etc Also style of asylum interview - not conducive to disclosure (Q & A rather than narrative). Dismissed by IJ as legal rep had not made special request for all female court for current hearing. Also during screening and asylum interview the claimant did not state she was not fit to conduct interviews and did not disclose rape despite being asked one open question: "...You were in prison...what happened during that time". "Given the above, I consider that she would have been able to disclose the claimed rapes during her alleged detention, even if she did not give full details". IJ states that as the claimant is intelligent and educated "...had she been detained as claimed, and raped repeatedly as she claimed, then she would have disclosed this at the earliest opportunity, regardless of the sex or nationality of the interviewing officer or interpreter." IJ Ignores MLR finding that "x manages her psychological difficulties by avoiding dwelling on her past traumatic experiences as much as she can" and that she has strong avoidance strategies common among rape victims.
Case 20	dismissed	Claimant states in screening interview in 'brief details of the claim' 'I have come to the UK to save my life..and 'I cannot return because of a fight going on in my country' The IJ states 'I find that such a vague reply at the appellant's first opportunity to state his basis of claim damages his credibility . he does not state that he was arrested/detained or tortured by the x authorities on 2 separate occasions.' The IJ does not take into account, trauma/ memory/ recall issues and fact that UKBA is not a conducive atmosphere to disclose. The IJ makes negative finding of credibility and dismisses MLR opinion.
Case 21	dismissed	MLR given no weight as IJ does not think the appellant credible. IJ refers to the appellants seeming inability to be consistent. 'This is an appellant who claims to have been educated at University: I therefore find it incredible that she is unable to maintain even a basic consistency in her account'. IJ judge fails to take account of the effect of trauma on memory and recall. The discrepancies are specifically mentioned in the MLR.
Case 25	dismissed	The IJ does not accept the appellant's account as credible in key areas of his testimony, esp. Inconsistencies with regard to his account of his actions (history). BUT IJ accepts MLR as carrying weight: 'I am satisfied that the appellant has suffered torture in the past in x... I am also satisfied having regard to Dr x's opinion that the appellant is suffering from PTSD, depression and memory loss'. However case dismissed on account of credibility.
Case 27	dismissed	Age is in dispute, MLR supports claimants stated age as 15, with reasons (also note clinical specialism). IJ rejects saying doctor does not give cogent reasons, but a 'care assertion' not supported by criteria for guidance. MLR given no weight, IJ decides that 'his youth alone is insufficient for his failure to mention anything about the ill treatment of his brother'. He goes on to say that 'he is making his case graver with each telling'. Does not take proper account of age and circumstances for failure to disclose relevant information to UKBA.
Case	allowed	IJ makes reference to MLR Doctor's findings of symptoms consistent with PTSD; criticises

28		the MLR for not dating the scars but states "... in the light of the appellant's consistency regarding the mechanism of the injury and treatment thereafter and Dr x's opinion as to the consistency of the medical evidence, on the lower standard I accept that the appellant sustained thee injuries in the circumstances as he claimed." MLR made reference to Dr Cohen's paper "Can omissions and discrepancies in successive statements reasonably be said to undermine credibility of testimony".
Case 31	dismissed	IJ comments about the appellant making alternative/contradictory statements about his detention and torture. The IJ questions why the Appellant did not disclose incidents until after his first refusal. "He explained this as being that he was too terrified at the time, and said that he was aware of having another opportunity to tell it at appeal. He said that counselling after receipt of the RFRL allowed him to speak of it freely...It is unclear why terror should drive him to silence on the matter during the interview or why his counselling should follow the RFRL rather than the experience itself 6 years ago. Exercising an option to speak of things on the next occasion appears to be inconsistent with memories being repressed."
Case 32	allowed	IJ comments regarding credibility and late disclosure & the UKBA screening process: "The interviewers constantly tried to persuade her to admit that her real name was not x. One of them even said to her 'you are lying through your teeth'. The tone was very intimidating and I was shocked to hear these words. In spite of this persistent pressure, she continued to insist on her real name. She wept uncontrollably for long stretches of time. "
Case 37	dismissed	IJ sates "If the appellant were recounting events which had actually taken place, it is highly probable his evidence would be consistent" also states that the recall of the events of torture on his detentions should have been consistent (what happened at each torture session). IJ notes that at the asylum interview the appellant makes no mention of certain things & that his written statement is inconsistent with his asylum interview. The judge says "If this appellant had genuinely been tortured over a period of three years it is highly probable his accounts of the methods of torture by him would be consistent." The MLR confirms all the torture methods mentioned.

Table 7c: Credibility: causation

	Accepts evidence of torture	Accepts attribution of cause	Decision	Comments
Case 2	yes	no	dismissed	The IJ states: "I accept entirely the evidence of the medical report as to the nature and extent of the scarring on the Appellant's body. However I have to weigh the evidence of the medical report against my overall findings as to the Appellant's claim and her explanation as to how the scarring occurred...I do not disagree with any of its findings as to the nature of scarring and the Appellant's general mental health. The conclusions of the report are that these injuries are diagnostic of torture. That finding simply does not fit in with my conclusions as to the credibility of the Appellant's account. After careful consideration I conclude that the medical report does not persuade me that my findings on credibility must be wrong... I conclude that although the scars on the Appellant's body do present as evidence of torture I am not satisfied that they were incurred in the manner claimed by the Appellant." "...she has set out to provide evidence..." "...whilst it is pointless to speculate how the Appellant's scarring may have occurred I am satisfied on the totality of the evidence before me that they did not occur in the manner

				claimed by the Appellant."
Case 3	yes	yes	allowed	The IJ states: "...The Appellant husband has clearly been diagnosed as suffering from PTSD as a result of ...his own later detention and ill-treatment. Of course it can always have arisen in other ways but it is perverse to ignore the obvious, which is that his state of health has arisen from the experiences he has claimed."
Case 5	yes	no	dismissed	The IJ comments:"...I note from the medical evidence before me that although it is the view of the practitioners that the Appellant suffered trauma, the reports do not clearly express the view that the trauma was a result of the specific incidents which the Appellant claimed. It is in my view entirely possible that the general country circumstances in the DRC may well have caused trauma...."and"...I am not persuaded by the conclusions of the medical specialists that the Appellant suffered trauma for the reasons he gave. Indeed I specifically find to the contrary."
Case 6	yes	yes	allowed	The IJ accepts the MLRs' attribution of physical & psychological findings overall and comments on the application of IP classification of causation of scars. The IJ states where scars are found to be 'consistent' the doctor should have stated explicitly her consideration of other possible causes before stating the Appellant's attribution was more likely, not just in introduction where history of previous illness, accidents etc are explored. Where range of possible causes is more limited ('highly consistent', 'typical'), the few other possible causes should be considered and mentioned, otherwise if no other possible cause, should be designated as 'diagnostic'.
Case 8	Yes	No	dismissed	The MLR doctor accepts the account is credible based on the compatibility of clinical findings with it and no obvious alternative explanation (having considered alternatives from life history). The IJ accepted clinical evidence of rape and ill treatment but does not accept that this occurred in detention as claimed. Case reviewed in First and Upper Tier, decision sustained. IJ states in Reason for Decision (First Tier Tribunal review): "It is simply unarguable that the medical report compelled a finding that the Appellant was raped and beaten over a period of time in detention, as claimed by the Appellant, as opposed to the ill-treatment having been sustained in other circumstances."
Case 12	Yes	Yes	allowed	The IJ accepts the MLR account of scars and the degree of consistency with the stated causation: “she deals with 35 lesions/scars on his body and it is difficult to see how he could have had so many" if they were caused by accident/injury, of which there is no particular history.
Case 13	Yes	No	dismissed	The IJ does not accept the MLR finding that the appellant suffers from PTSD (on the basis that the GP is not qualified to diagnose PTSD), though accepts the same diagnosis from an alternative expert. However, the IJ does not accept the basic credibility of the account and states: “There must therefore be another explanation why the Appellant is suffering from PTSD.” Furthermore, despite the fact that the MLR reports that 17 scars are diagnostic of torture and 11 are highly consistent with the claimant’s attribution to injuries, the judge finds that “I have rejected her claim of having those scars inflicted by others in x and am unable to reach a firm conclusion whether the scars

				were self-inflicted (or applied voluntarily) in the UK or against the appellant's will but in different circumstances from what she has claimed ". The MLR doctor states that self-infliction or voluntary infliction would be unlikely due to the location/nature and totality of scarring.
Case 16	No	No	dismissed	Although the doctor had assessed the claimant's injuries as "consistent" with the history, the IJ states "After such an alleged flogging, exacerbated by a day's detention without food or water I find it difficult to see how he could walk at all, let alone run for an hour. It is incredible that he could overcome two fit guards, even with his boxing skills".
Case 20	Yes	No	dismissed	The IJ accepts that the doctor is 'an expert'. He mentions the fact that there is one scar which is 'diagnostic' and a further 8 scars which are 'typical' and 4 which are 'highly consistent' with the appellant's attribution. But he then says 'Given my adverse findings of credibility.. I find the scars were not attributed to the torture as claimed by the appellant'.
Case 22	Yes	No	dismissed	The IJ states there was little to support the doctor's conclusion that she did not doubt the history given by the claimant. "Although she uses the words 'consistent' and highly consistent, she does not consider other possible causes by which the scars could have been caused. In particular the scar on the appellant's right upper thigh is highly consistent with her description of a burn from the tip of a cigarette there could be many other reasons for her having such a scar. What I take from the report is that the appellant has two scars that could have happened in the way the appellant describes'". In the MLR the Doctor states "this is consistent bearing in mind that such injuries are unusual on the inner aspect of the upper arm ... This lesion is highly consistent with the alleged cause on an area of the body that is usually protected by clothing. Only a heated object of the same diameter as a cigarette could cause such an injury".
Case 26	Yes	No	dismissed	The IJ rejects the MLR evidence, agreeing with the UKBA that the doctor has "assessed credibility". The IJ appears to conflate the assessment of the credibility and the assessment of the consistency of the evidence of trauma with the claimant's attribution. The MLR states "...the man described his arrest, detention, and severe ill treatment at the hands of the x ... For five days he was confined, punched, beaten with gun butts and kicked. During this period he was not fed, and was kept in his underclothes. His hands and fingers were deliberately burnt and before he was released he was rendered unconscious by a blow or blows to the head ... on examination he has scarring on the face consistent with his story of being beaten with a gun butt and evidence of marked burns of the hands and fingers that are unlikely to be self inflicted". The two scars are referenced and described according to the correct standards.
Case 27	No	No	dismissed	The IJ states "'all eight scars to the appellants right arm are cigarette burns and the scar on the appellants right thigh is allegedly caused by a nail... it is noteworthy that in none of his accounts had the appellant indicted that his captors pushed a nail into his person". The MLR states scar x "is highly consistent with a full thickness wound caused by a rounded, sharp-ended object such as a nail. The object would have been a sharp stick or the end of a sharp

				knife being stuck into the skin and then turned around". The IJ also states "'He was struck so severely that his right arm broke…there is no evidence of a fracture" yet the MLR states "He is tender to palpitation over the anterior aspect of his right forearm just below the elbow where there is a bony bulge… The bony appearance of his right forearm is highly consistent with a deformity secondary to an unset fracture and he has been left with restricted forearm movement because of pain". The IJ also states "… it is safe to assume if it was a fracture it was not a compound fracture and the bleeding from his right hand has nothing to do with the fracture…"
Case 28	Yes	Yes	allowed	The IJ states that although the UKBA has asserted that the MLR doctor had not considered alternative causation for clinical signs reported in the MLR. The IJ states "…as Dr x set out at paragraph 20 of the MLR 'other possible causes of these clinical signs could be ' arthritis or inflammatory changes in the connecting tissue of the feet, but the client does not give history of such problems' .."
Case 33	Yes	No	dismissed	The IJ comments: "I think it fair to say that Dr x does not look in detail at possible alternative causes for certain injuries which have been attributed to physical ill-treatment." The MLR described all the scars as 'consistent' with the attribution.
Case 37	No	No	dismissed	The IJ states "… I am not persuaded the medical report provided by the appellant establishes there is a reasonable likelihood he has been tortured as claimed and find it is probable that his scars have been occasioned by another cause such as a traffic accident." The IJ states that the appellant only mentions having hot water poured over him when he is with the Doctor "…Given my credibility findings in relation to this appellant's account, I find it probable that the hyper pigmentation observed by the doctor was caused by another trauma such as a domestic accident, perhaps spilling a hot cup of tea".
Total 15	**Accepts evidence of torture: 12** **Accepts evidence of torture and attribution of cause: 4 - all allowed Accepts evidence of torture but not attribution of cause: 8 - all dismissed** **Does not accept evidence of torture or attribution of cause: 3 – all dismissed** **Attribution of cause not accepted: 11 – all dismissed**			

Table 7d Credibility: causation/decision

Accepts torture	Accepts attribution of cause	Decision
yes	no	dismissed
yes	yes	allowed
yes	no	dismissed
yes	yes	allowed
Yes	No	dismissed
Yes	Yes	allowed
Yes	No	dismissed
Yes	No	dismissed
Yes	Yes	allowed
Yes	No	dismissed

APPENDIX 3

DOCUMENTS

- *Medical Foundation Methodology Employed in the Preparation of Medico-Legal Reports*
- *Istanbul Protocol (Excerpt)*
- *UNHCR Handbook (Excerpt)*
- *UK First Tier & Upper Tribunal (Asylum and Immigration) Practice Direction*
- *Joint Presidential Guidance Note 2 of 2010: Child, vulnerable adult and sensitive appellant guidance*
- *International Association of Refugee Law Judges: Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence (Excerpt)*

Medical Foundation for the Care of Victims of Torture, Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation, June 2006

Remit of the Medical Foundation

The Medical Foundation, a registered charity in the human rights field, works exclusively with survivors of torture and organised violence, both adults and children. It has received some 43,000 referrals since it began in 1985.

The Foundation exists to enable survivors of torture and organised violence to engage in a healing process to assert their own human dignity and worth. Our concern for the health and wellbeing of torture survivors and their families is directed towards providing medical and social care, practical assistance, and psychological and physical therapy. It trains health professionals and others to work with torture survivors, educates the public about torture, campaigns against torture and works to improve the legal framework regarding the treatment of asylum seekers and refugees.

Testimony Taking

It has been observed that in numerous instances that thoughtful, careful testimony taking and examination has a major therapeutic effect on victims of torture. For many it is the first time that they find the words to describe their ordeals. Putting unspeakable torture into words is an important step in rehabilitation. It was this observation among others that inspired the creation and development of the Medical Foundation for the Care of Victims of Torture in 1985. In some therapies the torture story is transformed into a testimony, to transform the survivor's story of shame and humiliation into a public story about dignity and courage, returning meaning to life. It has been noted in a recent desk study review of the literature around *Politically motivated torture and its survivors* that "Although retelling the trauma story for reframing and reworking has been a central tenet in treatment, recovering memories of the torture must be done in a safe setting, with the appropriate timing, and with acknowledgement of cultural variations in the expression and interpretation of these memories. If done within a therapeutic setting, this can lead to anxiety reduction and cognitive change."

Methodology of Medical Foundation Reports

We consider that our approach differs from those of other writers of medico-legal reports in the UK. Two of the most important differences are that MF reports are processed through a series of quality control measures and that we do not produce a report every time that we are asked for one.

First, new referrals are discussed by a multi-disciplinary panel of doctors, other clinicians and lawyers, at a meeting chaired by the Medical Foundation's Legal Officer, at which all documents relevant to the case are studied before a decision is made as to whether to proceed to the next stage. Many cases are then referred for an assessment interview by a non-clinical caseworker, usually with legal training, to establish what (if anything)

can be documented in a medico-legal report, for example to find whether scars are present, whether there are significant psychological sequelae and to establish a more detailed history of events if necessary. In this we are guided by the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the Istanbul Protocol, unanimously adopted by the UN General Assembly December 2000. Paragraph 160: "Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person was tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars."

The multi-disciplinary panel will review the case again, as above, to decide whether a report might make a material difference to the case, and whether the case is within the remit of the Medical Foundation. That remit is broadly allied to the United Nations definition of torture and the WHO definition of organised violence, but it also takes account of the developing concept of collective violence. "The instrumental use of violence by people who identify themselves as members of a group - whether this group is transitory or has a more permanent identity - against another group or set of individuals, in order to achieve political, economical, or social objectives" (World Health Organisation, 2002). It should be noted, however, that this definition also covers a broad range of forms of violence including conflicts within and between countries, organised violent crime, and various forms of structural violence that may or may not be state perpetrated. Limitations upon the expertise and resources of the Medical Foundation generally exclude many forms of collective violence. Distinctions as to whether or not a report will be forthcoming may also be made between children and adults (the impact of violence upon children, whether actual or witnessed, may be different to that on an adult) and because of certain gender issues.

An example of how our remit can apply differently according to gender might involve a case of sex trafficking where the victim found the police in her home country to be in collusion with those responsible for her situation. In these circumstances the unwillingness or inability of the police to protect her would amount to a failure of state protection which would then potentially bring the case within our remit. Another example might be a victim of domestic violence where the perpetrator is a state agent and the victim found no opportunity for redress as he prevented her from seeking any official assistance.

An example of a case not taken on might be one where torture has already been accepted in the first instance and refusal or the asylum claim now turns on other issues. In such cases, clearly, a medico-legal report would not make a material difference to the outcome of the case. Regrettably, given our limited resources, it has been our experience that 'reasons for refusal letters' are very rarely sufficiently focused on the issues to say whether or not torture is accepted.

Having decided that a case falls within the Medical Foundation's remit, the panel will refer the case to an appropriate doctor.

This doctor may be a generalist or a specialist, such as a paediatrician, gynaecologist or a psychiatrist. When appropriate the doctor will be assigned according to gender. The doctor makes the final decision on whether or not a report can be written, and may decline to write a report after seeing and assessing the patient for himself or herself. The majority of Medical Foundation doctors are volunteers, others are on salary. None are paid per report written. All Medical Foundation doctors are aware of the Civil Procedure Rule 35, which forms the basis of each of our doctors' declaration of his or her duty to the court.

The doctor sees the subject of the report on a minimum of two occasions, more if needed. A full history and examination are undertaken and physical and psychological findings documented. Photographs or body diagrams of scars may be made if they would assist (e.g., where recent bruising might fade).

Before taking the detailed history and conducting the examination, the doctor will familiarise herself with the papers provided to the Medical Foundation, (usually) by the subject's legal representative. These papers guide our doctors as to the areas on which they should concentrate. However, it is important to note that the testimony of the subject given elsewhere does not form the basis for the doctor's history taking, which is always done independently.

The whole of the subject's testimony is assessed in the light of, among other things: health reported prior to and after torture, the history and detail given of the torture and the subject's affect and behaviour. Affect means the objective observation of their mood. Behaviour in this context means the manner of giving their account, the facial expressions, body language and forms of speech as assessed by the doctor. There is no 'normal' behaviour of a torture victim, but the doctor assesses their observations within her consideration of the person's mental state in the overall context of the person's speech content, culture of origin, family history, employment, levels of education, current state of health and apparent personality. For example, culture of origin and social background as well as severity of depressive illness can affect the level of eye contact made. During an assessment some cry a lot, some cry a little or not at all. It is not the number of tears shed but the total picture of the person gained during two different meetings that gives the doctor their impression of 'behaviour'.

The specificity of the detail in an account, particularly sensory and geographical detail, as well as medical details of injuries received and the healing process of those injuries (e.g. how medically plausible is the account given of the healing process?) - all add to the often complex and detailed picture. It is our experience that, because doctors take their histories in ways quite different from lawyers or government officials, and because of the setting of a doctor's examination room compared to, say, the lawyer's busy offices or an interview room at the Home Office, a more detailed disclosure often results. Disclosure is sometimes significantly enhanced merely by the fact that the questions are put by a doctor, especially, we believe, if the doctor has had a level of specialist clinical training on interviewing survivors of torture and has gained experience from other such interviews of the immediate and long term impact of torture.

Memory difficulties are explored in detail and with reference to established psychology research in this field.[6] Further resources such as psychometric testing by a clinical psychologist are available if needed. An opinion is given on the examination in its entirety and not on isolated findings.

It is not the role of the report writing doctor to assess credibility. However, doctors do not, even in their everyday practice, accept at face value everything they are told by their patients. For example, amounts of alcohol consumed, exercise taken or severity of pain reported - all these are carefully interpreted by a doctor in the light of their observations of the patient's appearance, mobility and answers to questions exploring ability to function in everyday activities.

During the examination Medical Foundation doctors critically assess the account given in relation to the injuries described and the examination findings, in the light of their own experience and the collective experience of colleagues at the Medical Foundation, and may decline to write a report if the account and findings do not correlate.

Each report is read back to the subject to confirm details of the history have been accurately recorded. This process sometimes triggers further recall of details of the events as well as serving as a check that interpreter and doctor have understood the subject correctly.

A senior doctor then reviews the report and a legal officer to check that all relevant aspects have been addressed appropriately before it is signed off.

All Medical Foundation doctors understand and sign a declaration to the effect that the MLR is an expert witness report and that their duties to the court are those of an expert witness.

Medical Foundation Doctors

Medical Foundation doctors are mainly general practitioners, so their prior training and practice give them a valuable breadth of experience in all medical fields. Some have additional specialist qualifications and experience in fields such as paediatrics, dermatology, gynaecology and psychiatry. Victims of torture may have physical and psychological symptoms affecting many medical systems of the body, so a generalist approach is vital to their assessment.

GPs are also trained and experienced in balancing the priorities of a patient's requests, medical imperatives and finite health resources. Nowadays they act as the gatekeepers to the rest of medical care in the UK and, as

such, are effectively neutral experts rather than advocates. This aspect of a doctor's background and training are emphasised and enhanced during their induction and training with the Medical Foundation.
The majority of modern GPs have extensive experience in psychiatry both as a result of some time spent during GP training working in psychiatry departments and as GPs, where over 60% of consultations have a psychological component and 80% of psychiatric patients are managed by GPs. GPs have to decide who is referred for counselling and who needs specialist psychiatric care. GPs initiate treatment with anti-depressants and assess patients for suicide risk to determine the need for acute admission. GPs see the full range of patients, including those not coping well with everyday life, the acutely bereaved, victims of assault and rape and those with major psychiatric diagnoses. They manage drug addicts and schizophrenics on a daily basis.
Over the past 20 years the Medical Foundation has reached the conclusion that this experience can make a GP extremely well qualified to assess psychological symptoms in the context of a medico-legal report.
New doctors to the Medical Foundation undergo further, more specialised training in the clinical conditions of asylum seekers and refugees generally and the more technical aspects of the documentation of scars and medico-legal report writing, with special reference to the Istanbul Protocol and our own in-house publications and library. Our doctors are also taught the specialist skills required in working with interpreters. It should be pointed out that the majority of interpreters we use are also trained in-house and are expected to bring a high level of skill and dedication to the demands of working with traumatised torture survivors.
New doctors are supervised initially by experienced doctors, and all Medical Foundation doctors have an annual appraisal and attend one-day specialist academic meetings twice yearly as well as monthly lunchtime clinical meetings. All Medical Foundation doctors are actively encouraged to consult their colleagues on particular cases and more generally to share their thoughts and experiences with colleagues.
Thus, whilst each report is the product of a specially trained doctor, it is also prepared on the basis of the Medical Foundation's collective experience and expertise over more than 20 years of writing medico-legal reports for the courts.

Professional and Expert Reports

There has been considerable discussion of the relative weight that should be attached to 'professional' and 'expert' reports. Essentially an expert report is that of an impartial, experienced practitioner who sees the subject only for the purpose of preparing a report. In Medical Foundation cases, this is usually two appointments but may be more if the complexity of the case requires. A professional report is that provided by a clinician treating the patient. In Medical Foundation cases this is likely to be based on a number of treatment sessions over a prolonged period, as required by psychological therapies.
We are aware that both types of report have been criticised; expert reports for being based on too short, and therefore on an apparently incomplete acquaintance with the subject, and the professional report for being based on too long, and therefore on a biased and subjective knowledge of the person who has now become the clinician's patient.
At the Medical Foundation we acknowledge both these points and the time constraints inherent upon all parties, including those preparing reports, in a system trying to make asylum decisions within a reasonable time frame. The majority of Medical Foundation reports are expert reports, and our doctors are trained to make as full an assessment as possible in the time available. In fact, doctors' training tends to make them well able to assess critical points within the time available: 'Does this patient need urgent transfer to hospital?' 'Will they commit suicide before I can get them an appointment to see a psychiatrist?' This has become known as "see and treat" and has developed to a science within Accident and Emergency procedures.
Where a patient has already been in treatment for some time, or where it becomes apparent that a full picture of the impact of the trauma on them can emerge only during therapy, a professional report is preferred, as it will provide far better information for the court. In preparing professional reports a clinician is still aware of his or her duties to the court. Increasingly, the Medical Foundation may also produce an 'interim' expert report setting out briefly what it is anticipated may emerge through a longer, therapeutic relationship. This accords with the New Asylum Model philosophy of seeking the best evidence available at the earliest opportunity. It

may be that an interim report will be sufficient to allow the first instance decision maker or immigration judge to reach a decision. If not, then the interests of justice may be served by waiting for a further report. The Medical Foundation considers that it would be clinically inappropriate (to say the least) to create a culture of dependent patients, hanging onto therapy in the hope that the longer they spend in our care the greater their chance of asylum. However, some of those referred to us when first seen are simply too unwell, physically or mentally, for our doctors to complete their report in two sessions or so. In such cases an interim expert report or an expert report with recommendations that additional reports be obtained from treating professionals may be issued. In the latter case the interim report will generally specify the specialist area(s) of concern, such as neurology, clinical psychology, psychiatry, psychotherapy or counselling.

Dr Juliet Cohen Head of Medical Services
David Rhys Jones Refugee Policy Officer
2 June 2006

ISTANBUL PROTOCOL: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UNHCHR, 2004 (Excerpt)

...Introduction

...The Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is intended to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body.

...CHAPTER III

LEGAL INVESTIGATION OF TORTURE

...C. Procedures of a torture investigation

The investigator must adapt the following guidelines according to the particular situation and purpose of the evaluation...

...4. Medical evidence III C Procedures of a Torture Investigation paras 103-105

...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?...(p22)

...CHAPTER IV

GENERAL CONSIDERATIONS FOR INTERVIEWS

... A. Purpose of inquiry, examination and documentation

... 122. 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.

... L. Interpretation of findings and conclusions

157. Physical manifestations of torture may vary according to the intensity, frequency and duration of abuse, the torture survivor's ability to protect him or herself and the physical condition of the detainee prior to the torture. Other forms of torture may not produce physical findings, but may be associated with other conditions. For example, beatings to the head that result in loss of consciousness can cause post-traumatic epilepsy or organic brain dysfunction. Also, poor diet and hygiene in detention can cause vitamin deficiency syndromes.

158. Certain forms of torture are strongly associated with particular sequelae. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction.

Trauma to the genitals is often associated with subsequent sexual dysfunction.

159. It is important to realize that torturers may attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with wide, blunt objects, and torture victims are sometimes covered with a rug, or shoes in the case of falanga, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also forms of torture with the intention of producing maximal pain and suffering with minimal evidence.

For the same reason, wet towels are used with electric shocks.. (p31)

...CHAPTER V

PHYSICAL EVIDENCE OF TORTURE

161. Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person has been tortured.

However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.

162. A medical evaluation for legal purposes should be conducted with objectivity and impartiality. The evaluation should be based on the physician's clinical expertise and professional experience. The ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When possible, clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned and the common after-effects of torture. The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons. The physician should not assume that the official requesting a medical-legal evaluation has related all the material facts.

It is the physician's responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medical-legal report under any circumstance (p.33)

D. Examination and evaluation following specific forms of torture

187. The following discussion is not meant to be an exhaustive discussion of all forms of torture, but it is intended to describe in more detail the medical aspects of many of the more common forms of torture. 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. The following terms are generally used:

(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.

188. 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 (see chapter IV, sect. G, for a list of torture methods)... (p.36.7)

...CHAPTER VI

PSYCHOLOGICAL EVIDENCE OF TORTURE

... C. The psychological/psychiatric evaluation

1. Ethical and clinical considerations

... 261. Psychological evaluations provide useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims and as testimony in human rights investigations.

The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the individual's history, a mental status examination; an assessment of social functioning and the formulation of clinical impressions (see chapters III, sect. C, and IV, sect. E). A psychiatric diagnosis should be made, if appropriate. Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable for any evaluation of torture to include a psychological assessment.

... (k) Clinical impression

287. In formulating a clinical impression for the purposes of reporting psychological evidence of torture, the following important questions should be asked:

(i) Are the psychological findings consistent with the alleged report of torture?

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

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

(iv) What are the coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?

(v) Which physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture or detention;

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

288. Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. 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 should be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should be noted. Additional factors should be considered, such as forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, family and social status. The relationship and consistency between events and symptoms should be evaluated and described. Physical conditions, such as head trauma or brain injury, may require further evaluation. Neurological or neuropsychological assessment may be recommended.

289. If the survivor has symptom levels consistent with a DSM-IV or ICD-10 psychiatric diagnosis, the diagnosis should be stated. More than one diagnosis may be applicable. Again, it must be stressed that even though a diagnosis of a trauma-related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured. A survivor of torture may not have the level of symptoms required to meet diagnostic criteria for a DSM-IV or ICD- 10 diagnosis fully. In these cases, as with all others, the symptoms that the survivor has and the torture story that he or she claims to have experienced should be considered as a whole. The degree of consistency between the torture story and the symptoms that the individual reports should be evaluated and described in the report.

290. It is important to recognize that some people falsely allege torture for a range of reasons and that others may exaggerate a relatively minor experience for personal or political reasons. The investigator must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess. Inconsistencies in testimony can occur for a number of valid reasons, such as memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time or fragmentation and repression of traumatic memories.

Effective documentation of psychological evidence of torture requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report. If the interviewer suspects fabrication, additional interviews should be scheduled to clarify inconsistencies in the report. Family or friends may be able to corroborate details of the story. If the clinician conducts additional examinations and still suspects fabrication, the clinician should refer the individual to another clinician and ask for the colleague's opinion. The suspicion of fabrication should be documented with the opinion of two clinicians...

... ANNEX I

Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

...6... (b) The medical expert shall promptly prepare an accurate written report, which shall include at least the following:

(i) Circumstances of the interview: name of the subject and name and affiliation of those present at the examination; exact time and date; location, nature and address of the institution (including, where

appropriate, the room) where the examination is being conducted (e.g., detention centre, clinic or house); circumstances of the subject at the time of the examination (e.g., nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner or threatening statements to the examiner); and any other relevant factors;

(ii) History: detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, times when torture or ill treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

(iii) Physical and psychological examination: record of all physical and psychological findings on clinical examination, including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(iv) Opinion: interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment and/or further examination shall be given;

(v) Authorship: the report shall clearly identify those carrying out the examination and shall be signed...(p.60)

... ANNEX IV

Guidelines for the medical evaluation of torture and ill-treatment

... XII. Interpretation of findings

1. Physical evidence

A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.

B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)

C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.

2. Psychological evidence

A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.

B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.

C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual?

D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.

E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

XIII. Conclusions and recommendations

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.

2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.

3. Provide any recommendations for further evaluation and care for the individual.

UNHCR Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees, Reedited, Geneva, January 1992, UNHCR 1979 (Excerpt)

[...]PART TWO – Procedures for the Determination of Refugee Status

B. ESTABLISHING THE FACTS

(1) Principles and methods

195. *The relevant facts of the individual case will have to be furnished in the first place by the applicant himself.* It will then be up to the person charged with determining his status (the examiner) to assess the validity of any evidence and the credibility of the applicant's statements.

196. It is a general legal principle that the burden of proof lies on the person submitting a claim. Often, however, an applicant may not be able to support his statements by documentary or other proof, and cases in which an applicant can provide evidence of all his statements will be the exception rather than the rule. In most cases a person fleeing from persecution will have arrived with the barest necessities and very frequently even without personal documents. Thus, *while the burden of proof in principle rests on the applicant, the duty to ascertain and evaluate all the relevant facts is shared between the applicant and the examiner.* Indeed, in some cases, it may be for the examiner to use all the means at his disposal to produce the necessary evidence in support of the application. Even such independent research may not, however, always be successful and there may also be statements that are not susceptible of proof. In such cases, *if the applicant's account appears credible, he should, unless there are good reasons to the contrary, be given the benefit of the doubt.*

197. The requirement of evidence should thus not be too strictly applied in view of the difficulty of proof inherent in the special situation in which an applicant for refugee status finds himself. Allowance for such possible lack of evidence does not, however, mean that unsupported statements must necessarily be accepted as true if they are inconsistent with the general account put forward by the applicant.

198. A person who, because of his experiences, was in fear of the authorities in his own country may still feel apprehensive vis-à-vis any authority. He may therefore be afraid to speak freely and give a full and accurate account of his case.

199. While an initial interview should normally suffice to bring an applicant's story to light, *it may be necessary for the examiner to clarify any apparent inconsistencies and to resolve any contradictions in a further interview, and to find an explanation for any misrepresentation or concealment of material facts.* Untrue statements by themselves are not a reason for refusal of refugee status and it is the examiner's responsibility to evaluate such statements in the light of all the circumstances of the case.

200. An examination in depth of the different methods of fact-finding is outside the scope of the present Handbook. It may be mentioned, however, that basic information is frequently given, in the first instance, by completing a standard questionnaire. Such basic information will normally not be sufficient to enable the examiner to reach a decision, and one or more personal interviews will be required. It will be necessary for the examiner to gain the confidence of the applicant in order to assist the latter in putting forward his case and in fully explaining his opinions and feelings. In creating such a climate of confidence it is, of course, of the utmost importance that the applicant's statements will be treated as confidential and that he be so informed.

201. Very frequently the fact-finding process will not be complete until a wide range of circumstances has been ascertained. Taking isolated incidents out of context may be misleading. *The cumulative effect of the applicant's experience must be taken into account.* Where no single incident stands out above the others, sometimes a small incident may be "the last straw"; and although no single incident may be sufficient, all the incidents related by the applicant taken together, could make his fear "well-founded" (see paragraph 53 above).

202. Since the examiner's conclusion on the facts of the case and his personal impression of the applicant will lead to a decision that affects human lives, he must apply the criteria in a spirit of justice and understanding and his judgement should not, of course, be influenced by the personal consideration that the applicant may be an "undeserving case".

(2) Benefit of the doubt

203. After the applicant has made a genuine effort to substantiate his story there may still be a lack of evidence for some of his statements. As explained above (paragraph 196), it is hardly possible for a refugee to "prove" every part of his case and, indeed, if this were a requirement the majority of refugees would not be recognized. It is therefore frequently necessary to give the applicant the benefit of the doubt.

204. The benefit of the doubt should, however, only be given when all available evidence has been obtained and checked and when the examiner is satisfied as to the applicant's general credibility. The applicant's statements must be coherent and plausible, and must not run counter to generally known facts.

(3) Summary

205. The process of ascertaining and evaluating the facts can therefore be summarized as follows:

(a) The applicant should:

(i) Tell the truth and assist the examiner to the full in establishing the facts of his case.

(ii) Make an effort to support his statements by any available evidence and give a satisfactory explanation for any lack of evidence. If necessary he must make an effort to procure additional evidence.

(iii) Supply all pertinent information concerning himself and his past experience in as much detail as is necessary to enable the examiner to establish the relevant facts. He should be asked to give a coherent explanation of all the reasons invoked in support of his application for refugee status and he should answer any questions put to him.

(b) The examiner should:

(i) Ensure that the applicant presents his case as fully as possible and with all available evidence.

(ii) Assess the applicant's credibility and evaluate the evidence (if necessary giving the applicant the benefit of the doubt), in order to establish the objective and the subjective elements of the case.

(iii) Relate these elements to the relevant criteria of the 1951 Convention, in order to arrive at a correct conclusion as to the applicant's refugee status...

Practice Direction: Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal – Part 4 Section10: Expert evidence

[...]PART 4

PRACTICE DIRECTIONS FOR THE IMMIGRATION AND ASYLUM CHAMBER OF THE FIRST-TIER TRIBUNAL AND THE UPPER TRIBUNAL

... 10 Expert evidence

10.1 A party who instructs an expert must provide clear and precise instructions to the expert, together with all relevant information concerning the nature of the appellant's case, including the appellant's immigration history, the reasons why the appellant's claim or application has been refused by the respondent and copies of any relevant previous reports prepared in respect of the appellant.

10.2 It is the duty of an expert to help the Tribunal on matters within the expert's own expertise. This duty is paramount and overrides any obligation to the person from whom the expert has received instructions or by whom the expert is paid.

10.3 Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation.

10.4 An expert should assist the Tribunal by providing objective, unbiased opinion on matters within his or her expertise, and should not assume the role of an advocate.

10.5 An expert should consider all material facts, including those which might detract from his or her opinion.

10.6 An expert should make it clear:-

(a) when a question or issue falls outside his or her expertise; and

(b) when the expert is not able to reach a definite opinion, for example because of insufficient information.

10.7 If, after producing a report, an expert changes his or her view on any material matter, that change of view should be communicated to the parties without delay, and when appropriate to the Tribunal.

10.8 An expert's report should be addressed to the Tribunal and not to the party from whom the expert has received instructions.

10.9 An expert's report must:-

(a) give details of the expert's qualifications;

(b) give details of any literature or other material which the expert has relied on in making the report;

(c) contain a statement setting out the substance of all facts and instructions given to the expert which are material to the opinions expressed in the report or upon which those opinions are based;

(d) make clear which of the facts stated in the report are within the expert's own knowledge;

(e) say who carried out any examination, measurement or other procedure which the expert has used for the report, give the qualifications of that person, and say whether or not the procedure has been carried out under the expert's supervision;

(f) where there is a range of opinion on the matters dealt with in the report:

(i) summarise the range of opinion, so far as reasonably practicable, and

(ii) give reasons for the expert's own opinion;

(g) contain a summary of the conclusions reached;

(h) if the expert is not able to give an opinion without qualification, state the qualification; and

(j) contain a statement that the expert understands his or her duty to the Tribunal, and has complied and will continue to comply with that duty.

10.10 An expert's report must be verified by a Statement of Truth as well as containing the statements required in paragraph 10.9(h) and (j).

10.11 The form of the Statement of Truth is as follows:-

"I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion".

10.12 The instructions referred to in paragraph 10.9(c) are not protected by privilege but cross-examination of the expert on the contents of the instructions will not be allowed unless the Tribunal permits it (or unless the party who gave the instructions consents to it). Before it gives permission the Tribunal must be satisfied that there are reasonable grounds to consider that the statement in the report or the substance of the instructions is inaccurate or incomplete. If the Tribunal is so satisfied, it will allow the cross-examination where it appears to be in the interests of justice to do so.

10.13 In this Practice Direction:-

"appellant" means the party who is or was the appellant before the First-tier Tribunal; and

"respondent" means the party who is or was the respondent before the First-tier Tribunal.

Joint Presidential Guidance Note 2 of 2010: Child, vulnerable adult and sensitive appellant guidance (Excerpt)

1. This guidance, which covers appellants and witnesses, has been developed for the First Tier Immigration and Asylum Chamber following the Guidance issued by the Senior President of Tribunals regarding Child, Vulnerable Adult and Sensitive Witnesses1. Although specific to these groups it is also a reminder of good judgecraft.

2. Although some individuals are by definition vulnerable[160] others are less easily identifiable. Factors to be taken into account include: mental health problems; social or learning difficulties; religious beliefs and practices, sexual orientation, ethnic social and cultural background; domestic and employment circumstances; physical disability or impairment that may affect the giving of evidence.

3. The consequences of such vulnerability differ according to the degree to which an individual is affected. It is a matter for you to determine the extent of an identified vulnerability, the effect on the quality of the evidence and the weight to be placed on such vulnerability in assessing the evidence before you, taking into account the evidence as a whole.

Before the substantive hearing

4. In so far as it is possible potential issues and solutions should be identified at a CMRH or pre hearing review and the casepapers noted so that the substantive hearing can proceed with minimal exposure to trauma or further trauma of vulnerable witnesses or appellants. It is important not to assume that an individual will want specific or particular arrangements made.

5. Where there has not been a pre hearing review or CMHR or the parties were inadequately prepared these matters should in any event be considered at the commencement of the substantive hearing.

5.1 Generic

i. The primary responsibility for identifying vulnerable individuals lies with the party calling them but representatives may fail to recognise vulnerability.

...vii Consider whether expert evidence eg as to disability, age or mental health is required, particularly if there is a dispute on an issue over ability to participate in the proceedings; consider whether an adjournment would be appropriate to enable either party to obtain reports.

...5.3Vulnerable and sensitive witnesses

i. Consider any request for a single gender Tribunal but bear in mind that sensitive issues may not be the subject of questions or core to the evidence.

ii. There is no provision in our jurisdiction for support for vulnerable adults but you may consider it appropriate to suggest attendance by such an individual to assist the appellant in giving evidence.

6. In the final analysis it is the Tribunal's decision whether specific arrangements are made, what those arrangements are and whether the hearing can proceed in their absence.

The Substantive Hearing

7. Enable the appellant to have adequate time prior to the commencement of the hearing to familiarise him/herself with the hearing room and give instructions to his/her representative.

8. It may only be at the substantive hearing following service of all relevant documents including witness statements that you are able to assess whether oral evidence is required.

9. Agreement between the parties in advance of oral evidence as to the matters agreed or in dispute enables questioning to be focussed, sensitive and minimises potential trauma. If the parties have not spoken to each other, identify areas of dispute and agreement prior to commencement of oral evidence.

10. Hearing evidence

...10.2 During thehearing

i. Speak clearly and directly to the appellant/witness. Demonstrate active listening.

ii. Use plain English and avoid legal and other jargon; be sensitive to specific communication needs for reasons of language or disability.

iii. Ensure questions asked are open ended wherever possible; broken down to avoid having more than one idea or point in each question and avoid suggesting a particular answer.

iv. Curtail improper or aggressive cross examination; control the manner of questioning to avoid harassment, intimidation or humiliation. Ensure that questions are asked in an appropriate manner using a tone and vocabulary appropriate to the appellant's age, maturity, level of understanding and personal circumstances and attributes. Pay special attention to avoid re-traumatisation of a victim of crime, torture, sexual violence

v. Be sensitive to the possibility that the witness/appellant has understood the question, and, if there is a risk of confusion, check this.

vi. Ensure that adequate breaks are given during the hearing; check at intervals throughout the hearing that the appellant is comfortable and understands the proceedings; don t wait to be asked.

vii. If there is no or inadequate representation it is important that you obtain clarification of all matters of which you are unclear6.

viii. If an individual is, during the course of the hearing, identified as a vulnerable adult or sensitive witness, an adjournment may be required to enable expert evidence to be called as to the effect of this on the individual's ability to give cogent evidence of the events relied upon. Allow adequate time for the representative, if there is one, to consider and take instructions.

Be aware

ix. A person with special needs may be more easily influenced by the way information and choices are presented and there may be a tendency to guess an answer rather than say don't know.

x. People with special needs may need more time to understand and think about a question. Ensure adequate time is given to understand the question; reassure the appellant that don't understand, don't know don't remember are acceptable answers if true.

xi. People with special needs are not always used to having their views listened to and may be more easily influenced by others even when they have a different view themselves.

xii. Apparently contradictory answers may indicate a lack of understanding; a question may need to be asked in various ways to ensure understanding.

xiii. A possible power imbalance may exist between those asking the questions and the witness/appellant.

10. As evidence progresses and you become aware of changed circumstances, a short adjournment to later in the day may be appropriate to consider the format of the hearing, for both representatives to take further instructions, possibly for social services or the police to be informed. It may be that one or other of the parties is not represented and you may consider an adjournment for a longer period with an appropriate direction to enable representation in the light of the changed circumstances

10.3 Assessing evidence

Take account of potentially corroborative evidence. Be aware:

i. Children often do not provide as much detail as adults in recalling experiences and may often manifest their fears differently from adults;

ii. Some forms of disability cause or result in impaired memory;

iii. The order and manner in which evidence is given may be affected by mental, psychological or emotional trauma or disability;

iv. Comprehension of questioning may have been impaired.

Determination

11. An appellant is entitled to a clear decision with reasons.

12. Record whether the appellant had someone there to support him or her and the role played, if any.

13. The weight to be placed upon factors of vulnerability may differ depending on the matter under appeal, the burden and standard of proof and whether the individual is a witness or an appellant.

14. Consider the evidence, allowing for possible different degrees of understanding by witnesses and appellant compared to those who are not vulnerable, in the context of evidence from others associated with the appellant and the background evidence before you. Where there were clear discrepancies in the oral evidence,

consider the extent to which the age, vulnerability or sensitivity of the witness was an element of that discrepancy or lack of clarity.

15. The decision should record whether the Tribunal has concluded the appellant (or a witness) is a child, vulnerable or sensitive, the effect the Tribunal considered the identified vulnerability had in assessing the evidence before it and thus whether the Tribunal was satisfied whether the appellant had established his or her case to the relevant standard of proof. In asylum appeals, weight should be given to objective indications of risk rather than necessarily to a state of mind...

International Association of Refugee Law Judges: Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence

1. Introduction

1.1. The International Association of Refugee Law Judges (IARLJ) is committed to ensuring the provision of fair hearings and decisions to all claimants.

1.2. For the purposes of these Guidelines all references to judges include judicial and quasi-judicial decision makers.

1.2.1. These Guidelines are a tool designed to assist judges in the fulfilment of their task of ensuring that proper and adequate account is taken of all evidence, including any expert medical evidence1, within the refugee status determination process or other similar determination processes, for example immigration/migration appeals, humanitarian protection and human rights appeals, which are all matters that affect the lives of individuals directly and profoundly.

1.2.2. For the purposes of these Guidelines 'expert medical evidence' encompasses all matters relating to the physical and/or mental/psychological health/well-being of the claimant.

1.2.3. For the purposes of these Guidelines 'expert medical evidence' includes both written and oral evidence.

1.2.4. In some jurisdictions there may be no procedural provisions for expert medical evidence in place or little use is made of them. Judges should be receptive to expert medical evidence whenever it is thought helpful.

1.2.5. Any medical report or psychiatric report deserves careful and specific consideration, bearing in mind, particularly, that there may be psychological consequences from ill-treatment which may affect the evidence which is given by the applicant. Attention should be given to each and every aspect of medical reports.2 . The consideration given to a report depends on the quality of the report and the standing and qualifications of the medical or health care professional/expert. If the judge decides to reject any medical report there is a positive obligation to do more than merely state that it had been 'considered'. The decision maker must provide some meaningful discussion as to how he or she had taken account of the applicant's serious medical condition before making a negative credibility finding. The failure to do so in this case would be likely to be considered to be a 'reviewable error.'3

1

See below para 1.2.5, Section 4, and 6.(c) & (d) for elaboration of 'expert'.

2

As noted for example in *Ibrahim* [1998] INLR 511. These Guidelines address the subsequent criticism of *Ibrahim* in *HE (DRC)* *2004+ UKIAT 00321, namely that it, "was not a sound approach, of relevance to each and every medical or psychiatric report on issues of credibility, or indeed more generally. The experience of the Tribunal...since then is that the quality of reports is so variable and sadly often so poor and unhelpful, that there is no necessary obligation to give them weight merely because they are medical or psychiatric reports.

The consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor." (Para 16).

[3] See also note 8.

2. Use of Guidelines

2.1. These Guidelines should be used and considered in conjunction with any relevant guidelines on vulnerable persons. It is necessary to ensure equal treatment, with differentiation where appropriate, before the mandated asylum determination body.[4]

2.1.2. The United Nations' *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1999) represents an attempt to establish international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body. The manual includes principles for the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment.[5] For the current edition of the Istanbul Protocol see Office of the United Nations High Commissioner for Human Rights Geneva Professional Training Series No. 8/Rev.1 United Nations New York and Geneva, 2004 Istanbul Protocol *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.

[4] See for example Guideline 8 – Guideline on Procedures with Respect to Vulnerable Persons appearing before the Immigration and Refugee Board of Canada, December 2006, which aims to provide procedures for dealing with claimants who may encounter additional difficulties due to e.g. physical or mental health problems, age or gender issues.

[5] The guidelines contained within the *Istanbul Protocol* represent minimum standards.

3. The Role of Expert Medical Evidence

3.1. Expert medical evidence is obtained for one or more of the following purposes:

- to substantiate claims of ill-treatment;
- to establish a correlation between physical or psychological injuries and the alleged torture or ill-treatment;
- to explain a claimant's difficulties in giving evidence or recounting events by
    - (a) providing possible explanation(s) for inconsistencies and/or contradictions within a claimant's narrative of events;[6]
    - (b) providing possible explanation(s) for reticence or reluctance in divulging a full account of events, for example delay in divulging allegations of sexual assault and/or other forms of violence directed against an individual,[7]
- to address the possible effect of removal and return to the country of origin upon a person's physical or mental well-being or that of a family member;
- to assess treatment needs.

- to reduce the need for the claimant to give testimony about traumatic events.8

3.2. Expert medical evidence may not prove conclusively whether or not someone was tortured or had suffered serious physical or psychological injury. Rather, the medical report provides expert opinion on the degree to which the injuries or behaviour presented torture/ill-treatment.9

3.3. Expert medical evidence should form an integral part of any findings of credibility and should not be separated from other evidence.10

3.4. The judge may, in the context of the evidence as a whole, have to consider the possibility that the claimant is feigning the symptoms he or she puts forward.

[6] See for example *Feleke*, 2007 FC 539 in which it was stated that "*t+he medical assessment, which the Refugee Protection Division (RPD) accepted, stated that the Applicant suffered from "cognitive difficulties, avoidance behaviours, generalized anxiety symptoms", all of which could have provided an explanation for the Applicant's behaviour. The RPD, in finding a decision either way, with regards to credibility, had an obligation to explain how the diagnosis impacts the RPD's assessment of any discrepancies." (para 18).

[7] Supra note 2. See also *Atay v. Canada (Minister of Citizenship and Immigration)*, 2008 FC 201 at para. 16 (stating "*S+imply referring in its reasons to a psychological report addressing posttraumatic stress disorder is not sufficient; the Board must consider whether the psychological circumstance might help explain an omission, lack of detail, or confusion regarding the events if these are the exact cognitive errors referred to in the psychologist's report.").

[8] *X.E.B. (Re),* [2002] R.P.D.D. No. 230 at para 17.

[9] See for example *CASE OF R.C. v. SWEDEN (Application no. 41827/07),* European Court of Human Rights, 9 March 2010, in which the "Court notes that the forensic medical report submitted at its request has documented numerous scars on the applicant's body. Although some of them may have been caused by means other than by torture, the Court accepts the report's general conclusion that the injuries, to a large extent, are consistent with having been inflicted on the applicant by other persons and in the manner in which he described, thereby strongly indicating that he has been a victim of torture. The medical evidence thus corroborates the applicant's story." (para 53).

[10] *C.A. v. Canada (Minister of Citizenship and Immigration)*, [1997] F.C.J. No. 1082 at Para. 12 ("In this case, credibility was also the 'linchpin" to the Board's decision. Nonetheless, the Board failed to indicate, how, if at all, the psychological report was considered when making its credibility finding. The Board was obliged to do more than merely state that it had "considered" the report. It was obliged to provide some meaningful discussion as to how it had taken account of the applicant's serious medical condition before it made its negative credibility finding. The failure to do so in this case constitutes a reviewable error and justified the matter being returned to a newly appointed Board."). *Hassan v. Canada (Minister of Citizenship and Immigration)* (1999), 174 F.T.R. 288 (F.C.) (finding that the medical evidence at issue (a psychological report), formed a part of the basis for evaluating the claimant's credibility).

4. Standards to Ensure Uniformity and Consistency of Expert Medical Evidence

4.1. Expert medical evidence should include the credentials of the author of the expert medical report, including:

- medical education and clinical training;

- psychological/psychiatric training;
- medical qualification;
- membership of any professional bodies;
- experience in documenting evidence of torture/ill-treatment;
- experience of treating asylum seekers, refugees or victims of torture/ill-treatment;
- whether the expert is familiar with the *Istanbul Protocol* (see below);
- current Curriculum Vitae including relevant publications, presentations and Continuing Professional Development.

4.1.2. In situations where no formal medical training/qualification has been gained by the examiner, any relevant practical experience working with refugees/victims of torture which has culminated in the author of the report gaining expertise should be stated. However, this expertise must be recognised as having weight by a relevant authority e.g. the Minister of Health. As in all instances, circumstances peculiar to a particular country, e.g., having relatively few trained medical practitioners, should be considered.

4.2. Expert medical evidence should deal with the individual claimant's particular case so as to:

- advise on the duration, frequency and regularity of interviews and/or consultations the author of the report had with the claimant;
- advise on the examination (including the nature and the extent of) and diagnosis of the claimant, and make clear the diagnostic tests used and methodology employed;
- advise as to any suggested prescribed treatment;
- advise on the long term prognosis including;

(i) the likely impact return to country of origin could have on the claimant's physical and/or mental health including likelihood of re-traumatization;

(ii) availability of medical and psychiatric services in the country of origin;

(iii) drug availability and rehabilitation services in the country of origin;11

4.3. Expert medical evidence should be restricted to the author's area(s) of competence and expertise.

4.4. Expert medical evidence should demonstrate a critical and objective analysis of the injuries and/or symptoms displayed, rather than an unquestioning acceptance of the claimant's account of how any injuries were sustained.12

4.5. Expert medical evidence should address the relative likelihood of any other possible cause for the injury in question.

4.6. Expert medical evidence should provide an overall evaluation of all lesions and note the consistency of each lesion with a particular form of torture. However, the overall conclusion should not go further than what is commensurate with findings as detailed by the expert. That is, if all that a doctor does is say that the scarring/injury is 'highly consistent' with the claimed history, without also addressing the relative likelihood of

the few other possible causes, the report will clearly be of less potential value than if it does and an immigration judge may hold that a finding of "highly consistent" has very limited value.13

4.7. Expert medical evidence should remain impartial and refrain from giving any opinion as to the overall credibility of the claimant or of the merits of the claimant's case.

4.8. A holistic approach should be adopted to the evaluation of expert medical evidence. A report which does not contain all of the above should not be disregarded as deficient.

[11] 4.1. (b)(ii)&(iii) should only be addressed when such knowledge lies within the recognised expertise of the report's author. However a report should not be considered to be deficient if it does not include such information.

[12] *Mendez v. Canada (Minister of Citizenship and Immigration)*, 2005 FC 75 at Para 41 (stating "*t+he general rule is that while a diagnosis drawn from a claimant's account of facts already found not to be credible can be disregarded, a diagnosis drawn from independent observation of symptoms is not so easily set aside".).

5

[13] Reservations have been expressed that this could demand speculation and enumeration about a range of other possible causes. It is enough for the expert to state that there are other possible causes for the injury, and how likely they are considering what is known about the claimant's life history and experiences. The problem of this not being addressed can be seen in *RT (medical reports - causation of scarring) Sri Lanka* *2008+ UKAIT 00009 (paras 28-35).

- An objective description of the injury;
- A description of how the injury was incurred according to the claimant;
- An opinion on the consistency between the nature of the injury and the manner in which it was incurred, preferably with precise reasons;

5. Assessment of Injuries Pursuant to the *Istanbul Protocol* Criteria:

The following has been extracted from the *Istanbul Protocol* and is offered as what may be regarded as aspirational best practice. The *Istanbul Protocol* sets out in some detail the terms which should be generally used in describing/establishing the correlation between the alleged ill treatment and the injury sustained.

5.1. Visible Injuries

It is advocated that in cases of visible scarring for each lesion and the overall pattern of lesions the physician should indicate the degree of consistency between the lesion(s) and the alleged injurious conduct. The following terms, referred to as the five-fold hierarchy of degrees of consistency between the injury and "the attribution", are generally used:

(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. *14*

5.2. Non-visible Scarring

The *Istanbul Protocol* at para 287, whilst referring to cases of torture, suggests in assessing persecution/abuse/ill-treatment that the following should likewise be considered:

(a) The extent to which the psychological findings are consistent with the alleged report of torture, abuse/ill-treatment;

(b) Given the individual's circumstances the extent to which the psychological findings are expected or may be typical reactions to extreme stress;

(c) The stage at which the individual is in the course of recovery given the timeframe in relation to the torture events and the fluctuating nature of some psychological symptoms;

(d) The impact of external factors on the individual, such as ongoing persecution, forced migration, exile, loss of family and social role;

(e) Special physical conditions, such as head injury sustained during torture or detention.

5.3. Clinicians should comment on the consistency of psychological findings and the correlate with the alleged abuse. 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 should be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should be noted.

[14] This hierarchy is taken from the *Istanbul Protocol*, para 187 and has received judicial endorsement in the UK in *RT (medical reports - causation of scarring) Sri Lanka* [2008] UKAIT 00009; *SA (Somalia)* [2006] EWCA Civ 1302; *R (on the application of PB) v. Secretary of State for the Home Department* [2008] EWHC 364; and in the Republic of Ireland in *S v MJELR & Anor* [2007] IEHC 305

6. The Application of Expert Medical Evidence

6.1.

(a) Expert medical evidence should be treated as an integral element of all the evidence considered in establishing the facts15

(b) If expert medical evidence is dismissed by a decision-maker as being of little evidential value, this should be stated accompanied by appropriate reasoning.16 This is particularly the case if the expert medical evidence has been submitted by an organisation which has established itself as an objective and reliable provider of medico-legal reports in asylum or asylum related cases;

(c) A decision-maker, as a layperson, should not attempt to substitute his or her own opinion in preference to that of a reliable expert.17

[15] . See *Mibanga vs SSHD* [2005] EWCA Civ 36. See also Paragraph 42 of the UNHCR Handbook further advocating such a holistic approach to evidence.

[16] *Bains v. Canada (Minister of Employment and Immigration)* (1993), 63 F.T.R. 312 at para. 9 (F.C.)

17

Lozano Pulido, 2007 FC 209 in which in response to a decision not to give weight to a psychiatric report it was reiterated that "while members of the Refugee Protection Division have expertise in the adjudication of refugee claims, they are not qualified psychiatrists, and bring no specialized expertise to the question of the mental condition of refugee claimants." (para 28).

June 2010

CASE LAW

Case Law Excerpts

European Court of Human Rights (ECHR)

R.C. v. SWEDEN 2010 (application no. 41827/07)

... 53. Firstly, the Court notes that the applicant initially produced a medical certificate before the Migration Board as evidence of his having been tortured (see paragraph 11). Although the certificate was not written by an expert specialising in the assessment of torture injuries, the Court considers that it, nevertheless, gave a rather strong indication to the authorities that the applicant's scars and injuries may have been caused by ill-treatment or torture. In such circumstances, it was for the Migration Board to dispel any doubts that might have persisted as to the cause of such scarring (see the last sentence of paragraph 50). In the Court's view, the Migration Board ought to have directed that an expert opinion be obtained as to the probable cause of the applicant's scars in circumstances where he had made out a prima facie case as to their origin. It did not do so and neither did the appellate courts. While the burden of proof, in principle, rests on the applicant, the Court disagrees with the Government's view that it was incumbent upon him to produce such expert opinion. In cases such as the present one, the State has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture. The Court notes that the forensic medical report submitted at its request has documented numerous scars on the applicant's body. Although some of them may have been caused by means other than by torture, the Court accepts the report's general conclusion that the injuries, to a large extent, are consistent with having been inflicted on the applicant by other persons and in the manner in which he described, thereby strongly indicating that he has been a victim of torture. The medical evidence thus corroborates the applicant's story...

England and Wale Court of Appeal (EWCA)

Y (Sri Lanka) v SSHD (2009) EWCA Civ 362

[...]11. While no tribunal is bound simply to accept everything that such experts say because they have gone uncontradicted, it is well established that the tribunal must have, and must give, acceptable reasons for rejecting such evidence. Where the reason is that the evidence of one expert witness is so internally contradictory as to be unreliable, the obligation remains to make an objective decision on the rest of the evidence. Where the reason is that one expert has contradicted another, the judge may need to choose between them, but may not for that reason alone reject both.

12. Similarly, where the factual basis of the psychiatric findings is sought to be undermined by suggesting that the appellants have been exaggerating their symptoms, care is required. The factuality of an appellant's account of his or her history may be so controverted by the tribunal's own findings as to undermine the psychiatric evidence. This happens from time to time, but it did not happen here. What happened here was that the designated immigration judge himself formed the view that the appellants (who had not given oral evidence before him) had been calculatedly exaggerating the symptoms they recounted to the expert witnesses. That is in the first instance a matter for the experts themselves, a fundamental aspect of whose expertise is the evaluation of patients' accounts of their symptoms: see R(M) v IAT [2004] EWHC (Admin) 582

per Moses J. It is only if the tribunal has good and objective reason for discounting that evaluation that it can be modified or – even more radically - disregarded.

[...]23. This is only one of a series of findings which appear to be striving not to evaluate but to reject the evidence of suicidal ideation in both appellants. That evidence, taking the two psychiatrists' reports at face value, was unequivocal. But DIJ Woodcraft found reason to doubt it, first, in the want of sufficient explanation of why, having given evidence at two earlier appeal hearings, neither appellant had given evidence to him. He considered, in short, that while "it might be oppressive for them to relate their accounts of ill-treatment", both had been able to amplify their witness statements substantially. This he found "curious" in itself and a source of criticism of Dr Patterson for not going more thoroughly into how the appellants had managed to give evidence twice before.

24. In relation to Y, what Dr Patterson had written was this:

"With regard to whether [Y] is fit to give evidence, he told me he has found the experience acutely distressing in the past. He described the way in which his mind becomes numb and he is unable to concentrate.
I have observed the same mechanism at every interview with him, including the most recent.
..... being interviewed by me provoked symptoms of PTSD that is 'flashbacks' and dissociation on every occasion ...
The more formal, interrogatory manner of a hearing would be likely to be experienced as even more traumatising, especially if he were asked about the details of his ordeal because this would be an extremely powerful trigger to 'flashbacks'.
I recommend, therefore, that [Y] is not required to give further evidence as he would be retraumatised and would be unlikely, in that dissociated state of mind, to be able to give any more information than before. I think it would be particularly undermining of his mental state and current treatment if he were required to answer questions about his torture and sexual abuse."

25. With all possible respect, I do not understand how an advocate with such a report in his or her hands could responsibly tender an appellant for examination and cross-examination in proceedings in which the genuineness and intensity of their fear was an issue. Nor do I see what else Dr Patterson could reasonably have been expected to investigate. She knew perfectly well that Y had given evidence twice before, and she noted his account of how it had affected him. DIJ Woodcraft noted that Immigration Judge Craig had "not recorded ... that *Y+ had any apparent difficulty in giving evidence" on an earlier occasion; but there is no necessary inconsistency between the two things.

[...]30. I am also troubled by the recurrence, in § 113, of a critique of the expert evidence for not exploring more fully a factor that the Immigration Judge believes to be possibly significant – here Z's unsatisfactory living conditions. It is one thing to note that the psychologist deals with this but that the psychiatrists do not. It is another to call the latter fact "significant" without explaining what that word is intended to signify. If it was a significant lacuna, the right place to explore it was with Dr. Eberstein when she gave evidence, not by hinting in the determination at some oblique motive.

[...]34. With all possible respect, it is not acceptable to cherry-pick evidence like this. Given that the finding is clearly intended to be that Dr Eberstein was fixed with her initial report that neither appellant had expressed suicidal thoughts to her, Dr Patterson's evidence that they had expressed such ideas to her was distinct, was intact and had to be evaluated.

[...]37. In my judgment DIJ Woodcraft was not justified in interpreting Dr Eberstein's evidence as he did; nor in then selecting and relying on a single element of it; nor in any event in marginalising Dr Patterson's consistent evidence. There was no contrary evidence from the Home Office. In the result, whatever scepticism the judge had arrived at for himself or acquired from previous decision-makers (to whose findings he makes repeated

reference), and however discontented he was (for he makes no bones about it) with the handling of the case when it reached this court and was remitted by consent, the expert evidence before him was all one way and was materially shaken neither in terms of its authorship nor in terms of its content. The only available conclusion was that, notwithstanding the earlier finding that neither in fact faced any appreciable risk of future persecution or ill-treatment, both appellants were severely traumatised by what had happened to them as prisoners of the security forces, were frightened and seriously depressed at the prospect of return to Sri Lanka, and were likely to commit suicide if returned.[...]

HH (Ethiopia) [2007] EWCA Civ 306

...17. The first ground which is pursued orally this morning is that the Immigration Judge was wrong to disregard, as he said he did, the doctor's view that the appellant had been the victim of imprisonment and beatings. Mr Bazini, in response however to questions from this court, accepted that it was not for the doctor to reach an overall conclusion on the credibility or otherwise of the victim's account. The most that any doctor could say was the physical and psychological condition of an appellant was consistent with her story. Mr Bazini says that was all the doctor was doing in her report in this case.

18. I entirely agree that that is all that a medical report should do, but in fact the doctor in this case at paragraph 19 did purport to go further than that and did purport to pronounce on the credibility of the person's account which had been given to her. In my judgment she should not have done so. That is not the function of a medical expert. It is the task of the Immigration Judge to look at all the evidence, including the medical report, and to arrive at a conclusion on credibility...

...23. Next the appellant criticises the AIT for saying that Dr Hiley was not a psychiatrist or someone with other specialist psychiatric training and yet not mentioning that, according to her curriculum vitae, her experience included psychiatry. However, all that the AIT was doing was upholding the Immigration Judge's entitlement to attach little weight to Dr Hiley's diagnosis of PTSD because of her lack of a specialist psychiatric qualification. Mr Bazini says that the judge was wrong to attach little weight to that diagnosis of PTSD and wrong to say that the doctor should have considered other possible causes of the appellant's depression. I disagree. He was entitled to comment as he did, especially since the diagnosis was very largely dependent on assuming that the account given by the appellant was to be believed. I could see no error of law here.

24. Standing back and looking at the medical evidence in this case in the round, it seems to me that the Immigration Judge and the AIT were fully entitled to regard it as being of little real significance when it came to deciding whether or not the appellant's story was true. Physical scarring, according to Dr Hiley, was not something which one would expect from the injuries described. As for the appellant's mental state, there was no specialist evidence from a qualified psychiatrist. The report simply provides no basis for finding any legal error in the decision on credibility arrived at by the Immigration Judge or in the decision of the AIT...

SA SOMALIA [2006] EWCA Civ 1302

...Discussion

... All that Dr Madan's report does is to show that the account by the appellant to the adjudicator as to his treatment is consistent with the later account given to the doctor, without adding any additional confirmation or expert indication on the doctor's part as to the inherent likelihood that such explanations are true.

27. In my view, such a report is inadequate for the task it is tendered to perform, namely to corroborate and/or lend weight to the account of the asylum seeker by a clear statement as to the consistency of old

scars found with the history given. In this context the expert question of consistency should not be left to the adjudicator as a matter of inference or construction.

28. In any case where the medical report relied on by an asylum seeker is not contemporaneous, or nearly contemporaneous, with the injuries said to have been suffered, and thus potentially corroborative for that very reason, but is a report made long after the events relied on as evidence of persecution, then, if such report is to have any corroborative weight at all, it should contain a clear statement of the doctor's opinion as to consistency, directed to the particular injuries said to have occurred as a result of the torture or other ill treatment relied on as evidence of persecution. It is also desirable that, in the case of marks of injury which are inherently susceptible of a number of alternative or "everyday" explanations, reference should be made to such fact, together with any physical features or "pointers" found which may make the particular explanation for the injury advanced by the complainant more or less likely.

29. In cases where the account of torture is, or is likely to be, the subject of challenge, Chapter Five of the United Nations Document, known as the Istanbul Protocol, submitted to the United Nations High Commissioner for Human Rights on 9 August 1999 (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) is particularly instructive. At paras 186-7, under the heading "D. Examination and Evaluation following specific forms of Torture" it states:

"186... For each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution:

(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 anyway other than that described.

187. 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 (see Chapter IV.G for a list of torture methods)."

30. Those requested to supply medical reports supporting allegations of torture by asylum claimants would be well advised to bear those passages in mind, as well as to pay close attention to the guidance concerning objectivity and impartiality set out at paragraph 161 of the Istanbul Protocol.

...

33. In this case, if one has regard simply to that section of the adjudicator's decision headed "Determination and Reasons", it is open to criticism in the light of "Mibanga" that, as a matter of form, the content of the medical report is dealt with as an "add-on", following the section in which, as a result of an examination of the evidence of the appellant, the adjudicator found him to lack credibility and to have fabricated his case. Considered on that narrow basis, there appears to have been a breach of the approach prescribed in Mibanga, namely that medical evidence corroborative or potentially corroborative of an appellant's account of torture and/or fear of persecution should be considered as part of the entire package of evidence to be taken into account on the issue of credibility...

...LORD JUSTICE WILSON

24. It seems to me to be axiomatic that a fact-finder must not reach his or her conclusion before surveying all the evidence relevant thereto. Just as, if I may take a banal if alliterative example, one cannot make a cake with only one ingredient, so also frequently one cannot make a case, in the sense of establishing its truth, otherwise than by combination of a number of pieces of evidence. Mr Tam, on behalf of the Secretary of State, argues that decisions as to the credibility of an account are to be taken by the judicial fact-finder and that, in their reports, experts, whether in relation to medical matters or in relation to in-country circumstances, cannot usurp the fact-finder's function in assessing credibility. I agree. What, however, they can offer, is a factual context in which it may be necessary for the fact-finder to survey the allegations placed before him; and such context may prove a crucial aid to the decision whether or not to accept the truth of them. What the fact-finder does at his peril is to reach a conclusion by reference only to the appellant's evidence and then, if it be negative, to ask whether the conclusion should be shifted by the expert evidence. Mr Tam has drawn the court's attention to a decision of the tribunal dated 5 November 2004, namely HE (DRC - Credibility and Psychiatric Reports) [2004] UKIAT 00321 in which, in paragraph 22, it said: "Where the report is specifically relied on as a factor relevant to credibility, the Adjudicator should deal with it as an integral part of the findings on credibility rather than just as an add-on, which does not undermine the conclusions to which he would otherwise come."

25. In my view such was the first error of law into which the adjudicator fell. She addressed the medical evidence only after articulating conclusions that the central allegations made by the appellant were, in her extremely forceful if rather unusual phraseology, 'wholly not credible'. Furthermore she said that she considered that the evidence did not assist her because of her belief that the scars could well be reflective only of illness or disease. Although I accept that the fact that the appellant had identified only two of the scars as being thus reflective did not establish that the others were inflicted in the course of torture, it does -- and here I choose my words with care in the light of what I will be proposing to my Lords as the proper disposal of the appeal -- seem at first a little unlikely that, to take one example, the scars underneath the penis were the result of illness or disease rather than of the torture of the genitals, with which, by reference to a book on the medical documentation of torture, the doctor had regarded them as consistent. Unusually the adjudicator's determination had not included the usual express reminder to herself of the requisite standard of proof. Had she had the standard even more in the forefront of her mind; had she in particular considered the scars on the penis and also, perhaps, the multiple linear scars on the back; and above all, had she conducted her reference to the doctor's evidence at the right forensic time; then it is at least possible that she would have come to a different conclusion.

...

29. LORD JUSTICE BUXTON: In his careful submissions, Mr Tam urged that a broad and not a technical approach should be taken to an adjudicator's decision and to the reasons that he or she sets out. I respectfully agree. That restraint on the part of the appellate court is especially important when, as is now the case, an appeal to the Immigration Appeal Tribunal is on a point of law only. Where, as in this case, complaint is made of the reasoning of an adjudicator in respect of a question of fact (that is to say credibility), particular care is necessary to ensure that the criticism is as to the fundamental approach of the adjudicator, and does not merely reflect a feeling on the part of the appellate tribunal that it might itself have taken a different view of the matter from that that appealed to the adjudicator.

30. For the reasons given by my Lord, this case does meet that criterion. The adjudicator's failing was that she artificially separated the medical evidence from the rest of the evidence and reached conclusions as to credibility without reference to that medical evidence; and then, no doubt inevitably on that premise, found that the medical evidence was of no assistance to her. That was a structural failing, not just an error of appreciation, and demonstrated that the adjudicator's method of approaching the evidence diverted from the procedure advised in paragraph 22 of HE, set out by my Lord.

31. Further, though perhaps lest obviously, I agree that if an expert's view is to be rejected in the conclusive terms adopted by the adjudicator in this case, then proper procedure requires that at least some explanation is given of the terms and reasons for that rejection.

32. These failings were errors of law or principle, and not just the basis for a criticism of the adjudicator's actual finding of fact. The Immigration Appeal Tribunal should have recognised that, and thus quashed the adjudicator's determination and remitted the case for rehearing: an order which, as proposed by my Lord, this court should now make...

United Kingdom Upper Tribunal (UKUT)

RR (Challenging evidence) Sri Lanka [2010] UKUT 000274 (IAC)

...Guidance

In a case where there are obvious but not necessarily determinative difficulties in an appellant's oral evidence the Tribunal is likely to be helped considerably by independent expert evidence that supports the appellant's story.

If the respondent seeks to challenge such evidence then, ideally, the challenge should be supported by evidence put before the Tribunal.

If the appellant or expert chooses to give oral evidence then the respondent's cross examination should fearlessly and clearly include the suggesting to the appellant or expert that, for example, an injury was not caused in the way alleged by the appellant but by a different mechanism.

If the respondent does not put its case clearly it may well be very difficult for the Tribunal to decide against an appellant who has not been given an opportunity to deal with the respondent's concern.

If a party has no basis for challenging evidence so that a challenge to the evidence would appear to be abusive or foolish then that party must think very carefully before making the challenge. It will probably be fairer to abandon the point.

Findings

...

147. Whilst the fact that the appellant is scarred does not need expert evidence, the causes of such scars is a matter of expert opinion and it is clear that Dr Taghipour is of the view that the appellant could have sustained the scars in the way that he has described.

148. The apparent cigarette burns particularly interest us because it is very hard to see how injuries of that kind could be sustained unless they were inflicted deliberately.

149. It was never suggested to the appellant that the scars were the result of voluntary mutilation and there is no reason to suggest such a thing except cynicism. This is a particularly important feature in the case. Clearly the appellant is scarred. He has a row of three small round scars on his lower arm which he says are the result of torture. We dismiss as irrelevant any concerns that may arise from the appellant saying that he had scars on his hand rather than his arm. There scars are there on his arm. If the appellant really did say that they were on his hand then it was clearly the result of a slip of the tongue. They have not moved and we can see no reason why he would have made a mistake about their whereabouts or deliberately given a wrong answer.

150. We have no difficulty in accepting that the appellant is Tamil and that young Tamil men often were detained and ill-treated by the Sri Lankan authorities at the time the appellant said that he was ill-treated.

151. We do find a broad consistency in the way he had told his story. Ms Kiss has found things where the story has not been told in entirely the same way. This is why we have looked so very carefully at the interview record and it is our view that it reads more sensibly as the words of someone recalling a bad

experience that he had endured rather than recalling imperfectly an untruthful story he had learned to tell.

152. We are also satisfied from Dr Taghipour's evidence that the appellant has been knocked about. There are areas of the evidence that surprise us. It is disturbing that the medical report makes no comment on the appellant's alleged injury to his leg. However the injuries to the head on their own, and particularly with the symptoms picked up by Dr Taghipour, clearly support the appellant's claim to have been knocked about.

153. The injuries to his arm, mainly from cigarette burns, are highly suggestive of a person being tortured rather than simply being involved in a fight. We accept that Dr Taghipour does not exclude the possibility of these scars being caused in some other way but the best explanation before us is the one given by the appellant.

154. Once it is apparent that the appellant is scarred we have to ask ourselves how he came to be scarred. He says that he was tortured. The other possibilities are that the scars were the result of some innocent but unimaginable mechanism, or that they are the result of torture in very different circumstances to those advanced by the appellant. One might speculate that they were self-inflicted, presumably to promote the appellant's case. None of these explanations is beyond belief but they do not appear to us to be likely.

155. Ms Kiss was not able in her cross-examination to lay a foundation to support any suggestion that the scars were self-inflicted or otherwise the result of bad faith on the part of the appellant. As we have already mentioned it was not put to the appellant that the scars were self-inflicted or otherwise caused in a way inconsistent with the appellant's case. That implies no criticism of Ms Kiss. On the contrary, it seems to us to reflect the reality of the case.

156. In the absence of any evidence tending to suggest a different mechanism we do not see how we can fairly reject the appellant's evidence about their cause when no alternative mechanism was put to him and he was not cross-examined on the basis that he was making up his entire case.

157. We have no hesitation in saying, mindful of the low standard of proof, that on the totality of the evidence the appellant was telling the truth when he claimed to have been knocked about and to have been tortured by burning with cigarettes.[...]

BN (psychiatric evidence – discrepancies) Albania [2010] UKUT 279 (IAC)
... (1) The Tribunal is entitled to reject a clinical diagnosis that an appellant suffers from a depressive illness but it must give clear reasons for doing so which engage adequately with a medical opinion representing the judgment of a professional psychiatrist on what he has seen of the appellant.

(2) In the present case where the psychiatric evidence was being relied on to provide an explanation for admitted discrepancies in the appellant's evidence, the psychiatrists' comment on the role of depression in explaining inconsistencies could not and did not even purport to deal with all the aspects of the claim which the Immigration Judge had found incredible.

(3) On the facts of the present case even taking the diagnosis as correct, it provided no reasonable explanation for the many aspects of the appellant's evidence and behaviour which led to the rejection of his claim as credible. Accordingly, if there were any error of law in what the Immigration Judge had concluded in relation to the diagnosis, the error had no effect on the result...

United Kingdom Asylum and Immigration Tribunal (UKAIT)

RT (medical reports, causation of scarring) Sri Lanka [2008] UKAIT 00009
...Guidance

Where a medical report is tendered in support of a claim that injuries or scarring were caused by actors of persecution or serious harm, close attention should be paid to the guidance set out by the Court of Appeal in SA (Somalia) [2006] EWCA Civ 1302. Where the doctor makes findings that there is a degree of consistency between the injuries/scarring and the appellant's claimed causes which admit of there being other possible causes (whether many, few or unusually few), it is of particular importance that the report specifically examines those to gauge how likely they are, bearing in mind what is known about the individual's life history and experiences...

AJ (Assessment of medical evidence -examination of scars) Cameroon [2005] UKIAT 00060

33. That it is possible that evidence, for example of bruising and swelling, could have been provided by a report from another source, but was not provided, is not, we find, in itself a sustainable reason for rejecting or diminishing the value of the evidence that has been provided, which the Adjudicator has failed to consider and assess, either properly or at all.

34. In any event, it was not for the Adjudicator to embark upon her own medical examination and diagnosis, whether at the hearing or afterwards. Where an Adjudicator has specific skills, qualifications, knowledge and experience, then he or she should disclose that to the parties and make clear what, if any use it is intended to put them to in the course of the hearing and determination process...

XS (Kosovo- Adjudicator's conduct - psychiatric report) Serbia and Montenegro [2005] UKIAT 00093

38. The treatment of the psychiatric evidence was independently erroneous, though it stemmed from the adverse credibility conclusions. It is important to distinguish between the situation where the relevance of the psychiatric, or other medical, evidence is wholly or in part to support the truthfulness of the account given by the Claimant, and where its relevance is that the illness or condition exists, regardless of its cause. The one report may be relied on for both arguments. There are also cases and reports where the diagnostic conclusions are wholly dependent upon the history or the symptoms asserted by the Claimant, whose very truthfulness on those matters is at issue before the Adjudicator but not before the psychiatrist. The Tribunal's comments in HE (DRC) (Credibility and psychiatric reports) [2004] UKIAT 00321 are of general importance.

39. The psychiatrists here made some criticism of the concept of self-reported symptoms, in responding to Secretary of State criticisms. But the point made by the Secretary of State is clear enough, and is often obvious in many reports.

40. Where the Adjudicator erred in relation to these reports and Dr Turner's in particular, is that he failed to realise that they were seeking to address those two concerns which commonly arise: first, to what extent was their diagnosis dependant on the Appellant's account of what had happened, and second, to what extent had they deployed their experience and expertise to reach a conclusion which was objectively supportable rather than one which simply accepted symptoms which could be described but which could not be verified. The Adjudicator dealt with the issues as if Dr Turner's report was a commonplace report which simply accepted the Claimant's evidence, concluded that what he said happened had happened and accepted as equally truthful the Appellant's own description of symptoms; it is that type of report which is of such limited value in assessing credibility or illness.

41. We are very far from saying that an Adjudicator would be bound to accept the reports' conclusions however. He could still say that those issues were not persuasively addressed. But these were reports of significantly greater authority and care than is so often found. They did seek to grapple with those difficult

issues. They should have been considered on that basis. Instead, those material factors were ignored and they were dealt with as if the conclusions were simply dependant on an unqualified acceptance of whatever the Appellant told them, when the psychiatrists and Dr Turner in particular, with reason, were denying that that was so...

HE (DRC – credibility and psychiatric reports) Democratic Republic of Congo [2004] UKIAT 00321
... 16. We turn to ground two which relates to the role of the report of Dr Seear in the assessment of credibility. It is worth pointing out that the citation of what Forbes J had to say is of no assistance unless the medical report offers some corroboration for what an appellant is saying. If the report truly does offer that support it would of course be wrong to ignore it. But his comment does not suggest that medical reports should be seen as offering corroboration as a general proposition. Whether they do or not depends on the reports and the acts which it is said that they support. As to the citation of what His Honour Judge Pearl said in Ibrahim, we comment that that cannot be regarded as a sound approach, of relevance to each and every medical or psychiatric report on issues of credibility, or indeed more generally. The experience of the Tribunal over a number of years since then is that the quality of reports is so variable and sadly often so poor and unhelpful, that there is no necessary obligation to give them weight merely because they are medical or psychiatric reports. The consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor.

17. A particular difficulty arises in the contention that a report should be seen as corroborating the evidence of an applicant for protection. A doctor does not usually assess the credibility of an applicant; it is not usually appropriate for him to do so in respect of a patient or client. That is in any event the task of the fact-finder who will have often more material than the doctor, and will have heard the evidence tested. So for very good and understandable reasons the medical report will nearly always accept at face value what the patient or client says about his history. The report may be able to offer a description of physical conditions and an opinion as to the degree of consistency of what has been observed with what has been said by the applicant. But for those conditions, e.g. scarring, to be merely consistent with what has been said by the applicant, does no more than state that it is consistent with other causes also. It is not common for the phrases which indicate a higher probative value in the observed conditions to be used. That limits the weight which can be afforded to such a report when judging the credibility of the claim. Rather than offering significant separate support for the claim, a conclusion as to mere consistency generally only has the effect of not negating the claim.

18. Where the report is a psychiatric report, often diagnosing PTSD or some form of depression, there are often observations of behaviour at the interview, and a recounting of the answers given to questions about relevant conditions e.g. dreams and sleep patterns. Sometimes these answers are said to be consistent with what has been set out as the relevant history of the applicant. It is more difficult for the psychiatrist to treat what he observes as objectively verified, than it is for the description of physical conditions, because they are the more readily feigned; it is rare for a psychiatrist's report to be able to indicate that any part of the observations were undertaken in a way which makes them more objectively verifiable. It is the more difficult for there to be any verification of conditions which the psychiatrist cannot observe and for which he is wholly dependant on the applicant. The further major problem with the contention that a psychiatric report can be used to support an applicant's claim to have told the truth about the history, is that there are usually other obvious potential causes for the signs of anxiety, stress and depression. These include the fact that the applicant may be facing return to the country which he has left, at some expense to himself and family, and it may well not be a pleasant place to which to return. He may face the loss of friendships and lifestyle which he has enjoyed in the United Kingdom. There may be a loss of family contacts and of medical treatment. He may anyway suffer from some depression, without having been ill-treated in a way requiring international protection. He may have experienced difficulties other than those which he relies on for his claim. But it is very rare, and it will usually be very difficult, for a psychiatrist to assess such other factors without engaging in the

process of testing the truth of what the applicant says. This is not his task and if there is a therapeutic side to the interview, it may run counter to those aims as seen properly by the doctor.

19. Accordingly, the part which a psychiatric report can play in assisting the assessment of credibility is usually very limited indeed. It will be even rarer for the report to be or contain a factor which is of real significance in the assessment. Where the report merely recounts a history which the Adjudicator is minded to reject, and contains nothing which does not depend upon the truthfulness of the applicant, the part which it can play is negligible. In any event, and importantly, the report is unlikely to have considered other causes for what has been observed, or the possible diagnosis, if any, if the history is untrue. We must illustrate that in this case.

20. The report of Dr Seear is of no real value in assessing credibility. That is not a criticism of the report; it was not its purpose to be used in that way. He assumes, perfectly understandably, that what he has been told by the Appellant is true. He does not consider any other causes for any symptoms of depression which he records. He does not consider whether any of the matters which he observed could be feigned. Yet this was a woman of 62, not in the best of health, who had come to the United Kingdom allegedly by coincidence and by a remarkable stroke of good fortune, had found her daughter. She faced return to the Democratic Republic of Congo. It is obvious that there could be some scope for depression from that alone. Anyone living in the Democratic Republic of Congo for sixty years may well have seen events which were troubling mentally for a long while. She had an obvious possible interest in feigning or exaggerating symptoms or her descriptions of her conditions. Yet the report does not consider this. This comment, we emphasise, is not a criticism of Dr Seear: it would not have been his place to undertake such an exercise, for it is not his task as a doctor, but it is the Adjudicator's as fact-finder. Our comment is a warning against the argument addressed to us, which complained that a report was not put to a purpose for which it was not intended and which it cannot serve.

21. It is perfectly understandable, in view of the Adjudicator's finding that the Appellant planned her journey to the United Kingdom for economic reasons to join her daughter, that she would be depressed at the thought of returning, having wasted her money and having her naively entertained hopes dashed. The Democratic Republic of Congo may be far from pleasant for a 62 year-old woman and the medical facilities far worse. She may be depressed anyway. Had he been asked to assess her on the basis, as is perfectly obvious, that she had deliberately come to the United Kingdom to join her daughter here, and that the rest of her story was a fabrication, some of the diagnosis might have remained the same; it might not. An assessment of feigned or exaggerated symptoms and descriptions of conditions would have to be considered. It is difficult to see what value could be put on that report as a support for the Appellant's credibility.

22. Where the report is specifically relied on as a factor relevant to credibility, the Adjudicator should deal with it as an integral part of the findings on credibility rather than just as an add-on, which does not undermine the conclusions to which he would otherwise come. We asked Mr Bobb what part of it had been said to be of value in this respect to the Adjudicator. He was unable to say. Where an advocate seeks to support credibility findings by reference to a medical report, he must identify what about it affords support to what the claimant has said and which is not dependant on what the claimant has said...

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ENDNOTES

[1] The First Tier and Upper Tribunal (Asylum and Immigration Chambers) are referred to throughout the report as the Tribunal. The Medical Foundation for the Care of Victims of Torture is referred to throughout the report as the Medical Foundation. From 17th June 2011 the Medical Foundation for the Care of Victims of Torture will be known as Freedom from Torture.

[2] Tribunals Service, Customer Charter, Vision and Values, 12.11.2010

[3] The Immigration and Asylum Chamber President made the following statement in his submission to the Annual Report of the Senior President of the Tribunal: "*Immigration judges have an extensive training programme for induction into the jurisdiction and updating their knowledge in the light of recent developments. Training will continue to be delivered strategically with a joint committee of both tiers reviewing the topics and methods of delivery. The programme anticipates that each judge will receive five days training per annum at the appropriate level.*"
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[4] The Tribunals Service, Tribunal Procedure Committee, Terms of Reference, undated accessed 29 March 2011

[5] The Tribunals Service, Senior President's Responsibilities, The Senior President's Statutory Functions, undated accessed 29 March2011

[6] UNHCR, *Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees*, Reedited, Geneva, January 1992, UNHCR 1979, Part B Establishing the facts paras195-204
Symes M & Jorro P, *Asylum Law and Practice*, 2003, The Standard of Proof 2.1-2.10

[7] Ibid
See Part 4 for further discussion of the standard of proof.

[8] 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 (inhuman or degrading treatment or punishment) in Kacaj (01/TH/0634 19 July 2001 starred)

[9] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York Geneva, 2004

[10] The First Tier and Upper Tribunal (Asylum and Immigration Chambers) are referred to throughout the report as the Tribunal.

[11] Persecution for reasons that fall within the 1951 Refugee Convention or ill-treatment as understood in Article 3 of the European Convention on Human Rights (ECHR)

[12] Please refer to Appendix 1 for more detailed information about the methodology and the sample

[13] The findings for each section are first summarised and then explained with the use of illustrative case examples and quoted excerpts where relevant. The full findings are included in Tabular form in Appendix 2.

[14] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York Geneva, 2004

[15] UNHCR, *Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees*, Reedited, Geneva, January 1992, UNHCR 1979

[16] *Practice Direction*: Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal – Part 4 10 Expert evidence

[17] Joint Presidential Guidance Note 2 of 2010: *Child, vulnerable adult and sensitive appellant guidance*

[18] International Association of Refugee Law Judges: *Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence,* June 2010

[19] Amnesty International, *Amnesty International Report* 2010

[20] As of May 2010, 146 nations have ratified the UNCAT: International Rehabilitation Council for Torture Victims (IRCT), *What is Torture/ Convention Against Torture*

[21] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York and Geneva, 2004, para144-145 Review of torture methods

[22]Patel, N., Kellezi, B., Vara, R., Townsend, S., Christie, Z. & Williams, A, (2010) *Clinical Audit Report 2009*, London: Medical Foundation for the Care of Victims of Torture
[23] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York and Geneva, 2004
[24] A small number of Medical Foundation MLRs will be submitted as 'professional' reports where the report is prepared by the treating clinician or other professional, as opposed to an independent doctor.
[25] This figure is an estimate since the MLR invoice records and the Medical Foundation client database do not currently distinguish MLRs prepared for a first decision by UKBA and those prepared for an appeal.
[26] Rhys Jones D & Verity Smith S, *Medical Evidence in Asylum and Human Rights Appeals*, International Journal of Refugee law, Vol.16, No 3, 381-410
Peel M, *IAT Approach to Medico-Legal Reports, Medical Foundation*, September 2002 (Medical Foundation internal publication, unpublished)
Yates J, *Medico-Legal reports: Monitoring the Outcome of Asylum Applications*, December 2009 (Medical Foundation internal document, unpublished)
Cohen J, Head of Doctors, Medical Foundation MLR Service, interview
[27] The IAT is one of the predecessors of the current Tribunal (Asylum and Immigration Chamber)
[28] Peel M, IAT *Approach to Medico-Legal Reports, Medical Foundation*, September 2002 (MF internal publication, unpublished)
[29] For example Peel, M, *Problems in Medical Report Writing for Asylum Seekers* in Nicholson F and Twomey P (eds), Current Issues of UK Asylum Law and Policy, 1997 and Forrest D, *Guidelines for the Examination of Survivors of Torture*, Medical Foundation for the Care of Victims of Torture, 2000
[30] Decision makers in the former Immigration and Asylum Tribunal were known as 'Adjudicators'. In the Asylum and Immigration Tribunal which replaced the IAT they became known as Immigration Judges, a practice that has continued in the current Tribunal (Asylum and Immigration Chamber).
[31] Rhys Jones, D. & Smith, S. (2004) *Medical Evidence in Asylum and Human Rights Appeals*, International Journal of Refugee Law, Vol. 16, No. 3, pp. 381-410
[32] Yates J, *Medico-Legal reports: Monitoring the Outcome of Asylum Applications*, December 2009 (Medical Foundation internal document, unpublished). It should be noted that this research included MLRs submitted to UKBA and the Tribunal and the critique therefore relates to both UKBA and the Tribunal.
[33]Cohen J, Head of Doctors, Medical Foundation MLR Service, interview; the issues highlighted relate to letters of representation in response to decisions made both at first instance and at appeal.
[34] Please refer to Appendix 2 Tables 1a-b
[35] UKBA, *Control of Immigration: Statistics United Kingdom 2009*, August 2010, 5.2-5.4 Asylum Appeals
[36] Although other factors may impact on the rate of overturn, such as the availability of legal representation at the initial stage and the quality of that representation, it is nonetheless a matter of concern that merits further investigation.
[37] Note: Medical Foundation will only agree to prepare and submit an MLR for someone if they accept on the basis of their own independent assessment procedures that they are a survivor of torture. See Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation*, June 2006, p3
[38] Home Office, *Control of Immigration: Statistics United Kingdom 2009*, August 2010, 5.2-5.4 Asylum Appeals
[39] Please refer to Appendix 2 Table 2a
[40] Please refer to Appendix 2 Table 2a
[41] Please refer to Appendix 2 Table 1b
[42] Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation*, June 2006
[43] Please refer to Appendix 2 Table 1b
[44] Please refer to Appendix 2 Tables 3a-d
[45] UKBA Control of Immigration: *Statistics United Kingdom 2009, Home Office Statistical Bulletin 15/10*, Table 2j Asylum initial decision outcomes, excluding dependents, by country of nationality and sex, 2009
[46] Asylum Aid, *Unsustainable: the quality of decision-making in women's asylum claims*, 13 January 2010
[47] This compares with an overall rate of 28% of asylum cases allowed on appeal at the Tribunal in 2009 according to UKBA statistics. Home Office, *Control of Immigration: Statistics United Kingdom 2009*, August 2010, 5.2-5.4 Asylum Appeals
[48] Note; a number of claims are based on further grounds in addition to political opinion.

[49] Please refer to Appendix 2 Tables 4a-b
[50] UKBA, *Control of Immigration: Statistics United Kingdom 2009*, August 2010, 5.2-5.4 Asylum Appeals
[51] UKBA, *Terms of reference for the Asylum Update*, 14 January 2010 p , cited in Asylum Aid, *Unsustainable: the quality of decision-making in women's asylum claims*, 13 January 2010 p22
[52] Please refer to Appendix 2 Table 5
[53] Good A, *Anthropology and Expertise in the Asylum Courts*, 2007 Chapter 9 Weighing Expert Evidence 9.3 p216
[54] Ibid & Symes M & Jorro P, *Asylum Law and Practice*, 2003 Chapter 14 Procedure before Adjudicators and Evidence, (k) Medical Evidence 14.84
[55] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York & Geneva, 2004
[56] See Part 2; Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation*, June 2006
[57] Please refer to Appendix 2 Table 6
[58] Good A, *Anthropology and Expertise in the Asylum Courts*, 2007 Chapter 8 Assessing Credibility p187
[59] Asylum Aid, *Unsustainable: the quality of decision-making in women's asylum claims*, 13 January 2010, p 52
[60] See for example: Asylum Aid, Unsustainable: the quality of decision-making in women's asylum claims, 13 January 2010; Medical Foundation for the Care of Victims of Torture, *Right First Time? Home Office Asylum Interviewing and Reasons For Refusal Letters*, February 2004, Amnesty International UK, *Get It Right, How Home Office decision making fails refugees*, February 2004; UNHCR Quality Initiative Project, *Second Report to the Minister*, February 2006; Rhys Jones, D. & Smith, S. (2004) *Medical Evidence in Asylum and Human Rights Appeals*, International Journal of Refugee Law, Vol. 16, No. 3, pp. 381-410
[61] Good A, *Anthropology and Expertise in the Asylum Courts*, 2007 Chapter 8 Assessing Credibility p188
[62] Symes M & Jorro P, *Asylum Law and Practice*, 2003 Chapter 14 Procedure before Adjudicators and Evidence, (k) Medical Evidence 14.84
[63] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York & Geneva, 2004 IV General Considerations for Interviews A Purpose of inquiry, examination and documentation para122.
[64] Please refer to Appendix 2 Table 8a
[65] Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-legal Reports on Behalf of the Medical Foundation*, June 2006 p4-6
[66] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York & Geneva, 2004
[67] Ibid III Legal Investigation of Torture C Procedures of a Torture Investigation (4) Medical Evidence para105
[68] Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-legal Reports on Behalf of the Medical Foundation*, June 2006
[69] Please refer to Appendix 2 Table 8a
[70] Ibid
[71] Please refer to Appendix 2 Tables 8b-c
[72] Cohen J, *Errors in Recall and Credibility: Can Omissions and Discrepancies in Successive Statements Reasonably Be Said to Undermine Credibility of Testimony*? Medico-Legal Journal (2001) Vol. 69 Part 1, 25-34 and reprinted in International Journal of Refugee Law Vol .13 no3 2001
British Psychological Society, G*uidelines on memory and the law, Recommendations from the Scientific Study of Human Memory*, June 2008
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Herlihy, J., Scragg, P. & Turner, S. (2002) *Discrepancies in autobiographical memories: implications for the assessment of asylum seekers: repeated interviews study,* BMJ, 324, 324 -327
[73] Cohen J, *Errors in Recall and Credibility: Can Omissions and Discrepancies in Successive Statements Reasonably Be Said to Undermine Credibility of Testimony?* Medico-Legal Journal (2001) Vol. 69 Part 1, 25-34 and reprinted in International Journal of Refugee Law Vol .13 no3 2001
[74] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York & Geneva, 2004 VI 3k para289

[75] Cohen J, *Errors in Recall and Credibility: Can Omissions and Discrepancies in Successive Statements Reasonably Be Said to Undermine Credibility of Testimony*? Medico-Legal Journal (2001) Vol. 69 Part 1, 25-34 and reprinted in International Journal of Refugee Law Vol .13 no3 2001
[76] Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-legal Reports on Behalf of the Medical Foundation*, June 2006 p4-6
[77] American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder*s (DSM-IV)
[78] Please refer to Appendix 2 Table 8d
[79] Symes M & Jorro P, Asylum Law and Practice, 2003 Chapter 14 Procedure before Adjudicators and Evidence, (k) Medical Evidence 14.84
[80] Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-legal Reports on Behalf of the Medical Foundation*, 2 June 2006 p4-6
[81] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York & Geneva, 2004 Ibid V D para187
[82] Ibid
[83] Ibid para188
[84] Istanbul Protocol, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York & Geneva, 2004
[85] UNHCR, *Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees*, Reedited, Geneva, January 1992
[86] Please refer to Appendix 2 for relevant excerpts from the Istanbul Protocol
[87] IRCT International Rehabilitation Council for Torture Victims, *Action against torture, A practical guide to the Istanbul Protocol – for lawyers*, 2009 p3
[88] IP III C(c) para92
[89] IP III C 4 para105
[90] IP para162
[91] IP
[92] IP V D para187
[93] IP V D para188
[94] IP VI C. 1.para261
[95] IP VI 3k para288
[96] American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder*s (DSM-IV); World Health Organisation, ICD -10 *Classification of Mental and Behavioural Disorders* (ICD-10)
[97] UNHCR *Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees (UNHCR Handbook)*, Reedited, Geneva, January 1992, UNHCR 1979, para195. Please refer to Appendix 2 for relevant excerpts from the UNHCR Handbook
[98] *UNHCR Handbook* para196
[99] *UNHCR Handbook* para199
[100] *UNHCR Handbook* para204
[101] *UNHCR Handbook* para197
[102] *UNHCR Handbook* para198
[103] *UNHCR Handbook* para201
[104] Please refer to Appendix 3 for the full text of the Practice Direction
[105] Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal, *Practice Direction* – Part 4 10 Expert evidence para10.2
[106] *Practice Direction* para10.3-10.4
[107] *Practice Direction* para10.5-10.6
[108] *Practice Direction* para10.9
[109] *Practice Direction* para10.9-10.10
[110] Joint Presidential Guidance Note 2 of 2010: *Child, vulnerable adult and sensitive appellant guidanc*e, para10.2iv Please refer to Appendix 3 for relevant excerpts of the Guidance Note
[111] Ibid para10.3iii & 14
[112] International Association of Refugee Law Judges, *Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence (IARLJ Guidelines)*, June 2010
International Association of Refugee Law Judges, *Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence*, Explanatory Note, June 2010

International Association of Refugee Law Judges, *Working Party Expert Evidence*, as of August 2010
[113] *IARLJ Guidelines* para1.2.5
[114] *IARLJ Guidelines* para6.1(a)
[115] *IARLJ Guidelines* para1.2.5, 3.3, 5
[116] *IARLJ Guidelines* para3.2
[117] *IARLJ Guidelines* para4.2-4.8
[118] *IARLJ Guidelines* 4.2
[119] *IARLJ Guidelines* para4.4
[120] *IARLJ Guidelines* para4.6
[121] *IARLJ Guidelines* footnote 13
[122] *IARLJ Guidelines* para4.7
[123] *IARLJ Guidelines* paras5.1-5.2
[124] *IARLJ Guidelines* para5.3
[125] *IARLJ Guidelines* para1.2.5
[126] *IARLJ Guidelines* para6.1(b)
[127] *IARLJ Guidelines* para6.1(c)
[128] Please refer to Appendix 3 for the full text
[129] Istanbul Protocol: *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations New York Geneva, 2004
[130] That remit is broadly allied to the United Nations definition of torture and the WHO definition of organised violence, but it also takes account of the developing concept of collective violence, though due to limitations upon the expertise and resources of the Medical Foundation, cases involving many forms of collective violence are generally excluded.
[131] More clinical sessions may be needed due to any of the following reasons: multiple/ complex torture episodes to describe; clinical reasons such inability to conduct physical examination due to menstruation; the need to match a client with a particular specialist.
[132] Please refer to Appendix 3 for case law excerpts
[133] International Association of Refugee Law Judges, *Guidelines on the Judicial Approach to the Evaluation of Expert Medical Evidence, Explanatory Note*, June 2010
[134] International Association of Refugee Law Judges, *Working Party Expert Evidence*, as of August 2010
[135] Juliet Cohen, Head of doctors, Medical Foundation MLR Service, interview
[136] Ibid; the following NICE Guidelines discuss the vital role of General Practitioners in diagnosing and delivering treatment at the primary care level for both depression and PTSD: Common Mental Health Disorders: Identification and pathways to care, National Collaborating Centre for Mental Health, Commissioned by NICE, Pre-Publication draft guidance, 8 March 2011; Depression: The NICE Guideline on the Treatment and Management of Depression in Adults, By the National Collaborating Centre for Mental Health (NCCMH), Co-published by the Royal College of Psychiatrists and the British Psychological Society, 2010; NICE Guidelines, Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care, National Collaborating Centre for Mental Health (NCCMH), Commissioned by NICE, Co-published by the Royal College of Psychiatrists and the British Psychological Society, March 2005
[137] Tribunals Service, Customer Charter, Vision and Values, 12.11.2010
[138] The Immigration and Asylum Chamber President made the following statement in his submission to the Annual Report of the Senior President of the Tribunal: "*Immigration judges have an extensive training programme for induction into the jurisdiction and updating their knowledge in the light of recent developments. Training will continue to be delivered strategically with a joint committee of both tiers reviewing the topics and methods of delivery. The programme anticipates that each judge will receive five days training per annum at the appropriate level.*"
Tribunals Service, Senior President of Tribunals' Annual Report, February 2011, Immigration and Asylum Chamber: Chamber President Mr Justice (Nicholas) Blake, Training, Conferences and International Relations
[139] The Tribunals Service, Tribunal Procedure Committee, Terms of Reference, undated accessed 29 March 2011
[140] The Tribunals Service, Senior President's Responsibilities, The Senior President's Statutory Functions, undated accessed 29 March 2011
[141] Previous studies conducted from within the Medical Foundation and an ongoing audit project looking to evaluate the outcomes of MLRs, have noted the difficulty in obtaining evidence in the form of Tribunal

decisions. Determinations are issued to the asylum claimant directly and to the claimant's legal representative and are placed on the client's legal file. The Medical Foundation routinely requests information from legal representatives about the outcome of asylum claims where an MLR has been submitted. This request is attached to the completed MLR when it is returned to the claimant's legal representative. However, very few of these outcome forms are returned, with or without determinations. There is inevitably a time lag between the submission of an MLR and a decision being issued, and it may be assumed that the outcome letter is placed on the claimant's legal file with a copy of the MLR and is subsequently overlooked.

[142] This is based on an estimate from Dr Juliet Cohen, Head of Doctors, Medical Foundation MLR Service, that around half the MLRs are produced for appeal stage cases.

[143] Permission was obtained for the anonymised data obtained from these documents to be used for research purposes.

[144] This number of legal representatives contacted was limited by the time allocated for the collection of the sample and not according to a particular selective process, other than a date order with the most recent cases being prioritised. This was due to the fact that the older cases were more likely to have been put in storage and the determinations were therefore much less accessible to the legal representative.

[145] In many cases client files had been placed in storage and the cost of retrieval was felt to be prohibitive.

[146] 'Expert witness' reports are prepared by an impartial, experienced practitioner who sees the subject only for the purpose of preparing a report, and 'professional witness' reports are produced by other medical and non-medical professionals treating or otherwise involved with the subject.

[147] For further information see the section below entitled 'The Sample'.

[148] Please refer to Appendix 3 Tables 1a-b

[149] Please refer to Appendix 3 Table 2a

[150] The number of MLRs in the sample is greater than the number of determinations as in some cases more than one MLR has been submitted, from different clinicians and other professionals.

[151] Medical Foundation for the Care of Victims of Torture, *Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation*, June 2006, p7 Professional and Expert Reports

[152] Ibid

[153] Please refer to Appendix 3 Tables 3a-d

[154] Patel, N., Kellezi, B., Vara, R., Townsend, S., Christie, Z. & Williams, A, (2010) *Clinical Audit Report 2009*, London: Medical Foundation for the Care of Victims of Torture

[155] Control of Immigration, *Statistics United Kingdom 2009*, Section 2 Asylum, Table 2c Applications received for asylum, in the United Kingdom, excluding dependents, by country of nationality, age and sex, 2009

[156] Patel, N., Kellezi, B., Vara, R., Townsend, S., Christie, Z. & Williams, A, (2010) *Clinical Audit Report 2009*, London: Medical Foundation for the Care of Victims of Torture

[157] See Control of Immigration, *Statistics United Kingdom 2009*, Section 2 Asylum, Table 2c Applications received for asylum, in the United Kingdom, excluding dependents, by country of nationality, age and sex, 2009

[158] Medical Foundation for the Care of Victims of Torture, *Annual Report* 2009/10

[159] UKBA, Control of Immigration, *Immigration Statistics, 3rd Quarter 2010*

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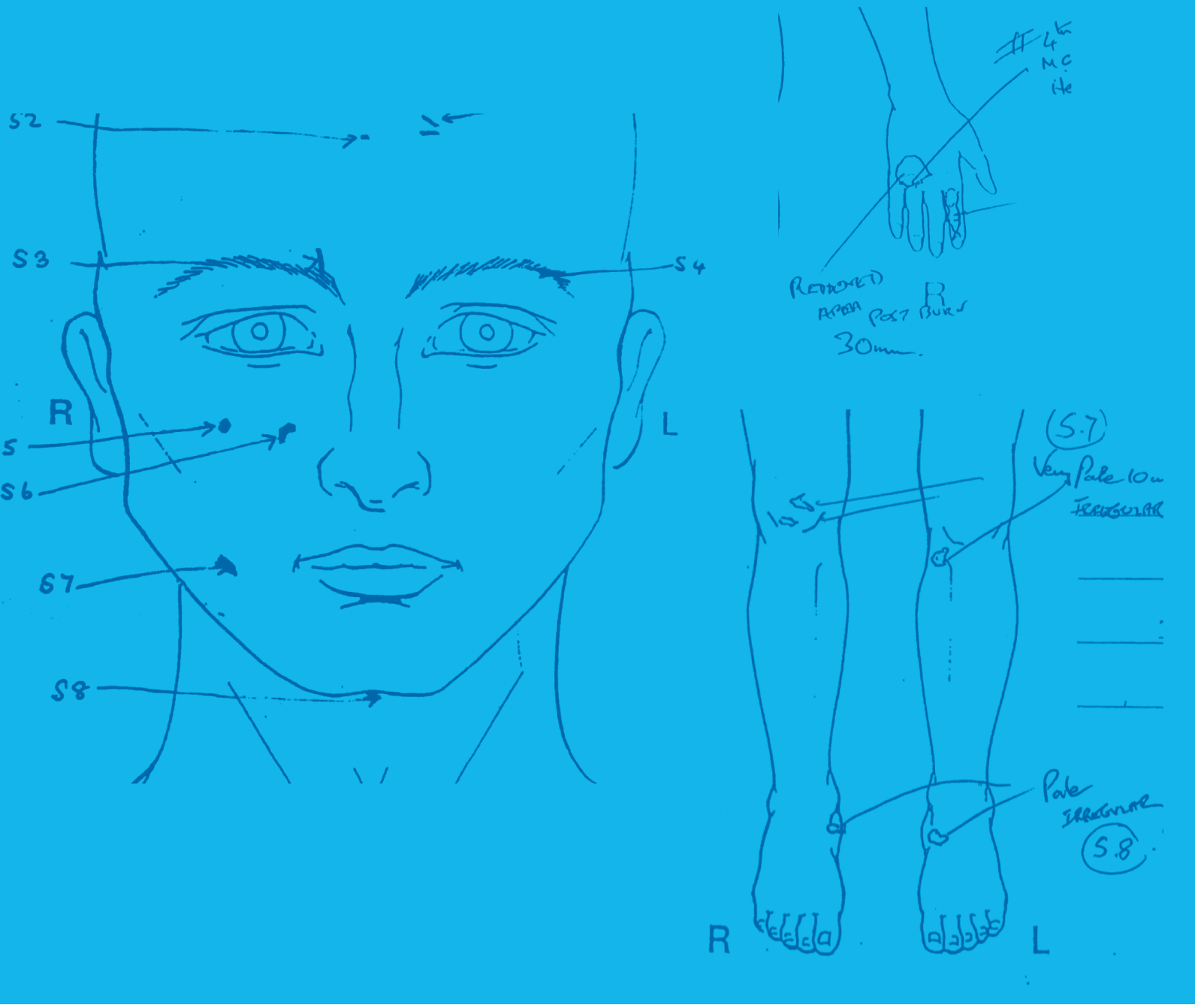
Freedom from Torture (Medical Foundation for the Care of Victims of Torture) is a human rights organisation that exists to enable survivors of torture and organised violence to engage in a healing process to assert their own human dignity and worth. Our concern for the health and well-being of torture survivors and their families is directed towards providing medical and social care, practical assistance, and psychological and physical therapy. It is also our mission to raise public awareness about torture and its consequences.



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