Detaining Torture Survivors: A Practical and Legal Analysis

PRIYA SOLANKI*

Despite international prohibition, torture is prevalent throughout the world, and victims of torture are routinely detained in the UK. Every time the UKVI detain an asylum seeker, there is a real risk they are actually detaining a victim of torture. This article examines how UK Visas and Immigration (UKVI) legally justify the incarceration of torture survivors through their policies and rules. In this article I will analyse the instruments used by the UKVI when detaining and consider how they are failing torture survivors by requiring independent evidence of torture. We will see that we are without a clear and comprehensive description of the term ‘independent evidence of torture’, and I will look at how independent medical evidence is frequently rejected or denigrated by the UKVI. Unfortunately, we will see that, even where there is independent evidence of torture, UKVI policies allow for continued detention in what is described as ‘very exceptional circumstances’. Sadly, this term is also not well defined and largely left open to interpretation. Victims of torture have often experienced the most traumatic mistreatment whilst being held captive. They are disproportionately adversely affected by detention. Being detained can be re-traumatising; it can stimulate memories of violence, their incarceration, and their abusers. It can lead to deterioration in their health. This evaluation will help to understand how the current safeguards are routinely failing to protect this fragile population from further harm and injury.

* Specialist immigration, asylum and human rights barrister at 1 Pump Court Chambers in London. Priya was called to the Bar in 2008. In November 2015 she presented this paper in an expert panel at the Birkbeck Law Conference. This topic was significant as through the use of recent case studies it allowed for real reflection upon the continuing violence and trauma facing the vulnerable asylum seeking population when in the UK. Email: ps@1pumpcourt.co.uk
Introduction

Victims of torture are routinely detained in the UK. This article examines how UK Visas and Immigration (UKVI) legally justify the incarceration of torture survivors through their policies and rules. I analyse these instruments and consider how they are failing torture survivors by requiring individuals to produce independent evidence of torture in order to avoid detention. I explore the difficulties with demanding independent evidence of torture and how medical evidence is frequently rejected or denigrated by the UKVI. I give examples of two of my recent cases, which demonstrate well the types of problems victims of torture face in struggling to escape imprisonment in the UK. This evaluation will help to understand how the current safeguards are routinely failing to protect this fragile population from further harm and injury.

Identifying Victims of Torture

The UN Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment entered into force in 1987. Article 1(1) provides a definition of torture:

For the purposes of this Convention, 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.¹

¹ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85.
Despite international prohibition, torture is prevalent throughout the world. Between 2009 and 2014, Amnesty International reported on torture and other ill-treatment in 141 countries and from every world region. Manfred Nowak, Patron of the International Rehabilitation Council for Torture Victims and former UN Special Rapporteur on Torture recently said ‘Torture is practiced in more than 90% of all countries in all regions of the world; big or small, dictatorship or democracy.’

UKVI policies make it clear that asylum seekers can be detained. In fact there is specific guidance which sets out the circumstances in which these individuals can be incarcerated and a ‘Detained Asylum Casework’ team set up to deal with the same. It is difficult to estimate the number of asylum seekers who have suffered torture. Not all victims carry the scars of their ill treatment; some are sexually assaulted, raped, electrocuted, and others are mentally abused. Victims naturally often do not wish to disclose and recall the embarrassing details of their mistreatment and it is not uncommon for individuals with mental health problems to have symptoms for years before they are diagnosed. There are real difficulties with identifying victims of torture. Every time an asylum seeker is detained, there is a real risk that a torture survivor is being imprisoned.

Requiring Independent Evidence of Torture to Avoid Detention

The UKVI policy requires an individual to provide ‘independent evidence that they have been tortured.’ Regrettably, there is no clear and comprehensive description in policy as to what independent evidence of torture means. The closest that we get to an explanation is

---


3 See, for example, UKVI Guidance, ‘Detention: Interim Instruction for cases in detention who have claimed asylum, and for entering cases who have claimed asylum in detention’, section 1, paragraph 3 (Version 2.0, 16 July 2015). See also UKVI Enforcement Instructions and Guidance, ‘Chapter 55, Detention and Temporary Release’ (1 October 2015).

4 UKVI Enforcement Instructions and Guidance (n 3) paragraph 55.10.
that it is said that the evidence ‘must have some corroborative potential (it must “tend to show”) that a detainee has been tortured, but it need not definitively prove the alleged torture.’ The same guidance gives the example of,

A report which details clear physical or mental evidence of injuries which would normally only arise as a result of torture (e.g., numerous scars with the appearance of cigarette burns to legs; marks with the appearance of whipping scars), and which records a credible account of torture, is likely to constitute independent evidence of torture.

Where ‘independent evidence’ is produced, an individual will not ‘normally be considered suitable for detention’, except in what is described in policy as ‘very exceptional circumstances.’ Again disappointingly, this term is not clarified exhaustively and as such it is largely left open to UKVI interpretation. I discuss the difficulties with this in more detail further on.

It is disturbing that a victim of torture can be detained at all. Of greater concern is the fact a sufferer is asked to provide independent proof of abuse to prevent detention because, as we will see later in this article, this requirement is very difficult to comply with. A large number of asylum seekers will simply not have independent evidence of torture. Abusers do not normally provide confirmation of mistreatment. Family and friends do not ordinarily witness the mistreatment an individual has been subjected to; more often than not victims have lost contact with these people during their journeys to the UK; and, as discussed above, in many cases medical reports cannot evidence torture for practical reasons. Where medical evidence can be helpful in documenting and detailing scarring and mental health problems, it should be considered as independent evidence of ill treatment. However, my own experiences in practice provide me with several examples of the UKVI rejecting medical evidence as independent evidence of torture. I will later discuss a couple of these cases.

---

6 ibid.
7 UKVI Enforcement Instructions and Guidance (n 3) paragraph 55.10.
Rule 35 of the Detention Centre Rules as a Safeguard for Torture Victims

The UKVI say that Rule 35 of the Detention Centre Rules 2001 and their guidance ensures that ‘vulnerable detainees are brought to [their] attention.’ Rule 34(1) states that every detained person will be given a physical and mental examination by a medical practitioner within 24 hours of admission to a detention centre. Rule 35(3) requires the medical practitioner to alert a manager, and in turn the UKVI, of any detainee where there are concerns that they may have been a victim of torture. This should lead to a review of the detainee’s detention. One would sensibly think that the initial medical examination under rule 34 would involve a consideration of rule 35 and an investigation as to whether a detainee was a torture survivor. It does not. They are two separate processes. The rule 35 examination is not completed on admission, or even soon thereafter.

The rule 35 process has failed many detainees. This has been shown time and time again, through legal challenges in the courts, inspection reports, and the Home Office’s own audit of the system. Rule 35 paperwork has been described as difficult to read, lacking in detail, and perfunctory. Reports have said that not all doctors who complete rule 35 paperwork have been trained and that caseworkers do not properly engage with reports.

Recently, one of my clients (AA) who disclosed torture and serious mental health problems to the UKVI before his detention,

---

8 ibid paragraph 55.8A. Also see UKVI Guidance, ‘Detention Services Order 17/2012, Application of Detention Centre Rule 35’, paragraphs 1-4 (22 October 2012).
9 EO & Ors, R (on the application of) v Secretary of State for the Home Department [2013] EWHC 1236 (Admin); BA, R (on the application of) v Secretary of State for the Home Department [2014] EWHC 4223 (Admin); Detention Action v Secretary of State for the Home Department [2014] EWHC 2245 (Admin).
11 ibid.
12 Her Majesty’s Inspectorate of Prisons, ‘Report on an unannounced inspection of Yarl’s Wood Immigration Removal Centre by HM Chief Inspector of Prisons’ (3-4 March 2014).
had a rule 35 completed some 20 days after he was first detained. This is far too late for an extremely vulnerable individual. In another recent case (discussed in more detail below) my client, BB, had a rule 35 report in which the doctor said ‘I have concerns that this detainee may have been the victim of torture.’ The doctor recorded an account of ill treatment, scarring on BB’s body, and said he ‘suffers with anxiety, flashbacks and has fear of... repeated abduction’. When BB’s detention was reviewed, the UKVI did not accept that the rule 35 report constituted independent evidence of torture. The report was described by the UKVI as ‘simply a record of what you said to the medical practitioner about your claimed treatment’ and the doctor did not ‘express their own reasoned concern that you may be a victim of torture.’ BB’s detention was maintained.

The UKVI’s response in BB’s case suggests that rule 35 reports are not considered as ‘independent evidence’. This then raises the question, what is the purpose of a rule 35 report? The response in BB’s case also indicates that the rule 35 report was seriously deficient. Regrettably, many rule 35 reports are all too brief. This may be the fault of the rule, as it is not prescriptive about what a report should contain. Fortunately, the UKVI guidance does give medical practitioners more direction as to what should be contained in a rule 35 report; it requires authors of reports to state why they have concerns about torture and to question about the alleged torture. However, the guidance also confirms that the rule 35 report is not an expert medico-legal report and it is not prepared by reference to internationally recognised standards and procedures on recognising and documenting symptoms of torture. This, of course, limits the value of the report.

The rule 35 report in BB’s case (prepared in 2015) was rejected owing to the doctor’s failure to set out a reasoned conclusion on BB’s claim of torture. This means the doctor did not apply the relevant guidance when completing the report; BB was punished for the doctor’s failure here. The doctor did tick a box to state that he had concerns that BB may have been the victim of torture, but this apparently was not satisfactory for the UKVI. In the case of BA, R (on the application of) v Secretary of State for the Home Depart-

---

14 Ibid paragraph 25.
a doctor ticking that box was found to be sufficient to amount to independent evidence of torture. BB’s case therefore demonstrates disregard by the UKVI of case law and their erratic approach to rule 35 reports.

**Medical Evidence as Independent Evidence of Torture**

**The Case of Malungu**

Often, asylum seekers are assisted by their representatives and medical charities in obtaining independent medical evidence. The UKVI routinely states that medical reports do not provide independent evidence of torture as they depend upon an expert accepting the account of the asylum seeker. Surprisingly, this was a view endorsed by the High Court in *Malungu, R (on the application of) v Secretary of State for the Home Department*. In *Malungu* the applicant made a fresh asylum claim following a refusal of asylum. Following her refusal of asylum she was detained pending removal. She made fresh representations for asylum, based upon a detailed and comprehensive report from a nurse from a specialist human rights charity concerning the claimant’s mental health and scarring. This indicated she was a victim of torture. The claimant had never mentioned torture or

---

16 UKVI Guidance, ‘Detention Services Order 17/2012’ (n 8) paragraph 25.
17 [2010] EWHC 684 (Admin) at 24. The scarring report provided independent evidence that the claimant bore scars in nine areas, two of which she attributed to childhood injury. Of the remaining seven, the first was judged by Ms Kralj to be ‘highly consistent’ with the explanation provided to her by the claimant of how she came by it. But it could have been caused by ‘any superficial burn with a solid instrument.’ The balance of the scars were consistent with having been intentionally inflicted by other people. It is clear, not only from the scarring report but also from the narrative part of Ms Kralj’s assessment report, that she believed the claimant, taking everything she said at face value. She was unaware of the history since the claimant’s arrival in this country including a judicial determination that she was not truthful in her accounts. Whether the scars were or were not the result of torture could only be judged by reference to the claimant’s account of what had occurred. Ms Kralj’s scarring report provided independent evidence that the claimant has the nine scars identified. It was independent evidence that seven of them were consistent with deliberately inflicted injury. But the report did not provide independent evidence that the claimant had been tortured because that depended upon accepting the claimant’s account of how they were caused.
mental illness before. The Secretary of State rejected the representations. The applicant brought judicial review proceedings on the basis that her detention was unlawful. The High Court found that the claimant’s detention was not unlawful. The Court found that the nurse’s report did not provide independent evidence of torture because although she did identify scars, the report depended upon the nurse believing the claimant’s account of the injuries causing the scars and this applicant had previously been found to be untruthful.

Of course there are inherent difficulties in establishing torture by way of expert evidence where the primary source of the information inevitably is the asylum seeker. However, medical experts do not accept accounts uncritically; they base their conclusions on diagnostic criteria, exercise their critical faculties and their experience, and they have regard to rules on expert evidence. Medical experts who practice in this field are bound to refer to The Istanbul Protocol, which is intended to provide 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.\(^{18}\) The nurse who provided the medical report in Malungu had in fact applied the Istanbul Protocol when writing her report, but despite this her report was disapproved by the High Court.

Fortunately, in 2012 the Court of Appeal found, in AM, R (on the application of) v Secretary of State for the Home Department,\(^{19}\) that Malungu was decided incorrectly. They concluded that the medical evidence did amount to independent evidence of torture, stating, Ms Kralj was an independent expert. She was expressing her own independent views. As the judge himself said, her scarring report provided independent evidence of AM’s scarring, and that seven of the scars were consistent with deliberately inflicted injury… it is evident from her assessment that she believed that AM had suffered torture and rape and that those misfortunes had rendered her the

---


\(^{19}\) AM, R (on the application of) v Secretary of State for the Home Department [2012] EWCA Civ 521.
‘grossly traumatized’ woman that she found her to be, with ‘feelings of deep and intense shame and self disgust’, ‘feelings of shame and stigmatisation’, and a ‘fragile mental state’. Those findings are Ms Kralj’s interpretation of what she found, they are not the mere assertions of AM.\(^\text{20}\)

Despite the view of the Court of Appeal in AM, the UKVI continue to reject medical evidence as independent evidence of torture.

**The Case of BB**

My client, BB, claimed to have been severely mistreated by the Sri Lankan authorities. This was as a result of suspected political activities. He fled his country and claimed asylum in the UK. A medical report from an independent practitioner concluded that he had scarring which was consistent with his account of torture. The UKVI and the Tribunal rejected this account and the medical evidence in 2011. Some time after the Tribunal rejected his claim, he disclosed that his mistreatment by the Sri Lankan authorities included sexual abuse. He was referred by his General Practitioner to a colorectal surgeon for probable rectal trauma. He was also referred to mental health services including a Consultant Psychiatrist; he was diagnosed with Post-Traumatic Stress Disorder, with symptoms of insomnia, nightmares, pseudo-auditory hallucinations associated with his trauma, and suicidal ideations. In medical evidence he was described as fearful of the dark and the authorities, including the police and sirens.

BB was referred to and seen by a charity that provides specialist clinical services to survivors of torture. It was at this stage that he fully disclosed sexual abuse he had suffered at the hands of the Sri Lankan authorities. Their medical evidence said that he provided a ‘vivid account’ of his mistreatment, which included being forced to perform fellatio to ejaculation and having plastic piping inserted into his rectum. The evidence said BB found it very hard and embarrassing to talk about his sexual abuse and was under the care of a psychological therapist and having regular appointments. It

\(^{20}\) ibid, Judgment of Lord Justice Rix, 29-32.
suggested that his rectal trauma was evidence of the physical consequences of sexual torture.

Whilst BB was under the care of medical practitioners, he was detained to effect his removal. This was in 2015. Three days after his detention, his representatives asked the UKVI to consider the range of medical evidence now available as independent evidence of torture. BB’s representatives asked there be a reconsideration of his asylum claim and that he be released from detention. The UKVI maintained their stance. Eight days later, BB was seen by a doctor provided by the UKVI in the detention centre. A positive rule 35 report was completed. BB’s representatives again asked the UKVI to reconsider the position. BB remained in detention on the basis that this did not constitute independent evidence of torture.

The legal representatives then obtained a medical report from an independent medical practitioner who visited BB in his detention centre. The doctor said that when BB was ‘recalling events of sexual torture and abuse he stared straight ahead’, his mood was ‘subjectively low and objectively low’, that his ‘displayed emotion matched what he was experiencing’, that he ‘found it very difficult to disclose information relating to sexual torture but was given time’. The doctor concluded that BB had major depressive episodes (with regard to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)) ‘compatible with [his] history of kidnap, detention, physical abuse, sexual abuse and torture’. He found that he met the full criteria, under DSM-IV, for a diagnosis of post-traumatic stress disorder (PTSD). He also concluded that the symptoms ‘of rectal pain, pain on defecation and rectal bleeding are consistent with the attributed cause’. He said that the reasons for not disclosing sexual assault earlier were ‘valid ones’ and studies showed that reporting of male rape was low owing to the associated humiliation and emotional trauma. The doctor said there was ‘nothing to suggest that he was trying to exaggerate or feign any psychological distress’. He noted that BB displayed ‘signs of distress and emotion at appropriate times’ and he ‘appeared to understate, rather than overstate his distress.’ He said that BB’s medical records showed that his ‘mental health had deteriorated since being in detention’. He said that he was engaged with therapy in the community and considered that the detention centre was unable to provide the level of care that BB required.
This report was submitted to the UKVI. The UKVI maintained detention after receipt of the same. They argued that material available on the internet demonstrated that BB’s rectal symptoms may have been caused by ‘peptic and gastric problems’ and that they are ‘not linked to sexual activity’. They also stated that the independent medical practitioner has no expertise on ill-treatment in BB’s home country (not that it was ever suggested that he did) and that ‘a diagnosis of PTSD must be made by a clinical psychiatrist’, not a General Practitioner or other medical expert. BB was detained for 50 days in total. He was eventually released by the Immigration and Asylum Tribunal following an immigration bail hearing. BB has challenged the lawfulness of his detention.

What this case demonstrates is that evidence from two independent medical practitioners, mental health services, a consultant psychiatrist, a psychological therapist and a clinician at a specialist torture charity, does not amount to independent evidence of torture. It establishes that the UKVI have not learnt from the Court of Appeal’s decision in AM. The meaning of ‘independent evidence of torture’ is lost. Perhaps it is the lack of a clear definition of this term in policy that is the problem. What can be seen is that the requirement for ‘independent evidence of torture’ is repeatedly failing these victims.

Detaining Torture Survivors in Exceptional Circumstances

Even where an individual has provided independent evidence, UKVI policy allows for a victim’s detention where there are ‘very exceptional circumstances’. Policy states that where a decision is made to detain a torture survivor, ‘the caseworker must set out the very exceptional circumstances for doing so on the file.’ As explained above, UKVI policy does not exhaustively set out the meaning of ‘very exceptional circumstances’. Policy asserts that ‘very exceptional circumstances could arise where, for example, release would create an unacceptably high risk of absconding, of reoffending or of harm to the public... The full circumstances applicable to the detainee and their reasons for detention must be considered, in order to establish

---

21 UKVI Guidance, ‘Detention: Interim Instruction’ (n 3) section 1, paragraph 3. See also UKVI Enforcement Instructions and Guidance (n 3).
whether there are very exceptional circumstances that mean detention is appropriate notwithstanding the rule 35 report.’ This broad and incomplete definition encourages the UKVI to adopt a haphazard and flippant approach.

The UKVI policy refers to the need to weigh risks to the public of releasing convicted criminal offenders, and indicates that a risk of absconding might provide reason for maintaining detention. Case law makes clear that the credibility of a torture claim is a relevant factor in considering whether there are exceptional circumstances for maintaining detention. However, it also states that these facts, which would ordinarily justify detention, would not do so without more where there is independent evidence of torture. Most torture survivors have not been convicted of any crimes and they are usually detained for administrative reasons. The UKVI has in the past misstated an individual’s risk of absconding to justify detention. The reality is that these ordinary factors are used to justify detention of torture survivors.

The Case of AA

Discussed above, my client AA’s case is a good example of the UKVI’s absurd approach to the term ‘very exceptional circumstances.’ When the rule 35 report in AA’s case was finally produced the doctor stated that she ‘had concerns that this detainee may have been the victim of torture’, that being in a confined environment ‘increases his anxiety and symptoms of PTSD’, and that if released he would be ‘better able to engage with mental health input and possible reduction in symptoms of PTSD.’ On a body map she noted that AA had ‘burns and marks from when strung up’, an ‘incised wound to finger from being cut’, and two blunt trauma scars ‘indicative of severe trauma to a small site’; she concluded the

---

22 UKVI Guidance, ‘Detention Rule 35 Process’ (n 5) Section 3.
23 UKVI Enforcement Instructions and Guidance (n 3) paragraphs 55.10, 55.14.
24 EO & Ors (n 9) 65-68.
25 ibid 68-69.
26 AM (n 21) Judgment of Lord Justice Rix, 35.
‘injuries were consistent with their explanation.’ AA was not released by UKVI after this report.

The UKVI accepted that this was independent evidence of torture. However, owing to the fact that AA had his case dismissed in 2011 and the judge found him not to be credible the UKVI concluded that the ‘injuries were not sustained in the manner claimed’ and the medical practitioner did not have access to the judge’s decision. The UKVI said that ‘in these circumstances it is considered that very exceptional circumstances exist such that continued detention remains appropriate.’

The problem was that in 2011 the judge did not have the benefit of any medical evidence, which detailed and set out AA’s scarring. There was in fact now a range of medical evidence (from a clinical psychologist, an independent medical practitioner, a general practitioner, a cognitive behavioural therapist, and the rule 35 report) all of which concluded that AA was a victim of torture. Reliance on the judge’s decision was a completely flawed approach. His decision, which pre-dated the medical reports, was not reasonably a factor that justified detention and most certainly not an exceptional factor. The range of medical evidence was not considered by the UKVI in reviewing AA’s detention. The policy of detaining in very exceptional circumstance is clearly open to misapplication and this case is one example of this.

Conclusion

Victims of torture have often experienced the most traumatic mistreatment whilst being held captive. They are disproportionately adversely affected by detention. Being detained can be re-traumatising; it can stimulate memories of the violence, their incarceration and their abusers. It can lead to deterioration in their health. The rules and policies in place should unmistakably preclude the detention of torture survivors. They do not do this and they are, in fact, frequently used or misused to justify the incarceration of this vulnerable population. Reconsider the policies, rewrite them, reeducate doctors and staff; something needs to be done to more effectively protect these victims from further distress and suffering.