Upper Tribunal
(Immigration and Asylum Chamber)

KV (scarring - medical evidence) Sri Lanka [2014] UKUT 00230 (IAC)

THE IMMIGRATION ACTS

Heard at Field House	**Determination Promulgated**
On 3 and 4 February and 3 March 2014	
	……

Before

UPPER TRIBUNAL JUDGE STOREY
UPPER TRIBUNAL JUDGE DAWSON
UPPER TRIBUNAL JUDGE KOPIECZEK

Between

KV

Appellant

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

and

THE HELEN BAMBER FOUNDATION

Interested party

Representation:

For the Appellant:	Ms C Bayati and Mr N Paramjorthy, Counsel, instructed by Vasuki Solicitors
For the Respondent:	Mr P Duffy, Senior Presenting Officer
For the Interested party:	Ms S Jegarajah and Mr C Yeo, Counsel, directly instructed

1. *When preparing medico-legal reports doctors should not – and should not feel obliged to - reach conclusions about causation of scarring which go beyond their own clinical expertise.*

2. *Doctors preparing medico-legal reports for asylum seekers must consider all possible causes of scarring.*

3. *Where there is a presenting feature of the case that raises self-infliction by proxy (SIBP) as a more than fanciful possibility of the explanation for scarring:-*

   (i) a medical report adduced on behalf of a claimant will be expected to engage with that issue; it cannot eliminate a priori or routinely the possibility of SIBP; and

   (ii) a judicial fact-finder will be expected to address the matter, compatibly with procedural fairness, in deciding whether, on all the evidence, the claimant has discharged the burden of proving that he or she was reasonably likely to have been scarred by torturers against his or her will.

4. *A lack of correlation between a claimant's account and what is revealed by a medical examination of the scarring may enable a medico-legal report to shed some clinical light on the issue of whether SIBP is a real possibility.*

5. *Whilst the medical literature continues to consider that scarring cannot be dated beyond 6 months from when it was inflicted, there is some medical basis for considering in relation to certain types of cases that its age can be determined up to 2 years.*

6. *Whilst if best practice is followed medico-legal reports will make a critical evaluation of a claimant's account of scarring said to have been caused by torture, such reports cannot be equated with an assessment to be undertaken by decision-makers in a legal context in which the burden of proof rests on the claimant and when one of the purposes of questioning is to test a claimant's evidence so as to decide whether (to the lower standard) it is credible.*

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INTRODUCTION

The general issues

1. The appellant's case raises a number of issues concerning medical evidence, in particular the issue of whether doctors and/or decision-makers, when assessing claimants who have scarring which they attribute to torture, need to consider the possibility that they have deliberately had their scarring inflicted by a third party acting with their consent. We apologise for its length but think this reflects the success of the parties in convincing us that the issues raised by the case were complex and were ones that have not been squarely addressed hitherto. From an early case management stage it became clear that the medical issues involved were ones which could potentially affect the work done by medical experts engaged in writing reports on the cases of asylum-seekers claiming to have suffered ill treatment in their country of origin. At that point Freedom from Torture (FFT), one of two organisations whose work in this field has been formally recognised by the Home Office (most recently in its Asylum Policy Instruction, Medico-Legal Reports from the Helen Bamber Foundation (HBF) and the Medical Foundation Medico-Legal Report Service, Version 3.0, 17 January 2014 which is reproduced as Appendix B of this determination), applied to intervene. Despite the Tribunal acceding to their request, they later chose to withdraw. We are fortunate that shortly after this, the HBF, the other main organisation in the field, sought to intervene and, upon our accepting them as an interested party, proceeded to submit a significant body of relevant materials covering the main issues that arise in this case. The appellant's representatives also assisted greatly. We are grateful too to Mr Duffy who took over the case at short notice. We particularly wish to record our gratitude to the doctors who gave evidence. We are acutely conscious that to do this they had to take time out from their onerous responsibilities. In the writing of the determination which follows all members of the panel have played a part.

2. We should clarify at the outset that, as we made clear at the case management stage, it is not our task in this case to re-examine the issue of the extent to which the fact that a Sri Lankan national has scarring constitutes a risk factor. This case is not a country guidance case and whilst we refer to Country of Origin Information (COI) relating to the methods of torture used by the Sri Lankan authorities – which include scarring - our concern about scarring is confined to its relevance to the credibility of an asylum claim made by someone who alleges that the authorities of his country of origin inflicted scarring on him.

Nomenclature

3. Throughout this determination we use the acronym "SIBP", which stands for self-infliction of injuries by proxy, meaning injuries caused by a third party at a person's invitation. That may not necessarily be an apt term in the asylum field where the focus is on actors of persecution or serious harm. If injuries are inflicted "by proxy" that means they have been inflicted by a third party; if inflicted by consent, then the adjective "self-inflicted" may confuse. We stick with the acronym nevertheless because that is what medical experts who gave evidence in this case

chose to call it and we are anxious not to encroach on their terrain. When we refer to claims brought by "asylum seekers" or to "asylum claims" or "asylum cases", we mean (unless otherwise clear from the context) to refer to claims or cases alleging that a person faces a real risk of persecution or of serious harm, or of ill treatment contrary to Article 3 ECHR. We should also mention that in this determination we refer to the person being examined by a doctor for the purposes of preparing a medico-legal report regarding his or her claim to have been the victim of torture variously as "individual", "alleged victim", "subject" or "patient". In so doing we reflect, we believe, usages prevalent in the medical evidence presented to us, but we would emphasise that we are of course aware that such a person will often not be receiving treatment from the doctor concerned and so may not be a "patient" in that sense.

The appellant

4. The appellant is a national of Sri Lanka born in 1982 and he appeals against the decision dated 1 April 2011 to remove him as an illegal entrant. It is his case that he arrived in the United Kingdom on 24 February 2011 on a passport in the name of another having previously applied for entry clearance as a points-based Tier 4 Student in 2005 and on two occasions in 2006. On 14 March 2011 he claimed asylum at the respondent's offices in Croydon and on 22 March 2011, he was interviewed substantively about that claim. His appeal against the removal decision was dismissed by First-tier Tribunal Judge Jhirad for reasons given in her determination dated 18 May 2011.

5. In a decision dated 7 September 2012, Upper Tribunal Judge Dawson found error in that determination and set aside the decision. A copy of his decision is at appendix A from which will be seen, he indicated that in re-making the decision, guidance would be given by the Tribunal on the approach to asylum cases where it has been asserted by the respondent that the scarring relied on in support of his claim was not caused in the manner asserted.

6. In summary, it is the appellant's claim that he had no problems with the Sri Lankan authorities until March 2007 when one of the young men he was sharing a house with in Colombo was arrested the day after Katunayake airport in Colombo was bombed. He decided to flee with a housemate, who, like the person arrested was an LTTE member, and go to Vanni, which was an LTTE-controlled area, where he stayed with relatives.

   The appellant claimed that he was arrested by the Sri Lankan authorities in May 2009 following his surrender with others to the army. He was detained in an army camp until he was able to procure his release or escape on 4 February 2011. During his prolonged detention he claims that he was ill-treated on a sustained basis including torture by heated rods being applied to his back and right arm. The respondent did not accept that these scars had been caused in the manner claimed. The appellant had presented nine photographs of that scarring at his substantive asylum interview. It appears the particular interest in him was because although not a member of the LTTE, he had assisted them with regard to their jewellery and gold. The authorities were interested in finding out the extent of the appellant's

involvement and where the LTTE had kept their gold as well as in what he knew about the whereabouts of LTTE members.

Case management and procedural issues

7. As already noted, on 9 May 2013, permission was granted to FFT to intervene as an interested party in the proceedings. On 13 August at a further case management hearing, a panel comprising Upper Tribunal Judges Storey and Dawson were informed that FFT no longer wished to intervene, essentially because of their reluctance to disclose for reasons of confidentiality the underlying data they intended to rely on in a proposed report regarding the burn scarring issue. The panel issued specific directions regarding the general issues to be addressed by the parties in the forthcoming appeal as follows:

> "8. The Tribunal proposes the following issues be addressed at the hearing in addition to the specific re-making of the decision in the appeal:
>
> Taking account of the decisions in *SA (Somalia) v SSHD* [2006] EWCA Civ 1302 and *RT v SSHD (causation of scarring)* Sri Lanka [2008] UKAIT 00009 the parties are invited to address the following matters in the context of the general issue regarding whether it is possible to distinguish between scarring arising from torture and that which results from injury brought about by consent (and with some amendment to the issues in [14] of the error of law decision):
>
> (i) whether it is possible to differentiate between burns scarring caused by hot rods or wires or similar heated instruments including cigarettes that has been brought about by torture and scarring caused by the above categories that has come about at the invitation of the person affected;
>
> (ii) whether it is possible to determine from the nature of scarring itself what if any medical intervention or palliative care has been provided to enable recovery;
>
> (iii) whether it is possible to diagnose with any precision with reference to the nature of scarring when it occurred."

8. On 26 September 2013 the HBF were granted leave to participate in proceedings as an interested party and further directions were given in anticipation of the hearing of the appeal proceeding substantively on 1 October. As matters turned out, that hearing had to be abandoned because of problems with interpretation. There were subsequent case management reviews resulting in additional directions. These included a direction to the respondent to disclose using all reasonable endeavours any evidence in her possession relating to a practice of claimants consenting to procedures, whether in Sri Lanka or elsewhere, that give rise to scarring which is subsequently relied on in asylum applications.

9. The evidence the respondent sought to rely on in compliance with that direction led to the hearing being adjourned again on 30 January.

The hearing and post-hearing: procedural issues

10. At the outset of the hearing counsel for the appellant and the HBF made an application under rule 15 of the Tribunal Procedure (Upper Tribunal) Rules 2008 to exclude a statement made by a Presenting Officer and emails between a Senior Presenting Officer and an unidentified person which the respondent had served (late) in answer to Tribunal directions. Having heard submissions we acceded to that request: not only was that evidence served late but the anecdotal nature of that evidence raised more evidential questions than it answered.

11. The same counsel also requested that the Tribunal exclude two unreported Tribunal determinations. UV and BV. In BV, decided in March 2010, the judge mentioned the possibility of SIBP but did not make a finding that this had occurred, simply holding the appellant's case "not proved". The judge had found that at the time BV said his scars were inflicted he had been in the UK for 2 years. In UV, decided in November 2011 the judge concluded in the light of damaging evidence regarding credibility that notwithstanding a medical report attributing the appellant's scarring to torture, it must have been caused by a third party at the request and with the consent of the appellant.

12. In support of their application, counsel pointed out that previous findings of fact do not set precedents for later cases except where there is a close overlap in the factual matrix (AA (Somalia) and AH (Iran) v SSHD [2007] EWCA Civ 1040. They sought to rely on the Senior President's Practice Direction of 15 February 2010 paragraph 11 on citation of unreported determinations. We decided to admit these two determinations but only insofar as they constituted two examples of determinations in which tribunal judges had seen fit to address the issue of SIBP.

13. At the hearing on 3 February, with Mr Duffy substituting for the previous Presenting Officer, we heard evidence from the appellant, his two brothers and his uncle. In addition we heard from a number of experts on the general issues set out above and specifically on the appellant's claim. We have therefore ordered our determination so that it begins with a brief account of the Istanbul Protocol, followed by a summary of the evidence of the appellant and his witnesses, the expert evidence and relevant background evidence, then submissions, before giving our conclusions on the evidence in the context of the issues to be decided. Thereafter we have turned our attention to the appellant's appeal including our further assessment of the medical evidence in so far it is specific to his claim.

14. Following completion of the hearing on 3 March, the Tribunal gave time for the appellant's representatives to produce a further medical report from an anaesthetist, Dr Allam (which was sent on 11 March (together with a supplementary statement from Mr Rhys-Jones) and received a response from Mr Duffy concerning the anaesthetist report on 19 March. On 2 April the appellant's representatives made an application under rule 15(2) of the Tribunal Procedure (Upper Tribunal) Rules 2008 to adduce further evidence which it was said had not been available at the time of the hearing. It consisted of a report by Yasmin Sooka, of The Bar Human Rights Committee of England and Wales and the International Truth and Justice Project, Sri Lanka, "An Unfinished War: Torture and Sexual

Violence in Sri Lanka 2009-2014", March 2004, relating to conditions in Sri Lanka and the use by the Sri Lanka authorities of torture. This report stated that it was based, inter alia, on 57 medico-legal reports, although none of these was appended. We decided to refuse this application. As already noted, it was made clear by the Tribunal at the case management stage that the general issues arising in this appeal were not country guidance issues and that we would not be revisiting any country guidance issues and the parties have known that this was the position throughout: see paragraph 2 above. At the hearing the appellant's representatives did not alert the Tribunal to any imminent reports on torture in Sri Lanka and in our view the Tribunal must be permitted to deal with evidence as at the date of hearing. We made an exception in relation to an anaesthetist's report and a further supplementary report from Mr Rhys Jones because they helped complete the medical picture; neither item related to conditions in Sri Lanka. Further, if we were to have admitted this report we would in fairness have had had to afford the respondent the opportunity to adduce further COI or country reports relating to the same matters. Another consideration was that insofar as this new report seeks to document that one of the methods of torture used by the Sri Lankan authorities is burning with hot metal instruments, we already had evidence that this is the case and it became clear during the hearing that the respondent accepted that this was indeed one of the methods of torture used.

The Istanbul Protocol

15. The Istanbul Protocol (hereafter "IP" or "Protocol") – the Manual on the Effective Investigation and Documentation of Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment, as revised in 2004 - has come to occupy a central role in cases in which medical evidence is sought to support claims made by asylum applicants that they have been ill treated by the authorities in their country of origin.

16. The IP deals with both physical and psychological *sequelae* of torture (i.e. conditions resulting from torture).

17. In relation to the assessment of physical scars or lesions, it is stated at paragraph 187 of the Protocol that there are 5 degrees of consistency in an ascending scale:

> "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 any way other than that described."

18. Paragraph 188 adds:

> "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)."

19. Assessment of psychological *sequelae* is dealt with in Chapter VI and at paragraph 287 therein it is said that:

> "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?"

20. At paragraph 105, which is in the chapter dealing with "Legal Investigation of Torture" (chapter III), in what seems to be an attempt to give an overview covering assessment of both physical and psychological *sequelae* (see also Annex 1), it is stated that in formulating a clinical impression for the purposes of reporting physical and psychological evidence of torture, "six important questions to ask are:

> "(a) Are the physical and psychological findings consistent with the alleged report of torture?
>
> (b) What physical conditions contribute to the clinical picture?
>
> (c) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual:
>
> (d) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where in the course of recovery is the individual?
>
> (e) What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc)? What impact do these issues have on the victim?

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

THE EVIDENCE

The Appellant

The appellant's claim at interview

21. We should explain at this stage that although the appellant is recorded by interpreters as having referred to being burnt with "hot metal wires" and sometimes to being burnt with "hot metal rods", we have accepted that the words in Sinhalese are the same and can be rendered for the purposes of this case as "hot metal rods".

22. At his screening interview on 14 March 2011 the appellant was interviewed in the usual way by the Secretary of State in order to establish his bio-data detail and method of journey to the United Kingdom. Questions for him also included enquiries as to his health (at part 3) and the basis of his claim (part 4). As to whether he had any medical conditions the appellant disclosed that he had back pain which he had suffered from for one and a half years and that the treatment he was receiving was over the counter medication in the United Kingdom, being painkillers. Against the enquiry as to the name and address of his GP, the answer recorded is "none".

23. As to his reasons for coming to the United Kingdom, the appellant is recorded as saying they were to seek safety and to seek asylum. As to his claim, he referred to having gone to Vanni after his entry clearance had been refused in Colombo to join the struggle for his community. He valued jewellery and other valuables for the LTTE. He confirmed that he had been detained in Pampai Madu Camp for one and a half years from 10 May 2009 and that he escaped on 4 February 2011. The appellant also referred to the presence of his two brothers N V and P V in the United Kingdom.

24. On 22 March, as noted above, the appellant produced nine photographs of scarring and was asked 133 questions. The following key matters emerged in the course of that interview:

    (i) He last attended school in 2007 where he studied a CIMA course. He also referred to having last worked for the jewellers in March 2007.

    (ii) He had started working for the LTTE in 2003 when he valued jewellery that had been brought by them. In addition, he helped them to dig bunkers and transported food. He had had no LTTE training. That involvement with the LTTE had been when he was in Trincomalee when he was working with his father in his jewellery shop. This included his father melting gold brought by the LTTE and returning it to them.

(iii) The appellant's problems first began in Sri Lanka in March 2007. He had been studying in Colombo and on 25 March 2007 the airport was attacked by the LTTE. Two others who were members of the LTTE shared his house. Following the attack, one of them was arrested and the other was scared and proposed to go to Vanni. The appellant decided to accompany him as he believed his life too would be in danger. They travelled by bus to Vanni on 27 March 2007 where he stayed in a house owned by his father's relatives. His "mother's brother", a jeweller as well and a LTTE member also lived there. Although asked to join the LTTE, the appellant did not wish to but began helping them in other ways. He had stopped helping the LTTE in connection with the jewellery (valuation) in 2008.

(iv) The appellant was arrested in Mulliviakal on 10 May 2009. He had gone with other people to surrender and the army had taken him to the camp. They had gone with white flags and surrendered. Despite having been invited to do so, the appellant did not reveal himself as a member of the LTTE because he had not been.

(v) In the course of his time in the camp the appellant was beaten almost every day. He was forced to sign a confession paper. The ill-treatment included severe beatings to his back and elsewhere resulting in him having a problem bending his knee. When his captors learnt of the work that he had done for the LTTE with the gold, he was taken for further interrogation and asked about where it had been kept. His fingerprints and photograph were taken and the torture he had received led him to faint. Hot iron rods had been used to torture him on his back and right arm. The ill-treatment continued until about five days before his escape.

(vi) The appellant's father had not been arrested due to his involvement with the LTTE but the army had gone to his family and asked for the appellant's whereabouts.

(vii) As to whether he was conscious when tortured with hot iron rods, the appellant answered in the affirmative. This particular torture had occurred, he thought, in August 2009 [4 months after the end of the civil war]. He needed medical treatment but was not given any. As to how long this particular torture had continued for, the appellant was unconscious so did not know. He became unconscious when the hot iron was applied to his arm. As soon as he became conscious he was beaten with gun butts. Petrol was poured on his body and he was threatened with being set on fire. It had taken about three months for the skin to heal over after the torture.

(viii) As to his escape, the appellant came to know that the Elam Peoples Democratic Party (EPDP) were helping people escape for money. He approached an individual who got in touch with his parents. In February 2011 the appellant learned he would be taken out, concealed in a lorry loaded with empty vessels. As part of the arrangements for his departure the appellant was given a Sri Lankan ID card with a Muslim name.

(ix) The appellant stayed in Negombo at an agent's address before setting out by flight for France and subsequently the UK where on arrival the agent called his maternal uncle, a British citizen, S S. The appellant confirmed his mother also had another brother in the United Kingdom.

The reasons for refusal by the respondent

25. In addition to the matters disclosed by the appellant in the screening and substantive asylum interviews, the respondent had before her, when she came to formulate her reasons for refusal, nine photographs of the appellant which showed scarring on parts of his body, in particular his back and arms. Her reasons for rejecting the claim are set out in her letter dated 31 March 2011. That letter begins with an accurate account of the claim given at the substantive asylum interview. The respondent did not accept the appellant was entitled to either asylum or humanitarian protection and in essence this was because she disbelieved him for the following reasons:

(i) The evidence when the appellant had first worked for the LTTE had been inconsistently given at interview (either 2002 or 2003).

(ii) The appellant had been inconsistent as to when he had last worked. Earlier in the asylum interview he had stated that he had not worked since March 2007; however he later stated that whilst in Vanni (from 27 March 2007) he had worked in his uncle's jewellers.

(iii) It was "not considered consistent" that the appellant would put himself at risk by travelling with a known LTTE member to Vanni when he was already fearful that the authorities had connected him to the LTTE.

(iv) Inconsistent evidence had been given by the appellant regarding the frequency of torture "almost every day" and "every two or three days".

(v) The appellant had claimed an EPDP member had identified him as an LTTE member to the Sri Lankan authorities which was "inconsistent" with his account that an EPDP member had assisted him in his release.

26. The respondent observed that by the appellant's own admission he had never been an LTTE member and it was not accepted that as a non-member he would be entrusted with such an important role as handling valuable LTTE belongings such as jewellery. No documentation had been offered regarding the valuation of jewellery, either for the LTTE or for any other reason, and it was not accepted he had therefore ever worked for the LTTE.

27. The respondent did not accept that the appellant had been arrested or detained.

28. As to the claim to have been tortured and in particular the photographs produced showing several scars on his back and two on his arm, the appellant had provided no medical evidence to suggest that those scars had been obtained in the manner claimed. There was no "objective" evidence to suggest that the Sri Lankan authorities tortured suspects with iron rods and in the absence of any evidence to

corroborate that claim, taking account also of previous inconsistencies, the respondent did not accept the appellant had been tortured by the Sri Lankan authorities.

29. The respondent also considered the account of release from army detention to have been "inconsistent". The appellant's release effected in the manner claimed undermined his claim that he was personally of adverse interest; reference was made in this regard to the Tribunal decision in PT (Risk – bribery – release) Sri Lanka [2002] UKAIT 03444. It was considered that had the appellant been suspected as an LTTE member and the Sri Lankan authorities had an interest in him, it would have been a risk for the EPDP member involved to have associated himself with his release. Had the appellant been held in the manner claimed, he would have found it extremely difficult to have spoken with the EPDP member whilst being locked up as claimed. With further reference to the Country of Origin Information Report of November 2010, the respondent considered the appellant had not proved he would suffer any more than any other Tamil citizen of Sri Lanka due to the general country situation. Even if he had been involved in previous political activities, his release from detention was in accordance with the protocol that the authorities had in place for detainees who were not of any interest to them.

30. The respondent considered the appellant's claim against the risk factors identified in LP (LTTE area – Tamils – Colombo – risk?) Sri Lanka [2007] UKAIT 00076 and TK (Tamils – LP updated) Sri Lanka CG [2009] UKAIT 00049 and concluded the appellant did not have a well-founded fear of persecution in Sri Lanka and so did not qualify for asylum.

31. Similarly, the respondent addressed humanitarian protection and found that this was not made out, nor that the appellant's rights under Article 8 would be breached. His case was addressed in accordance with paragraph 395C of the Immigration Rules and stated her view that removal of the appellant was appropriate.

The appeal before the First-tier Tribunal

32. The error of law decision (see Appendix A) sets out the judge's conclusions on the evidence. Although the appellant was cross examined the determination does not reveal what was said; the evidence set out appears to be from the above statements. The judge rejected the claim as not credible and as to the report by Professor Lingam, her criticisms are set out in the error of law decision. The judge considered that there "must be a method by which injuries capable of being inflicted on the appellant by invitation to a third party to do so and injuries caused by third parties as a result of torture and detention could be differentiated".

Further evidence on the appellant's claim

33. For the purposes of this hearing the appellant relies on two witness statements dated 11 May 2011 and 26 September 2013, the earlier having been placed before the First-tier Tribunal Judge when she heard the appeal on 13 May 2011. In addition, the appellant relies on statements by his brothers VN and VP, neither of

whom gave evidence before the First-tier Tribunal. Both are here as students. VN's first statement is dated 30 August 2012 and his second statement dated 30 October 2013. Similarly, VP relies on two statements of the same dates. Finally, reliance is placed on a statement by the appellant's uncle, V S, dated 31 January 2014.

34. In his first witness statement, the appellant adds more detail and addresses points raised by the respondent in the refusal letter. He clarifies that he began working for the LTTE from 2003. His father helped them (on this basis) in 2002 and the appellant misunderstood the question as referring to him personally. He valued the jewellery for the LTTE providing then detail of weight and carats. Although he had helped the LTTE dig bunkers and transport food, he wanted to study and he was able to appease them, when asked to join, by providing assistance in other ways. They were not forceful as the ceasefire was in place at the time. The appellant clarifies that he had been working in his father's shop as an assistant, not as a jeweller. His father would melt gold for the LTTE.

35. The appellant refers also to being a student as well as a jeweller in Sri Lanka. He started work as a jeweller in 2007 from which he earned a reasonably good living. His family were doing well before he was compelled to relocate to Vanni. Prior to that he had been studying in Colombo. He confirmed that both the Tamil boys living with him in the house in Colombo were LTTE members and one had received a message from the LTTE hierarchy in Vanni to return there.

36. The explanation for travelling with an LTTE member to Vanni was that this was the best way for him to enter Vanni and seek refuge as he knew the authorities would be after him as they had arrested one of his LTTE housemates, the appellant having left the house in Colombo the day after this had occurred.

37. In Vanni the appellant stayed in his father's relative's house. His mother's brother, who was also an LTTE member, lived there. The LTTE did not ask him to help them straightaway but after they came to know that his uncle was an LTTE member and that he had helped them in Trincomalee, he was approached and started to provide assistance.

38. He had been helping them whilst in Colombo and in Trincomalee but had to gain trust from the LTTE as members were separated from different districts. The LTTE started gathering information about him and it was only after they had liaised with the LTTE Trincomalee office that they allowed him to do so.

39. The appellant was not paid for helping the LTTE. He had been paid for the help he provided to his father who was also a jeweller. He ceased helping the LTTE in 2008 as they did not have a permanent base and kept moving. The Sri Lankan authorities were making serious advances and were being supported by China with airstrikes. There was a massive exodus of the LTTE and Tamil people into other areas.

40. The appellant's arrest on 10 May 2009 had been in Mullivaikal. Following the final war there, people had surrendered to the army and were taken to different camps. The appellant was taken to Pampai Madu detention camp where he declared

himself as a civilian and not as a LTTE member. The army separated civilians and LTTE suspects and he was asked to stand with the latter. There were around 200 to 300 people in that camp. He was not taken to a rehabilitation camp as in reality that did not always happen.

41. As to his ill-treatment, the appellant was beaten almost every day and "if not at least it mainly occurred every two or three days". The beatings had been with gun butts and wooden poles. He was forced to sign a confession on the fifth day of his detention and did so under duress due to the torture. He was severely beaten on his back and knee which his left him with problems in bending that knee. A member of the EPDP and People's Liberation Organisation of Tamil Eelam (PLOTE) stated the appellant had been involved with the LTTE and that he had helped them with their gold. When (the authorities) became aware of this he was taken to another room and interrogated about the LTTE and where they had kept their gold. His fingerprints and photos were taken and he fainted due to the torture. They burned his back and right arm with hot rods and he thought this was in August 2009 (the burning with the rods). He was given no treatment. He believed he had also been beaten with gun butts when he was unconscious. The authorities also poured petrol on his body and threatened they would set him on fire. Since the petrol was on fresh wounds it was very painful. There were around ten officers, some of whom questioned him and some of whom were on guard and others undertook the ill-treatment which happened every two or three days and for around two hours at any one time. The length of questioning varied. They would torture him first and the whole period would last four to five hours. The torture was for a period of two hours in a four to five hour period during which they would then bring break off and question him and then restart the torturing. This occurred in front of other prisoners and sometimes he was also taken into a separate room. The appellant signed the confession as he considered the torture might reduce. He was tortured further after that signing after being identified by the EPDP/PLOTE member. This member was not the man who had helped him escape. The timing of the identification by the EPDP/PLOTE occurred a week after the confession was signed.

42. The ill-treatment was continuous until around five days before the appellant's escape which occurred at a time when the authorities were concentrating on Independence Day celebrations. The appellant's skin healed some three months after he endured his torture but, not being medically qualified, he could not be sure.

43. As to his account, the appellant noticed a lot of people from the camp were escaping and he was informed by one of the five who shared his room that EPDP were helping people in return for money. He thus spoke to an EPDP member named S whom he had known as he helped him unload things in the past and he had spoken to him in the toilets. In November 2010 he got his parents' contact number and returned in December that year to inform him he had spoken to the family and would need money to get out of detention. He returned on 3 February 2011, explaining that he would return the following day and take him away.

44. He did so as promised after asking him to lie down in a lorry which was carrying empty vessels, S having brought food and water to the camp. He placed things on top of him.

45. The lorry was checked by an army officer at the exit to the camp but he did not see the appellant. The journey lasted around 1.5 hours and when it did the appellant was introduced to a Sinhalese man. In the light of the appellant's reluctance to go with him, he called his uncle J who lives in Colombo who confirmed he should follow the Sinhalese man called D. He was given a false Sri Lankan ID card in a Muslim person's name and a name to give the army were they stopped. The second leg of the journey was to Negombo which took around six to seven hours and they did not stop at any checkpoints, although they passed two and the appellant recalled being informed that he must lie down and not come up for any reason when they did so. He remained at D's house in Negombo with the latter's wife and children. D brought him painkillers and clothes. He took a photograph of him. Two days later someone else came and explained that he was the appellant's agent who would get him out of the country under the guise that he was his son. The appellant was first informed to be ready for direct travel to the UK but the plan changed and he was informed the travel would be via France. He was given a French passport in the car. The appellant was informed not to claim asylum in France and arrived in the United Kingdom travelling with the agent on 24 February 2011 around 4am. They slept in the car until 8am after which the agent called the appellant's uncle again. There was no answer to the phone call initially. That uncle spoke to a solicitor and the next day the appellant was given an appointment to see his solicitor. An appointment was then with the Home Office to claim asylum. He identifies his uncle as S S. In addition to that uncle, the appellant's mother's two brothers are also in the United Kingdom.

46. In his second witness statement, the appellant explains that the idea that he could have caused the injuries he has is something that disgusts and offends him. He did not have any reason to do this to himself. He refers to his family circumstances with his father earning sufficient income and that they had everything they needed. When he went to Colombo in 2003 he studied there and worked in a jewellery shop in Sea Street. He also returned home to Trincomalee once a month where he worked in his father's jewellery store as well.

47. As to UK activity, the appellant refers to having attended Nullivakail remembrance days in May 2012 and 2013 and Heroes' Days in November 2011 and 2012.

48. As to the way in which he had been ill-treated the appellant refers to having been kept in a cell with around ten other males, all of whom were Tamil, although the number was not exact. Some were taken out for questioning and some were taken for rehabilitation and not seen again. The floor was bare concrete and there was no bedding, nor any sheets. There was no toilet and detainees were allowed out at irregular times to use the toilet but they were permitted to use water from a large vat to wash themselves. The appellant refers to being beaten almost everyday and the way in which food given to him had often been kicked away.

49. As to his ill-treatment, in particular the burning, the appellant explains he saw one of the soldiers with a metal rod and the end was glowing red and easy to make out. Before he could think about what was going to happen, it was pressed against his right arm. He recalls screaming in pain, feeling intense heat, and then passing out. He could not place a time span on how long he had been out for:

> "But the pain to my back and right arm was so harsh, that I could not bear the pain but at the same time I could feel the burning sensation. The officers then continued to ask me questions as to where the gold had been hidden and they had stated that they had information from the outset from EPDP or PLOTE (I cannot quite remember which group they mentioned now) [stating] that I helped the LTTE to hide gold."

50. The appellant went on to explain that he was held by five to ten people and they poured petrol over his face and his back and they said they were going to set him alight. He could not see his back but kept looking at his right arm and saw that the outer layer of skin, already so dry from being in the cell, was now wet and slimy and starting to peel off. He was taken back to his room by two people and recalls the looks of the other detainees. He slept on the floor at a strange angle and as he could not lie on his back or lean on his arm. He was allowed to bathe the following day and was permitted to go first by the other detainees. When he came to take his T-shirt off it was stuck to his back and another detainee assisted him. He could see layers of blood and skin in different colours on the shirt. One of the officers threw a new T-shirt into the room and although it caused him so much pain to wear it he did not want the wounds to be exposed and had to wear a T-shirt thereafter for quite some time. He had a very bad fever for around two or three days after the burning and kept asking the other detainees to describe the scars as he wanted to see whether they were getting better or worse.

51. After coming to the United Kingdom, he registered with a GP to whom he showed his scars but was told there was no treatment that could be given. The natural healing process must take its course. He was however treated for his knee. The appellant made clear that he did not inflict these scars himself.

52. The appellant concluded by explaining that he and his brothers had not called his parents for a number of years now. Their father was paranoid that the home phone was tapped by the authorities in that the phone there was clicking. At the date of that statement (26 September 2013) the appellant did not know whether his father's business was still running. His brothers had sent letters to his father to which they had had no reply but he had received a telephone call from his father in July 2013 from a mobile number. It had been his father and he stated that he was using somebody else's mobile and that the authorities in the east had started registration of the houses. They had information that the appellant was in the UK and involved with the LTTE.

53. At the hearing before us the appellant was tendered for cross-examination. When it was put to him that he was surely at risk in travelling with another LTTE member, he responded that he had no choice but to use that member's knowledge to get to the LTTE area. Given that he had connections in the LTTE, he was asked why he would need assistance. The appellant explained that it was an immediate decision he had to take and it was highly improbable to ask relatives to come to

Colombo. As to why he chose to take the bus, he said that his housemate said it would be safer. As to why he needed assistance to take the bus, the appellant acknowledged that he could go by bus but did not have knowledge of how to get to the place he referred to as the LTTE area. The appellant explained in terms that one could not just enter the LTTE area and one was checked up on before being let in.

54. The appellant, in response to further questions, explained that he had stayed with his father's relative in Vanni. He had not contacted his family in Trincomalee to tell them he was there. The appellant explained that he thought they may have had trouble and so therefore he sent messages through the relatives he was staying with in Vanni. Those relatives had travelled to Trincomalee themselves.

55. The appellant explained that he had worked in the shop of his father's relative in Trincomalee where he took orders and gave a description of the range of work he undertook as a jeweller. He was first asked by the LTTE to help with the gold three months after arrival and he had provided services to them for one year. In addition to melting and forming gold into ingots he assisted them with supplying food and digging bunkers in Vanni. As to the regularity of activity, once a week the LTTE came with a big sack of gold. No-one else provided such a service. They came and collected it. He had no idea what they did with the gold after taking it away.

56. Turning to the circumstances of his detention, the appellant explained that he was directly taken to the camp where he was held where there was a mixture of those suspected as well as members of the LTTE. He confirmed that he had been tortured mostly every two or three days and others were treated the same. They were also burned. He could not give an accurate account of how many were in the camp but on the first day some 200 to 300 were there but then some were taken away. He had no liberty and was locked up which was always the case. There were ten people in the cell and explained the reference he had made at interview about there being five people in the cell as being because whilst he was in detention some people were taken and did not return. He had not read the confession which he signed about five days into his detention and did not therefore know what was in the document. He was not fingerprinted and photographed the same day.

57. As to the nature of the questions he was asked, the first were where the LTTE leaders were hiding. He was tortured because he did not know the answer. As to whether the questions were the same throughout, the appellant explained after some time he realised EPDP members were coming into the camp and he believes they must have told the army that he had been assisting with the gold. As to whether he knew they were EPDP members or simply made an assumption, he explained that during the torture he could vaguely recall his torturers saying they had got information from EPDP or PLOTE.

58. The appellant had been burned on only the one occasion. As to how he had been restrained, he demonstrated this with the assistance of Mr Paramjorthy. He kneeled and his head was being pushed down. He was able to see a little bit of the burning on his arm.

59. As to how he had made contact with EPDP or PLOTE, this was when he used the toilet, confirming that the cell did not have such facilities. He had been escorted by the army and as to how he was able to speak to someone else they had not accompanied him into the toilet and so therefore he had the opportunity to speak. In the first instance he approached someone in the toilet and begged to help him get out of the place and this was the person who assisted him escaping. He took the appellant's home address and on the second occasion had talked to his father and said that he would assist if he received money.

60. As to the manner in which he escaped the camp in the lorry concealed, the appellant explained that he was covered by empty water cans and was unable to comment on the thoroughness of the check the guard had undertaken, although he had heard someone open the door and shut it. In noticing other escapes, he had the opportunity to talk to other members who were missing who explained the EPDP had been given money to rescue people. He asked other people how the escaping was taking place.

61. In re-examination, Mr Paramjorthy asked about what happened at the LTTE checkpoint. He referred to a conversation between the person he had been living with and those manning the checkpoint and thereafter he had been permitted to enter the area.

62. Our questions were for clarification of aspects of the evidence. The appellant said he was 22 years old when he went to Colombo where he remained from 2003 until 2007. As well as studying he worked in a jeweller's shop owned by distant relatives. The bus he had taken when leaving Colombo was travelling to Omanthi. **(**The appellant did not understand our question whether Vanni was on the way to this place.) When the bus passed from the army area to the LTTE area the appellant and everyone else had their IDs inspected. He had to produce his ID which he had with him. They asked him why he was travelling and he said that he was going to see relatives.

63. The appellant also explained that the burn scarring had taken place after the army came to know about the gold. The reference by the appellant to torture otherwise in the witness statement was to beatings with a gun on his back. As to the studies he had been pursuing in Colombo, this was an IELTS course. At the beginning he had taken an English exam and thereafter had undertaken CIMA first stage which had been in English.

64. As to the process of melting the gold, the appellant explained that equipment called *Tirubal* was used which revolves, the fire is kept burning, and the gold is put into a container. When the air is blown, the gold melts. It was not possible to hold the container with hands and so it was necessary to lift it with tong-like instruments after which the gold was poured. (We would observe that in giving evidence on this aspect of his claim the appellant spoke with great animation and confidence.)

65. The appellant was then referred to what he had told Professor Lingam (that he definitely felt heat and pain before he fainted) and clarified that he had not told Professor Lingam that he felt the burning each time it had occurred. He clarified

that it was the next day when he was allowed to have a bath for the first time. One of the detainees had helped him to take off his T-shirt.

66. In re-examination he was asked whether there were shower facilities in the detention centre and the appellant responded that there was a tap and a bucket which could be used.

Family evidence

67. The statement by the appellant's brother, VN, dated 30 August 2012 gave the same chronology of the appellant's account as to his move to Colombo and from there to Vanni explaining that the family lost contact with him after he moved to the latter location. VN explains that he went to Colombo in December 2009 to apply for a student visa to come to the United Kingdom and at that time he did not have any news about the appellant although they knew thousands of Tamils had ended up in camps in Sri Lanka. He remained in Colombo until he obtained that visa. His father called him on the day the appellant left Sri Lanka on 22 February 2011 to explain that the appellant was coming to the United Kingdom although he could not state much on the phone and that he was unsure of the appellant's exact travel plans. The appellant called VN on 24 February to explain that he had arrived and that the agent had dropped him at their uncle's house in Wellington which is not far from where VN lived. VN did not make contact with their parents due to their father's concern that his phone was being tapped. He has not returned to Sri Lanka since being in the United Kingdom.

68. VN's more recent statement dated 30 October 2013 further clarifies that he left Sri Lanka on 30 May 2010 on a Tier 4 Student visa which after renewal resulted in leave to remain until February 2015. He lives with his brother, PN, and their uncle, V near Croydon. He describes his background as a middle class affluent family and that his father was a jeweller. He and his brother, PN, did not know exactly why the appellant "was going to Vanni from Colombo but I remember that our parents told me and PN that he was travelling to Vanni". In response to questions, he said that the appellant's parents stated that he had had problems after the LTTE had attacked Katunayake Airport and that he had had problems from the authorities. VN and PN found out that the appellant had been arrested when their father called them in the United Kingdom to tell them so and to say he had only managed to get him out of detention on 4 February 2011.

69. In late July 2013, the appellant's father called him and stated that he was using another person's mobile and that the authorities were maintaining a high presence in the east due to the elections. JN and AN had stated to their father that they knew the appellant was in the United Kingdom and he was involved with the LTTE. Apparently their father had stated that he did not know where he was and their response was that it was only a matter of time before he was sent back to Sri Lanka. VN had not heard from his father since and they have not written to him in case this causes him any problems. In his first statement dated 30 August 2012, VP discloses nothing materially different from VN. Similarly in his more recent statement, he explains that he too has leave as a Tier 4 Student until 2015. Again, he discloses nothing new of a material nature not covered by his brother.

70. According to his statement, the uncle VS explains that he went to Sri Lanka "after years" with his wife and 2 year old son in October 2013. Their purpose was to accomplish prayers and to see relatives. He wished to complete those prayers in Trincomalee temples but he had been told by his family not to try to go there in any circumstances. VS explains that his mother had brought his relatives to Colombo to see them at 3.15 in the morning without VS being aware. He was forced to stay in Colombo. VS said he had planned to see his elder sister and her husband and had had no contact with his sister since the appellant had arrived in the United Kingdom because of concern that his sister's phone calls were tapped and being recorded by the Sri Lankan government authorities. He had had contact with his mother before he reached Colombo. He went on to explain that his sister and brother-in-law, the appellant's parents, had met him the last day before his departure to London without any prior notification. He was told also by her about unknown phone call threats and that she could hear clicking noises on the phone and so considered it could be tapped. They could also hear some unusual digital sounds and conversation in Sinhala. They also observed a white van standing in front of the house most of the day and night, sometimes they heard the heavy stomping of boots in the yard.

71. VS explains that on the day the appellant had an interview at the Home Office he had taken the photographs at his house (of the scars).

72. At the hearing, VS gave evidence after the appellant and was tendered for cross-examination.

73. With reference to his statement that he had no contact with his sister since the appellant had arrived in the United Kingdom, VS explained that he was told by his mother that all telephone calls they were receiving were monitored by the Sri Lankan authorities and that they were recorded. It was for that reason that he was not able to contact them, and he was not aware of the location in which they were living. Asked why, although the phones were monitored they could not have discussed other things, he said that they had changed contact numbers. Asked to confirm then that the reason for the lack of contact was in fact that he did not have their phone number, he said that if he contacted his sister "they" would know that she had contact with him. As to why the sister being in contact would give trouble, it was because VS believed they (the authorities) had come to know the appellant was here. To the questions why they did not speak about the appellant and why would that cause problems, VS responded that he did not have their contact number and did not know where they were living. VS also referred to the appellant's father having been beaten, although he could not remember exactly when, but stated it was during the eastern province election time in 2012, although emphasising that he was unsure.

74. In response to questions from the Tribunal, there being no re-examination, VS explained that he is a British citizen which he had become in 2001. He confirmed that his brother-in-law (the appellant's father) had been tortured he thought in 2012 and that he had not contacted his sister because of calls being tapped. As to how it was he felt safe going back, VS responded that he had not had direct contact as his life was "separate from them". He felt fear only when he arrived in Sri Lanka;

however he did confirm concern that he might be linked to the appellant. His reason for going back was a compelling one and was for a religious purpose.

75. Since the day he arrived in Colombo, his mother lived with him. She previously lived in Trincomalee. When reminded of the appellant's answer at interview that he had an uncle in the LTTE, VS confirmed that it was his brother. As to where he is now, he knew him to be safe but did not know where he is. As to the relatives the appellant had stayed with in Vanni, he knew them when he was young, and as to their relationship to the appellant, he described it as his father's mother's sister's son.

76. As to the meeting up with the appellant's parents in Colombo, VS referred to his mother having brought them in the night as she knew where they were living. As to why she had not telephoned them and invited them to the city, VS explained that she was scared to mention on the telephone that he had arrived. She also told him that she did not have their number. As to when he had first told his mother of his return to Colombo, he said it was on the day previous (to his travel). As to why he had not given more notice, VS said he could not make a decision because his son was not well. As to whether his mother knew of the possibility of his journey to Sri Lanka, VS responded that because of the son's illness he was unable to give specific dates but she anticipated him coming. She had warned him about the danger.

77. As to the white van treatment VS responded in re-examination by Ms Bayati that this had been mentioned by his mother. He had been in England and had made the call from his house here.

78. The appellant's brother, VN, was similarly tendered for cross-examination. He explained how he had totally avoided contact with his father when it was suggested that he could have spoken to him and not talked about the appellant. He confirmed that his father still had the same gold shop.

79. There was no re-examination and in response to questions by the Tribunal he explained that in 2007 he was living in Trincomalee. His visa to come to the United Kingdom had been issued in Chennai as the High Commission (in Colombo) had been shut for renovations. When the LTTE surrendered to the army in 2009 he had been living in Trincomalee. With reference to his mother's brother being a member of the LTTE and as to what had happened to him, VN explained that he knew he was there in 2007 but did not know what had happened after the war. He had not discussed his circumstances with anybody.

80. Likewise, PN was tendered for cross-examination. He explained that his studies are sponsored by his father.

81. The Tribunal sought clarification about the uncle who had been a member of the LTTE. PN explained that he had been told he was working for the movement and he had no idea what had happened to him. He had not asked anyone recently but he knew that he was married and had no children.

Expert Evidence

Professor Sundara Lingam: written report

82. Professor Lingam has lengthy medical experience as a Consultant Paediatrician and a First Contact Physician in Harley Street. He is the Executive Director of Medical Express Clinic. He is trained in medico-legal matters and in report writing for the courts. We did not hear oral testimony from Professor Lingam. His report was before the First-tier Tribunal and although we indicated in earlier directions that he should appear before us, the dates fixed were not convenient.

83. Professor Lingam had examined the appellant on 6 May 2011 and his report of the same date. He described the appellant as having six hyperpigmented scars. Their appearance indicated they were caused by heated metal rods applied at nearly the same time and by the same mechanism. He considered that his findings on the scars "are highly consistent with the history provided by the patient that all these scars were due to burn by heated metal rods. The scars are very typical of burn injury".

84. Professor Lingam next considered alternative causation. He first ruled out the possibility they were self-inflicted because the areas where the scars are located are not reachable by the appellant. Secondly, he considered whether they were caused deliberately to mislead. "I have ruled that, no way I could scientifically differentiate between the wounds inflicted deliberately from the wounds inflicted from the said torture". Thirdly he ruled out the possibility the scars were caused by a medical condition or a surgical procedure. Fourthly, he considered if these were caused by accident or wounds from training as LTTE or childhood injuries. He rejected these possibilities because "the patient denied any wounds or accidents other than the injuries caused by torture".

85. Professor Lingam went on to say that the appellant was "much stressed and may have depression which will explain his poor memory and slowness in recollecting events". When he administered the Beck Depression Inventory (a 21-question multiple-choice self-report inventory, created by Dr. Aaron T. Beck, which is one of the most widely used instruments for measuring the severity of depression), it showed the appellant was severely depressed.

86. Under the sub-head "Conclusion" Professor Lingam stated that "I have concluded that the scars and other injuries I saw are consistent with the history provided by the patient. I have considered other alternative causation as to the scarring, namely childhood illness and diseases and accidental injuries which might have caused the scarring".

David Rhys Jones: written evidence

87. Mr Rhys Jones is not a doctor but an advisor on matters of law and policy at the HBF. Previously he had worked for the Medical Foundation for the Care of Victims of Torture, first as a policy officer and then as a legal officer. He had extensive experience of training volunteer doctors and clinicians on legal aspects of medico-legal report writing. He was co-author (with Dr Juliet Cohen) of FFT's paper on

"Methodology Employed in the Preparation of Medico-Legal Reports on Behalf of the Medical Foundation", 2 June 2006.

88. Applying, he said, the UN Convention Against Torture (UNCAT) definition of torture, it was clear that SIBP could not be described as an act of torture. Injuries inflicted in such circumstances would amount to a "false allegation of torture" as described in paragraphs 105(f), 287(vi) and 290 of the IP.

89. Whilst in the context of asylum claims the judge is the ultimate arbiter of fact, it was consistent with the duties to the court of a medical expert to consider whether there was a false allegation of torture. The HBF would not prepare a report if it was concluded that this was the case.

90. It was a misconception to think that doctors preparing medico-legal reports simply accept the history told to them at face value. Thus in everyday practice doctors will carefully interpret matters such as the amount of alcohol consumed, exercise taken or severity of pain reported in light of their observations of the patient's appearance, mobility, answers to questions etc. During the examination, doctors critically assess the account given in relation to the injuries received. This is not an assessment of credibility but a proper consideration of the overall clinical picture as required by paragraphs 105(f) and 287(vi) of the IP. The minimum content of a medico-legal report as set out at Annex 1 of the IP encompassed a thorough and exhaustive process, including circumstances of the interview; history; physical and psychological examination; and opinion.

91. Mr Rhys Jones highlights the contrast between Chapters V and VI of the IP, the former dealing with physical *sequelae,* the latter with psychological *sequelae*. The well-known hierarchy of degrees of likelihood at paragraph 187 in Chapter 5 finds no equivalent in Chapter 6. The temptation therefore to extrapolate the hierarchy available in paragraph 187 should be avoided.

92. One component of a medico-legal report was psychological/psychiatric evaluation so as to form an impression of the degree to which torture has contributed to psychological problems. Such a report should consider both the physical and psychological *sequelae* of torture. Mr Rhys Jones considers that the IP methodology ensures that there is consideration of whether there was a false allegation of torture. It also deals with whether there is a possibility that torture has not contributed to psychological problems. The absence of a correlation between events and symptoms may well indicate psychological findings inconsistent with the allegation of torture. However, even though diagnosis of trauma-related mental disorder supports the claim of torture, absence of such symptoms does not mean the person was not tortured.

93. Mr Rhys Jones states that in his training work emphasis was placed on what factors can reasonably be established in clinical terms and what cannot. What cannot be determined in a medico-legal report is "the hand behind the implement of torture". Clinicians are also advised against being drawn into speculation about the survivor which cannot be clinically tested, so the motivation of the torturer was ordinarily outside their field of expertise.

94. Mr Rhys Jones concludes that the IP provided a comprehensive means by which possibilities that injuries may have been self-inflicted or SIBP can be considered and made the subject of clinical findings. However, in his opinion SIBP should only be considered as reasonably likely if there was evidence that it had occurred.

David Rhys Jones: oral evidence

95. Mr Rhys Jones said that whilst it was not the place of clinicians to conduct a far-ranging assessment of credibility, within the HBF there was a great wealth of knowledge about torture, which could include conditions in a particular prison based on patients' information.

96. That medical reports which were not IP-compliant should not be discounted and could still have value was well-illustrated by the report considered by the European Court of Human Rights in R.C. v Sweden [2010] ECHR 307.

97. Asked how important the social and cultural context was for doctors examining patients, Mr Rhys Jones said the IP made clear that this was always important. He was aware that patients from certain parts of Africa, for example, could have ritual scarring and there could be an overlap between such scars and ju-ju rituals. He accepted that in broad terms such scarring was inflicted by consent. Ritual marks tended to be symmetrical. He had heard of "crocodile scarring" [i.e. tribal initiation rites that leave the men's skins scarred all over in patterns resembling crocodile scales]. But how much regard doctors had for the social and cultural context depended very much on the particular case. For example, if a patient said that scars which were patently vaccination scars were cigarette burns, the doctor would need to test the evidence that much more. It remained that it was unusual to find scarring deliberately inflicted by consent.

98. Mr Rhys-Jones said he accepted that given such phenomena as tribal scarring, even horrific scarring may be caused by voluntarily inflicted harm (of course sometimes it could be involuntarily inflicted, as with FGM) but the psychological response could be very different.

99. Mr Rhys-Jones said he knew of the occurrence of tattoo scarring (i.e. scarring resulting from tattooing).

100. Doctors were always mindful of the possibility of self-inflicted harm. Thus a cigarette burn which could have been made by the patient's dominant hand was a possibility a doctor would be alert to.

101. In his opinion doctors have to focus not on theoretical possibilities but what was reasonably likely. Unless there was sufficient evidence of a practice of SIBP generally, doctors did not need to address it.

David Rhys Jones's supplementary statement, 11 March 2014

102. In a further statement Mr Rhys Jones sought to give more detail about HBF training for doctors writing medico-legal reports: At paragraphs 10 and 13 he stated that:

"10. MLR writers are reminded that their reports may be subject to criticism. For example, if they suggest: bias; exaggeration; credulity; advocacy; stray outside one's field of expertise; that the contents of the report is inconsistent with what the subject has said elsewhere; that the content of the report is internally inconsistent; that the report lacks reasoning, is inadequately reasoned or the reasoning is flawed.

13. If credibility is clearly an issue in any of the papers or the HBF is directed to consider credibility issues in instructions then MLR writers are expected to be alert to the possibility of feigning or exaggeration. The case of BN (psychiatric evidence - discrepancies) Albania [2010] UKUT 279 (IAC) usefully demonstrates some of the issues here. However, see the sub heading below - 'Credibility, inconsistency and logical fallacies.' "

103. Under the sub-heading "Discrepancies" he states:

"14. MLR writers are reminded that there may be many explanations for discrepancies in addition to the fallibility of the human memory or intent to deceive. For example: interpreter(s) error, interviewing officer error, legal representative error, the interviewing technique adopted. However, discrepancies should not be ignored and simply passed over, not least because in addition to the above they are capable of being introduced unwittingly by the MLR writer himself.

15. Discrepancies should therefore be put to the subject as they arise. For example, "*you told me that this happened on x date but in your statement you said y date?*" The explanation for the discrepancy should be noted. The MLR writer is then expected to provide an opinion on those matters when clinically relevant. Obviously, this will vary from case to case. For example, occasional discrepancies on matters of little significance are inevitable in any retelling of an account, but numerous discrepancies or discrepancies in significant areas may be of clinical relevance.

16. MLR writers who have undertaken examinations of torture survivors before will be aware that the means and level of disclosure of traumatic events is often significantly different from that given elsewhere. It ought therefore not to be considered discrepant if the subject discloses to a clinician something not previously said.

17. Again, there are numerous possible explanations for this. For example: stigma/shame; confidentiality issues; the gender of the interviewer/interpreter/legal representative; the development of trust and rapport between the report writer and the subject; or following a period of therapeutic intervention.

18. MLR writers are reminded to anticipate comments in the Secretary of State's decision letter or in an Immigration Judge's determination. They are also told that their role is to assist the court in its understanding of matters in which the court may not have expertise, and that it is therefore very important that all steps in the process which goes to preparing the report are clearly set out."

104. At paragraphs 23-25 he addresses shortcomings in decision letters:

> "23. MLR writers are taught in their training at the HBF that credibility is a matter for the decision-maker and that to deal directly with credibility 'usurps the function of the immigration judge'. However, in my experience, both at the Medical Foundation … and the HBF the Secretary of State's decision letters frequently do not address true credibility (for want of a better expression) but actually engage in logical fallacies.
>
> …
>
> 25. MLR writers are invited to bring such statements to the reviewers. In my experience, the conclusions drawn in the decision letter can at time be 'unpicked' by the MLR report writers by taking a forensic approach to the facts…."

Dr Frank Arnold: written report

105. Dr Arnold is a specialist in problems of wound healing, having been Director of Research at the Oxford Wound Healing Institute (Churchill Hospital) and has published more than 40 research papers on problems of wound repair. Since undergoing clinical training at the Medical Foundation for the Care of Victims of Torture in 2004-2005, he has written approximately 1,000 medico-legal reports, mainly about survivors of human rights abuses. He has taught on courses for doctors organised by the Department of Health and the Medical Justice Network.

106. In a report dated 10 January 2014, Dr Arnold states that he had not had an opportunity to examine the appellant. He had read the criticisms made by the First-tier Tribunal Judge of Professor Lingam's report. In his view the judge was wrong to assert that "[t]here must be a method by which injuries capable of being inflicted on the appellant by invitation of a third party to do so and injuries caused by third parties as a result of torture and detention could be differentiated". There was no such method. As regards the judge's view that the professor had failed to consider whether "the nature and extent of the injuries were such that the appellant would have been able to undertake a protracted air journey to the UK without some form of medication or assistance", the appellant had stated in his asylum interview that he received pain-killers after his release from detention. Given that the appellant said that the branding was in August 2009 it was unlikely that the torture he received five days before his escape was branding by burns because the wounds would have been at a much earlier stage of healing.

107. Dr Arnold states that if burns were inflicted by a third party at the subject's voluntary request it would be necessary for the subject to hold or be held still for the duration of each episode of burning; otherwise the edges of the scarring would tend to blur as the involuntary withdrawal reflex causes a person to try and move away from the injurious object. For immobilisation/anesthetization to occur, one would need to postulate a site "(a counterfeit torture factory?)" at which people could deliberately choose to have marks deceptively suggesting torture inflicted on their bodies by a third party or parties surreptitiously. Such an 'enterprise' would need to:

- Immobilise or anaesthetize the subject; or
- Be in an extremely isolated place; or
- Employ gagging; or
- Enjoy protection sufficient to prevent publicity and the dissolution of such a 'torture factory'."

108. It was possible for an experienced medical rapporteur to distinguish roughly by examination, the stage of repair a scar had reached at the time of examination. If the chronology of the subject was grossly discordant it will be possible to draw conclusions about the veracity of the account (e.g. if a wound is in early stages of repair but the subject says it was inflicted some years earlier), but such a finding would not "prove" SIBP.

109. The characteristics of wounds and scars can be affected by whether the wound has been infected but usually not by the way it has otherwise been treated. Infection can increase tissue damage, causing an expansion or irregularity of the edges of the scar. Impairment of or delay in healing can be caused by serious illnesses, severe malnutrition etc. However, "infection is probably not a relevant issue here…" Treatment to prevent or eradicate infection would not be detectable months or years after (apart from one rare exception relating to silver compounds). He observes, "[h]owever, I have no way of ascertaining what infection control might have existed in the hypothetical circumstances of an alleged "torture factory" – for which I have not been shown evidence of – and therefore decline to speculate further on this question".

110. Dr Arnold states there was no known method that would enable doctors to differentiate between branding scars due to SIBP (if the phenomenon exists) and those due to torture.

111. Dr Arnold sought to clarify the ways in which doctors made a diagnosis. It was a process of continuing refinement of alternative hypotheses thereby reducing uncertainty. "In this process of reducing uncertainty, the competent doctor will not consider causes which are clinically implausible. They are not, in strictly medical terms, a reasonable likelihood". In the absence of evidence supporting a contention that a torture fabrication facility actually exists it was neither feasible nor reasonable to require that medical rapporteurs should explicitly consider a hypothetical cause of branding scars.

<u>Dr Frank Arnold: oral evidence</u>

112. Dr Arnold confirmed that he had not examined the appellant's scars himself. Dr Arnold was asked several questions about possible pain management measures in response to burn scarring. Use of morphine/heroin carried dangers e.g. to breathing and did not necessarily eliminate pain. Use of alcohol carried dangers too. Once a few days had passed, strong painkillers such as codeine could assist.

113. He said that complications that could arise from burn scarring included infections. Chronic complications could affect the nature of the scarring e.g. by blurring its edges.

114. As regards the effects of fainting/losing consciousness on someone having burn scars inflicted on them, it was difficult to say because there were different levels of unconsciousness. At a shallow level, muscles might still involuntarily react for example. He did not think one could tell from looking at scars whether a person was conscious or unconscious when they were inflicted.

115. In regard to the apparent difference of opinion between Dr Odili and Dr Zapata-Bravo on the aging of scars – see below paragraphs 129, 139, 154, 159, 162 - Dr Arnold said Dr Odili had only referred to "up to two years" and she did not define what she meant by "new scars". Dr Arnold thought the difference was not material, as precision was not possible. The proportion of scars over which there might be disagreement about ageing was likely to be relatively small. Plastic surgeons and forensic medical experts have different purposes and approaches.

116. In relation to the possibility of SIBP, he did not think it was right to speculate about such things. Medical students had drummed into them a version of Occam's Razor[1]: when in an English field one does not look for zebras - unless there is a safari park nearby. You would need some presenting evidence to make SIBP a scenario to be considered. It was within the spectrum of possibilities, but at the speculative end.

117. Asked by the Tribunal whether he had dealt with cases of ritual scarring, Dr Arnold said he had seen around twenty cases, but not one was consistent with thermal burns on a visible part of the body. It was important to be sensitive to different cultures, but there were certain human constants and the fact was there was no evidence of branding by consent for the purposes of deception anywhere in the world. He had seen cases of tattoo scarring but they were pretty rare. With them the aim was broadly to introduce colour into the skin, not to cause scarring.

118. Asked whether the length of the repair process for scars could be significantly affected by beatings inflicted on the site of fresh scars, Dr Arnold said it could, but after four months, beatings would have a diminishing effect.

119. Dr Arnold was asked about his dismissive references to "torture factories": did he mean by them to say SIBP could not occur in other contexts, as administered by, for example, an ex-doctor or nurse or "backstreet" medic or even a "quack"? Dr Arnold said he could not exclude such possibilities but he had to focus on what was medically plausible.

120. Asked what he would do if he had a case where there was clear findings of fact by a judge that at the time a claimant said he had been tortured abroad he was in the UK, Dr Arnold said that if the age of the scar was wholly inconsistent with the claimed torture it would be his duty to point that out in the report, although

[1] That is, the thesis that the simplest explanation is the most likely one.

whether the claimant's lawyer would then submit that report was not for him to say.

121. Asked whether he considered the IP a "complete code", Dr Arnold said he found some parts of it problematic: e.g. he thought it quite confusing that in an ascending order of likelihood paragraph 187(c) should say that "typical of" meant "few other possible causes" whereas paragraph 187(d), at a lesser threshold, should not make that qualification. He also echoed Mr Rhys Jones' opinion that paragraph 187 did not really apply to psychological assessment.

122. Asked whether he thought the dousing of petrol on a fresh burn could delay repair, Dr Arnold said it could but it would depend on the circumstances. He could not really say if petrol would increase the likelihood of infection. The appellant's burns were "partial thickness burns" i.e. burns which left some of the epidermis intact.

123. Asked whether he would prepare a report where he was satisfied there was a false allegation of torture, Dr Arnold said if it was blindingly obvious the allegation was false he would contact the lawyer and say so as it would be a waste of his time. If the situation was not entirely black or white he would more likely prepare a report voicing his concerns. He had encountered the problem only on rare occasions.

<u>Dr Enrique Zapata-Bravo: written report</u>

124. Dr Zapata-Bravo is a Consultant Psychiatrist (he had previously worked as a consultant in Chest Medicine). Currently he is an independent consultant and a medico-legal expert for the HBF. His past medical experience included working in accident and emergency departments and surgical services where he had treated burn patients and at HBF.

125. In a report dated 9 October 2013 Dr Zapata-Bravo set out his assessment of the appellant's scarring based on the account the latter had given of a session of torture he had experienced in August 2009. He examined the appellant's scars on 3 September 2013.

126. He identified two scars on the appellant's upper right arm (S6 and S7) and five on his back (S1-S5).

127. Dr Zapata-Bravo explains that burns are classified according to the depth of tissue injury into: superficial epidermal burns, superficial dermal burns; deep dermal burns (partial thickness burns); and full thickness burns. The deeper the burn the longer it takes to heal. Scars are formed where the full thickness of the skin has been breached. The scar is initially pink or reddish in colour and becomes paler as the scar tissue gradually fades. In some skin types bruises can lead to hyperpigmentation which may last for several years. The intensity of hyperpigmentation is proportional to the severity of the burn, which in turn depends on the temperature of the source of heat and the time of contact. Burns from hot objects tend to take the shape of the surface that caused the burns ("branding" effect).

128. In the appellant's case Dr Zapata-Bravo found seven scars that the appellant attributed to torture (scars S1–S7). All exhibited hyperpigmentation, suggesting that the initial burns were deep dermal burns. The long and narrow shape of each of the scars (with a very similar width in all of them) and the precise margins of these marks suggest that the hot object causing the original burn was solid, narrow and relatively long. Scar S6, situated at the top of the right deltoid area, is raised which suggests it was a full-thickness burn caused by a more severe burn than all the others. All of these scars were located in places that could not be reached by the appellant in order to produce these particular marks. For that reason he excluded self-infliction as a possible cause for these scars. To produce these particular marks there would have had to be immobility and lack of reaction during a certain time.

129. The 'quiescent' appearance of the scars meant that they were all more than six months old. To his understanding it is not possible to date the scars more accurately than this: he referred in this regard to a publication by Forrest, 2000. In any event, in this case there was already evidence of the scars being quiescent when Professor Lingam looked at them in May 2011 and prior to that the appellant's GP had told him in February 2011 that there was no treatment he could give him for the scars.

130. Dr Zapata-Bravo states that none of the appellant's scars showed ostensible signs of having received treatment in the past, although non-surgical treatments such as antibiotics or analgesics would not be traceable by any physical examination that can be done today.

131. Under a sub-head, 'Possible causes of the scars' Dr Zapata-Bravo considers but eliminates the possibilities that the appellant's scars were caused by skin diseases, tattoos (their size, shape and appearance would be highly unusual for tattooing), lacerations, surgical incisions or other cuts, lashings, strikes given with a wooden rod, electricity, radiation. The marks S1–S7 were "diagnostic of specific burns caused by a hot solid object".

132. Whilst the appellant's activity as a jeweller brought him into contact with fire and molten metal, they were unlikely to have caused burns to his upper arm and back and the expected burns would not have resulted in patterns such as the ones observed in this case.

133. Any other accidental setting was also unlikely as the said pattern did not correspond to any known object (for example a radiator or other manufactured article) and would not have affected two quite different sites (arm and back).

134. The appellant being unconscious would provide a good explanation for the perfect 'branding' of the scars on his back that resulted. If he had been conscious but restrained by third parties during the branding, faultless hyperpigmentation marks would not have resulted. The two scars in the right deltoid area (S6 and S7) were shorter and the shape of the rod is not replicated in the shoulder scars which suggests that he may have been conscious when they were inflicted. At [63] he concludes that "[a]s to the possibility that [the scars] were produced by the instrument described by [the appellant] and in the way depicted by him, I should

state that my findings not only do not contradict his history, but they are highly consistent with it".

135. Dr Zapata-Bravo then addresses the possibility of SIBP. It was significant that in the appellant's case there were at least five original burns. This meant that the person who inflicted the burns did so on at least five occasions, twice to burn him in the deltoid area and three more times in the back. "It should be assumed that a mechanism to heat and re-heat the rod should have been available during this operation and that the appellant was immobile." The use of sedation by alcohol or medication would not have produced the total analgesia required to eliminate all reaction to pain. "The severity of the pain in an operation repeated many times would have woken up the individual and therefore the resulting scars would not have had the characteristics they had".

136. In Dr Zapata-Bravo's opinion the only way to achieve complete analgesia and immobility, other than the unlikely one of inducing the process of shock or coma that [the appellant] might have suffered on the day of the incident was to use general anaesthesia. "This would restrict the number of available people capable of cooperating with [the appellant] to those belonging to the health professions, which would have the appropriate training. In my opinion, the hypothesis that [he] invited somebody else to cause his burns is unlikely. The history provided by the client offers a plausible explanation for my findings".

137. Dr Zapata-Bravo says that he had not been asked to produce a psychiatric report but he noted (a) that the episodes of torture and other ill-treatment recounted by the appellant were likely to have caused him pervasive distress and PTSD; (b) in May 2010 Professor Lingam had found him "severely depressed".

Dr Enrique Zapata-Bravo: oral evidence

138. We heard oral evidence from Dr Zapata Bravo by telephone link to Chile.

139. Asked by Mr Duffy about whether he agreed with Dr Odili that scars could be dated up to two years, Dr Zapata-Bravo said that most of the literature put the time limit as six months.

140. Dr Zapata-Bravo said that because S6 was a very profound burn it could have been infected early on; the appellant did say he suffered from fever; that is something that can happen with open wounds.

141. Asked if the appellant would have been at high risk of infection given that he was in a very run-down condition prior to being tortured, Dr Zapata-Bravo said he would have been, although the fact he was allowed to bathe on a daily basis would have been in his favour.

142. Asked if fresh scars from burns would take longer to heal if a subject was beaten in the same area, Dr Zapata-Bravo said that was very possible especially in the second and third months, but it would not necessarily affect the outline of the scarring fundamentally if there was no open wound.

143. Dr Zapata-Bravo was asked on what basis he thought it unlikely the appellant had had a general anaesthetic in the context of SIBP. He said that the relevant drugs were not easily obtainable and would need to be administered by a person with some experience. But he could not rule out "back-street" health professionals doing it illegally.

144. He had not had any personal experience of a SIBP case and had not been able to find any colleagues who had.

145. Dr Zapata-Bravo said he had come across tribal scarring many times and assumed in most cases there had been social consent to it by the person scarred. He had heard of persons having pain free operations whilst conscious through acupuncture although he had no expertise on that subject.

146. He had considered what motives the appellant's torturers might have, but he was not an expert on countries or politics. He thought it was quite plausible to consider from the patterns formed by the appellant's scarring that it was "tiger branding"; although it had not occurred to him when he first saw it.

147. As regards the state of unconsciousness caused by the shock of infliction of a burning hot instrument on his arm, its duration could not be predicted. When the appellant had further burns inflicted that could have woken him up. He was burned at least a further four times which would have required at least ten minutes. This led him to think something else must have happened to the appellant to make him unconscious for that period of time. The fact that he was in a poor state of health, with a poor diet, had lost weight and had not eaten or had fluids could possibly explain it. A blow to the head could explain it, although that was not the appellant's account. Pure shock through pain was not enough to explain the appellant remaining unconscious.

148. Asked whether drugs other than a general anaesthetic could ensure immobilisation during infliction of such scarring, Dr Zapata-Bravo said he did not think any morphine or heroin or analgesic would have been sufficient. Restraint whilst he was still conscious would have meant his muscles would have contracted violently and the scars would not have been as precise as they were.

<u>Dr Joy Odili: written report</u>

149. Dr Odili is a Consultant Plastic Surgeon based at St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton. She is an Honorary Senior Lecturer at St George's Hospital and her teaching roles include delivering the plastic surgery curriculum to undergraduates. She routinely deals with issues around wound healing and burns. She is often called to comment on wounds particularly where non-accidental injury is being considered. On 13 September 2013 the appellant's solicitors asked her to prepare a report addressing the issues identified in the Tribunal directions and "[i]n addition. 1. Could you kindly assess the scarring on the Appellant's body and provide your expert opinion on how the scarring was caused with reference to the Istanbul Protocol addressing each scar/area of scarring individually together with detailed reason for those conclusions".

150. In her written report of 24 September 2013 she explains that she examined the appellant's scars on 10 and 24 September 2013. Her examination of the appellant revealed that he had two scars on his right arm and six scars on his back. Her opinion is that all these were caused by the same object and all were typical of a burn "with a heated rod". She considered the fact that the scars on the appellant's arm were slightly wider and darker to indicate that these were inflicted first when the heated rod was hottest.

151. She had considered but ruled out that these scars could have been caused by a stain or by skin diseases or by burns sustained in childhood or by cuts or lacerations. They had not been surgically treated. They could not have been the result of skin grafts because that left tell-tale signs of which there were none. She considered the scars were not consistent with sports injuries. As regards the possibility that they were work-related, she thought that as the appellant worked with fire and molten gold, it was feasible he would have sustained burn injuries at work but the pattern, distribution and location of the burns made this highly unlikely. Clinically she could not tell if these burns were caused as part of military training.

152. Whilst it was feasible that the scars on his right upper arm could have been inflicted by the appellant, he would not have been able to inflict the burns to his own back.

153. Dr Odili also considers whether the appellant's scars could have arisen by accident. "The client reports that his scars are a result of torture. They could only have arisen by accident if he was pressed against a heated metal rail such as a radiator with multiple horizontal rails. However the appearance of the client's scars are not consistent with this theory". The burn scars were not perfectly parallel, also if one touched a very hot radiator instinct and pain makes you pull away; the time and contact between skin and metal would be too short to leave such scars.

154. As regards their age, the appearance of the scars was typical of burn scars more than two years old; "The exact age of the scars cannot be determined beyond this". Burn scars fade with time: the scars were darker in the 2011 photographs and paler now. The scars on his body were not consistent with any types of injury other than a burn.

155. The fact that the burn scars were so similar with no blurring or smudging indicated to her that the appellant must have been immobilised or unconscious when they were delivered.

156. In reply to specific written questions raised by the Tribunal following an earlier case management hearing, Dr Odili states that it is not possible clinically to differentiate between scars inflicted by torture and scars inflicted by consent. Burns caused by torture tend to be deep and the torturer persists until the desired effect is achieved.

157. In response to a written question whether it was possible to determine from the nature of the scarring itself what if any medical intervention or palliative care measures had been provided to enable recovery, Dr Odili states that in general the

appearance and texture of burn scars can be modified by such measures for any period up until two years after the burning.

158. As regard whether it is possible to diagnose with any precision with reference to the nature of the scarring when it occurred, Dr Odili states it can take up to two years for a scar to heal perfectly. Therefore one can tell new scars (pink and raised) from scars older than two years (pale and flat).

Dr Joy Odili: oral evidence

159. Dr Odili said that from the time a burn was inflicted she had between eighteen months to two years to make an impact as a plastic surgeon. It is not possible to tell, looking at old burn scarring, whether the patient had palliative care at the time. The appellant would have been very prone to infection – he was very lucky and may have been saved by the fact he was allowed to wash daily.

160. Dr Odili said beatings delivered to the same area as fresh burn scarring would alter the healing process but not the nature of the scarring, so that healing took up to four months.

161. Dr Odili said she had dealt with patients who had tribal scarification, and also with patients who had tattoo scarring. She had dealt with patients who had deliberately burnt themselves. It was rare for her to deal with burn scarring inflicted by torture. As she had said in her written report, she was sure the appellant's scarring could not have been caused accidentally.

162. Having looked at the photos taken of the appellant's scarring in 2011 she said that from the coloration of some (pink) she considered they had been inflicted within a period of two years before that.

Professor Cornelius Katona: written report

163. Professor Katona is Honorary Professor, Department of Mental Health Sciences, University College London, Emeritus Professor of Psychiatry, University of Kent and also Medical Director, HBF. From 1998 until July 2003 he was Dean, Royal College of Psychiatrists. He has published widely and held many teaching posts. He has been involved with the Medical Justice Network since 2006. He currently chairs a Royal College of Psychiatrists working party on the writing of asylum and immigration related psychiatric reports for the courts.

164. Professor Katona states that the IP contemplates that doctors consider the possibility of fabrication of the clinical picture both physical and psychological, referring to paragraphs 105(f), 287(vi) and 290.

165. His report seeks to address the psychological aspects and the techniques used by psychiatrists in assessing the mental state of the patient. The main tool for doing this is the psychiatric interview which is wide-ranging in scope. The mental state examination involves detailed description of the patient's appearance, behaviour, speech, mood, thought content, any abnormal experiences and an assessment of

cognitive function. The interview is often supplemented by a physical examination.

166. In broad terms the idea that mental illness is easy to fabricate is a misconception. Any pretence cannot usually be sustained and "real" symptoms or "real" elements in the causation of the illness tend to reveal themselves in the context of sustained and supportive interviewing.

167. Whilst it is crucial within a psychiatric interview to establish and maintain rapport and be non-judgmental, the psychiatrist will attend closely to the patient's behaviour and, as conveyed by paragraph 290 of the IP, any apparent inconsistencies (such as exaggerated distress or apparent indifference) will contribute significantly to the overall conclusions drawn. They will be gently and non-judgmentally explored. Any conclusions within a psychiatric report will involve consideration of all relevant information and in particular any apparent discrepancies.

168. Torture survivors may have difficulty in giving specific details of their torture due to the trauma it causes associated with high emotional arousal, impaired memory, mental illnesses such as depression and Post Traumatic Stress Disorder (PTSD). Some patients have difficulty in disclosing what happened to them because of feelings of guilt or shame.

169. Where there had been a previous finding that the claimed events had been fabricated, the medical expert had then to consider whether the illness may provide an explanation for any feigning or exaggeration, whether the illness may be real despite the feigned or exaggerated claims, and whether the finding of feigning or exaggeration might have been mistaken. "It is not always possible in psychiatric practice to be sure about the aetiology (causation) of illness in the particular context of PTSD. The psychiatrist must also consider whether the illness may have been caused by stressors other than the reasons initially stated. Particular care is taken by psychiatrists to assess for feigned symptoms or history."

<u>Professor Cornelius Katona: oral evidence</u>

170. Professor Katona said that over the past 30 years he had written nearing two thousand medical reports, a third on patients from cultures other than our own in the UK. He said it was important for medical report writers to make an overall clinical assessment integrating physical and psychological aspects. In a psychiatric assessment doctors do not base their assessments just on what patients say. Just as with NHS doctors, HBF doctors writing reports had to consider whether a patient was feigning symptoms. It was good practice for a doctor to make explicit that he or she had considered feigning as a possibility. Feigning was difficult to maintain, as patients were unlikely to have the detailed knowledge to enable them to do that. The starting point should always be the clinical features of the case. Consistency between the injury or trauma and the patient's attribution was medical consistency.

171. Professor Katona said the IP provides guidance on best practice devised by a very large committee of experts.

172. Regarding whether the first infliction of branding on the appellant would have kept him unconscious, he did not understand unconsciousness to be an absolute; there was a continuum between consciousness and unconsciousness. Psychological trauma could play a part. Such events could affect memory and cause severe traumatisation and PTSD may vary over time. Clinical manifestations may be delayed.

173. Asked by Mr Duffy whether a person could be traumatised by SIBP, Professor Katona said he had not seen such a case, but it was plausible. Patients undergoing operations in which the anaesthetic had failed had been known to suffer trauma.

174. Asked if people living in war zones were more likely to suffer PTSD, Professor Katona said that was likely but people vary in their degree of resilience.

175. Stories people have been told to use by smugglers and traffickers tend not to be clinically convincing.

176. If he had doubts about the veracity of a patient's stay he tried to express that in the interview itself, with sensitivity especially if the case involved sexual trauma, where patients may not be able to disclose the truth for some time. The doctor had to combine being non-judgmental and fostering trust with being critical and probing. He did not start with any absolute assumptions. If he was satisfied a patient had feigned symptoms he may well decide not to make a report.

177. Psychiatrists used structured interviews to help differentiate between PTSD and, say, biological depression.

178. Professor Katona said he had never seen SIBP; although he had seen ritual or tribal scarring; he could not recall if he had seen tattoo scarring.

179. In reply to questions from the panel Professor Katona said issues about states of unconsciousness caused by fainting in reaction to acute pain were on the edges of his experience, although he was familiar with the Glasgow coma scale [a neurological scale that aims to give an objective reading of varying states of unconsciousness].

180. He was primarily concerned with making a diagnosis that was reliable.

<u>Dr Sonia Allam: written report</u>

181. It became clear during the hearing that there were questions arising relating to whether there are different levels of unconsciousness. The parties agreed that this required an opinion from an anaesthetist and the Tribunal gave directions to facilitate this. A report by Dr Sonia Allam dated 17 March 2014 followed.

182. Dr Allam is a Consultant Anaesthetist at Forth Valley Royal Hospital and has specialised in this area of medicine for over 10 years. Her report first addresses the question of whether it was possible to achieve a state of unconsciousness similar to that existing under anaesthesia by administering heroin or morphine so that burns and/or scars inflicted upon someone would not cause pain or discomfort or

discernible flinching of the muscles. She said that to attempt deliberately to achieve "general anaesthesia" using diamorphine or morphine would be extremely dangerous and difficult even for an experienced clinician. Further, such a state could not be sustained for any length of time.

183. By contrast, when anaesthetists induced planned general anaesthesia in medical practice, numerous mandatory safety measures are in place. Dr Allam considers that attempts using alcohol would be more difficult to achieve but would carry the same life-threatening dangers. The sixth question she was asked was, "If someone faints from ill treatment, how likely would he/she [to] regain consciousness if the same pain was inflicted again?" Her reply was that a "faint" or vasovagal syncope can be caused by any painful or unpleasant stimuli and she had experience of patients who had experienced this in the course of insertion of intravenous cannulae and epidurals:

> "Following lying down, consciousness was regained very quickly, usually within seconds. I believe in the above situation in question any vasovagal syncope would be likely be short lived and self-terminate once lying down, which is usually the case, as any upright individual would fall unless impeded. Further appropriate response to a painful and unpleasant stimulation in the individual would then likely be seen again. Other factors, such as the health/physical state of the individual, could affect the speed with which they regain consciousness or could increase the propensity for further vasovagal response".

The appellant's GP

184. Although not an expert this is a convenient point to record the evidence of the appellant's GP. The appellant produced a letter from his GP stating that the appellant came to see him on 13 April 2011 complaining of lower back pain. He had recently arrived from Sri Lanka on 24 February 2011. He alleged he was subjected to ill-treatment by the army in Sri Lanka. He alleged that he had four burn marks on his back due to hot iron rods being applied and was also hit by the butt of a rifle in his back. "On examination he was noted to have four dry burn marks across the back which were horizontal which may have been due to iron rods being applied. There were no signs of infection or inflammation. He was given a combination of topical and oral analgesia. There was no record of subsequent attendances at the surgery."

Other Medical Documentation

185. The evidence submitted to the Tribunal included Medical Investigation Documentation of Torture: A Handbook for Health Professionals, written by Michael Peel and Noam Lubell with Jonathan Beynon, 2005 published by the Human Rights Centre, University of Essex, Shedding light on a dark practice: Using the Istanbul Protocol to document torture, a 2009 Handbook produced by the International Rehabilitation Council for Torture Victims.

Background Country Evidence

COI reports

186. Several of the background reports, including the COI Bulletin dated 30 November 2011 document the use by the Sri Lankan authorities of torture. Several include reference to one of the methods of torture used being burning with hot metal instruments. For example, the Country of Origin Information Report for Sri Lanka dated November 2010 ("COI") at 8.42 quotes from The USSD report 2009, which contains the following reference to torture methods in Sri Lanka at this time.

> "Civil society groups and former prisoners reported on several torture cases. For example, former detainees of the Terrorist Investigation Division (TID) at Boosa Prison in Galle confirmed earlier reports of torture methods used there. These included beatings, often with cricket bats, iron bars, or rubber hoses filled with sand; electric shock; suspending individuals by the wrists or feet in contorted positions, abrading knees across rough cement; *burning with metal objects and cigarettes*; genital abuse; blows to the ears; asphyxiation with plastic bags containing chili pepper mixed with gasoline; and near-drowning. Detainees reported broken bones and other serious injuries as a result of their mistreatment." (Emphasis added)

187. At 8.39 the COI quotes the EU report of October 2009 as follows:

> "International reports indicate continual and well-documented allegations of widespread torture and ill-treatment committed by State forces (police and military) particularly in situations of detention. The UN Special Rapporteur on Torture has expressed shock at the severity of the torture employed by the army, *which includes burning with soldering irons* and suspension of detainees by their thumbs." (Emphasis added)

188. Paragraph 3.9.17 of the OGN v14 issued July 2013 records that the FFT report, "Out of the Silence: New Evidence of Ongoing Torture in Sri Lanka", released on 7 November 2011 noted that high levels of scarring [based on a data set of '35 medico-legal reports (MLRs) prepared by FFT clinicians in relation to clients, most of whom are asylum seekers or refugees' in the UK] could reflect a policy of permanently 'branding' victims not only to inflict long-term psychological and physical damage, but also to ensure that the individual may be easily identified in future as having been suspected of links to the LTTE.

189. In the preceding paragraph (3.9.16) it is noted that the British High Commission observed in a letter of 5 January 2012 that whilst scarring has been used in the past to identify suspects, this practice has either ceased or is used less frequently.

190. Elsewhere the OGN refers to various sources stating that torture continues to be used by the authorities in Sri Lanka.

191. We also need to note that the July 2011 COI at 8.35 stated the following:

> "A letter from the British High Commission (BHC) Colombo dated 11 May 2011, reported:
> —I asked the Senior Government Intelligence officials if there was any truth in allegations that the Sri Lankan authorities were torturing suspects. They denied

> this was the case and added that many Sri Lankans who had claimed asylum abroad had inflicted wounds on themselves in order to create scars to support their stories.
> —[A Colombo based human rights worker] added that it was well known that many persons who were held in IDP camps at the end of the conflict scarred themselves so that on release they could make allegations that the Sri Lankan government had tortured them."

However, by the time of the later COI report for March 2012, that paragraph had been removed. We note that in the skeleton argument of the HBF it is said that that passage in the COI for 2011 had been withdrawn under pressure from the Chief Inspector of the UKBA (John Vine) and from NGOs.

Report by Appathurai Vinayagamoorthy, LLB (Col)

192. In an undated but seemingly recent report Mr Vinayagamoorthy stated that he was an Attorney at Law in Sri Lanka. He was also an MP elected as one of the Tamil National Alliance candidates in 2010. As a lawyer representing detainees under prevention of terrorism legislation he had an opportunity to handle the case of torture survivors in Sri Lanka on a day to day basis. Torture perpetrated by state actors within both the military and police has continued in Sri Lanka after the conflict ended in May 2009. The authorities had a culture of branding going back to 1983. Research showed that people were subjected to a range of torture methods including deliberate burns with cigarettes and heated metal instruments. His report gives several examples of cases he had dealt with. They included a Mr KT and Mr JJ and Mr SM who are said to have been severely tortured and left with permanent scars of burning. His report concludes:

> "In my opinion, burning with hot metal objects (branding) is the second most common method of torture among the above, which I see on a regular basis…This particular method is used for a number of reasons. Firstly, it is the easy way to cause severe pain without any special apparatus. Secondly, burning with iron rods or other objects will leave permanent scarring and this is used as identification technique by the authorities. This is deliberately used to humiliate the victim and to identify the victim easily in the future. This also prevents the victim from escaping from the detention as this scarring is permanent and visible. I have seen approximately 1500 of my clients who were burned in a way that left permanent marks. In my observations, although the size and number of the burns differ from person to person, these marks resemble the tiger stripes. It is widely said that the police deliberately want to brand the victim with tiger stripes, so that they can easily identify him or her in the future".

193. Having stated that Sri Lankan medical experts did not properly document such injuries caused by torture for fear of getting into trouble with the security forces, his report goes on to say that nonetheless in some cases medical experts:

> "[I] have examined and have concluded that these scars were consistent of [sic] torture account. Also the medical experts could not find any other alternative method of causation. I personally do not have any reason to believe that these branding scars could have caused by any other means. This is mainly because I have seen such scars during my prison visits and there is no way my clients would have sustained these burns, other than torture, whilst in the detention".

SUBMISSIONS

Written submissions

194. The respondent's skeleton argument rehearsed the reasons for refusal given by the respondent in her decision letter and then turned to comment on the new evidence relied on in recent witness statements from the appellant and his family members. The respondent submitted that it was not credible that the appellant had been told by his father in late July 2013 that the Sri Lankan authorities were looking for him and that they were aware of his presence in the UK. It was not accepted there would have been no other contact between the appellant or his brothers and their parents. The respondent also challenged the appellant's claim in his witness statement to have had no reason to leave Sri Lanka, given that prior to his illegal entry and application for asylum he had made no less than 3 applications to leave Sri Lanka and study abroad in the UK and his two brothers had also sought to migrate abroad. In the alternative the respondent submitted that even if the appellant were found credible as to his activities for the LTTE in Sri Lanka, he would still not be at risk on return in the light of the current country guidance case of GJ. In relation to the medical evidence, the respondent highlighted the difference of opinion between Dr Zapata-Bravo and Dr Odili over the dating of scarring over 6 months old. The respondent reminded the Tribunal that a finding by a medical report identifying scarring consistent with a claimant's account was not binding on a tribunal judge. Albeit in general unlikely that a person would undergo scarring to establish an opportunity to remain in the UK, it remained open to a judge to conclude that a claimant has undergone scarring to support a false claim.

195. Counsel for the appellant submitted that the medical evidence produced in support of the appellant's claim was capable of amounting to independent corroborative evidence that he had been tortured. Dr Odili had concluded that his scarring was "typical" of being burnt with a metal rod as claimed. She expressly considered possible alternative causes, including employment, self-infliction and infliction by a third party with consent. Whilst she concluded that it was not clinically possible to differentiate between scars caused by torture and those with consent of the individual, she was adamant that if carried out with consent, it would have been necessary for him to be immobilised due to the extent of the pain caused. The written submission states:-

> "It is submitted that this report, based upon a clinical assessment of the appellant's scars and his history, is a report which should be accorded considerable weight. No evidence has been adduced to displace this report and there is no reliable evidence that there is a practice of self-infliction or infliction by proxy of scars. Further, the physical evidence taken together with the medical evidence produced from a doctor with considerable expertise and the background evidence of torture meted out by the Sri Lankan authorities of detainees (a fact accepted by the respondent in GJ (Sri Lanka) is such that applying the lower standard of proof the appellant's account of being detained and tortured is credible."

196. In relation to the evidence the appellant gave of being tortured, his account that he was beaten almost every day and or every two to three days was consistent with that which he gave to Dr Odili and Dr Zapata-Bravo. The written submissions stated: "[T]he Tribunal is reminded that the appellant was ill-treated in detention erratically between 2009-2011 and the appellant's evidence is that there was no regular frequency to his pattern of ill-treatment."

197. It was submitted that the appellant had been able to give a detailed account of being burnt in detention. The assertions that there is no background evidence to demonstrate that the Sri Lankan authorities use heated metal implements to burn and/or brand detainees (which was one of the reasons relied on by the respondent in her refusal letter for finding him not credible), is irrational and is completely at odds with the background evidence.

198. Regarding the written submissions by the HBF, it will be convenient to refer to relevant passages when we turn to analyse the medical evidence below.

Oral Submissions

199. For the respondent Mr Duffy's submissions on the general issues were brief He urged the Tribunal to apply the guidance given in AJ (Cameroon) [2007] EWCA Civ 373 which at [11] made clear that the burden of proof rested on the claimant to show that his scars were caused by torture and that it was not necessary for the decision-maker to do more than decide whether that burden had been discharged. If the decision-maker concluded it had not been discharged it was not incumbent on him to prove what he considered the actual cause of the scarring. That would be an unduly speculative enterprise anyway because such evidence as there was about the practice of SIBP in the context of Sri Lanka was little more than hearsay.

200. Mr Duffy said he agreed with HBF that SIBP was unlikely to arise as an issue except in rare cases, in particular where the evidence, medical and/or non-medical, indicated a person's injuries could not have happened in the way claimed. Such was the situation in the case of BV where it was found that at the time when the claimant said he was in Sri Lanka being tortured he was in the UK: see above paragraph 11.

201. Mr Duffy said the medical answers the Tribunal had received to its three questions highlighted the limits to the medical expertise available to decision-makers in scarring cases. To the first question the clear answer was there was no way of telling the difference between scars inflicted by torturers and scars that were SIBP: It was likely a proxy would try and replicate what was done by torturers, although a proxy might be in a position to achieve more precise scars (because the patient would be immobilised).

202. To the second question the equally clear answer was that there was no way of telling whether after the scarring had been inflicted there had been palliative treatment. If there had been surgery on skin grafts they could show up, but lesser forms of medical intervention would not be discernible.

203. As to the third question regarding the period of time after which a scar could not be dated, he thought that whilst the answer was not entirely clear-cut (Dr Odili saying two years; Dr Arnold one year and Dr Zapata-Bravo six months) he was prepared to accept that the differences in the range between six months and two years, reflected the different contexts in which medical specialists worked. In the case of Dr Odili, she would normally be seeing patients shortly after they had suffered burns. In the typical case of a doctor asked to do a medical examination of an asylum seeker, six months to one year was more likely to be the medical norm.

204. In relation to the evidence given by Mr Rhys Jones and the medical witnesses, Mr Duffy said that he did not in broad terms take issue with any of it. In broad terms the Home Office would attach significant weight to reports from doctors working for FFT and the HBF because it was known these organisations had good working practices. In respect of Professor Katona's evidence, he thought it significant that it reaffirmed that doctors in their reports are concerned with medical plausibility, not with the wider issue of the plausibility of an asylum claim. He considered that when doctors were asked to write reports addressing a person's psychological condition, that could be a very formidable task if they came from a country like Sri Lanka which had experienced civil war. That could make assessing the cause of PTSD very difficult.

205. For the HBF Mr Yeo said that it was significant that having originally maintained in her refusal decision that there was evidence of a practice of SIBP by Sri Lankan asylum seekers, the respondent through Mr Duffy had accepted there was not a shred of admissible evidence to show that. It had not originally been the Home Office case that SIBP was an issue in this case; that had only arisen as a possibility as a result of the FtT assessment; proceedings since then had shown it should never have been an issue.

206. As regards the age of scars, Mr Yeo submitted that there was no real difference between the witnesses and to the extent that there was, he thought (like Mr Duffy) that was likely to be a function of the different context in which doctors in different fields operated.

207. The core HBF position, said Mr Yeo, was that the decision makers had to look at the evidence in accordance with IP guidelines and not to speculate.

208. Recognition of the different functions of doctors and decision-makers should not obscure the fact that a medical report was capable of strongly corroborating a claimant's account, as the European Court of Human Rights (ECHR) made clear in R.C. v Sweden App. no. 41827/07 judgment 9 March 2010.

209. The HBF was particularly concerned that decision-makers should not disregard medical reports just because they did not emanate from HBF and FFT doctors or did not match the "gold standard" of the IP. It was noteworthy that in R.C. v Sweden the ECtHR attached important weight to a medical report even though it was not IP-compliant.

210. Adverting to the scenario mentioned by Mr Duffy, where an appellant was found to be in the UK when he claimed to be in his country of origin being tortured, it may simply be that the Secretary of State and/or the judge was wrong. There could be all sorts of reasons why such an asylum-seeker might not have told the truth.

211. Ms Jegarajah, also instructed by HBF, pointed to the recognition of the importance of the IP in UK case law, SA (Somalia) [2006] EWCA Civ 1302 in particular. A central plank was that decision-makers should look at an appellant's account in the round and not compartmentalise the medical evidence. A holistic approach also meant, in relation to assessment of physical scars, not simply analysing each in isolation, but making an overall assessment.

212. Another key plank was the principle established in AM, R (on the application of the Secretary of State for the Home Department) [2013] EWCA Civ 521, that a medical report is independent evidence and cannot be rejected just because it bases itself on a patient's narrative. Furthermore, it was a misconception to think that doctors uncritically accepted the patient's narrative. If the HBF decided a patient's account was false, either it would not endorse it or not produce a report. This case afforded a very useful opportunity for the Tribunal to develop the case law further in the light of the important evidence from leading experts. She drew attention to the Joint Presidential Guidance Note No 2 of 2013 on Child, Vulnerable Adult and Sensitive Appellant Guidance.

213. It was hoped that the Tribunal would recognise that just because a medical report did not deal with both physical and psychological s*equelae* did not mean it was not creditworthy.

214. Ms Jegarajah asked the Tribunal to take cognisance of the procedural fairness aspects to cases in which a decision-maker considered there was a real possibility of SIBP. If there was considered to be such a real possibility, that should be put to the claimant. If one looked to see the genesis of the suggestion that SIBP was occurring, it turned out, in the Sri Lankan context, to be a statement by the Sri Lankan Government and a hearsay account of what had been said by one Colombo-based human rights worker. It was wrong that such dubious speculation should be treated seriously. If a case worker or Presenting Officer had concerns about SIBP, these should be put to the claimant. If a judge lent credence to such a scenario, that would be wrong in law because it would amount to taking account of an irrelevant consideration. Certainly it would be wrong to treat such a concern as a reason for marginalising a medical report finding that scarring was caused by torture.

215. Ms Jegarajah submitted that existing case law indicated that to treat SIBP as a serious possibility in the absence of any evidence of such a practice happening would be to elevate what the Tribunal in RR (Challenging evidence) Sri Lanka [2010] UKUT 000274 (IAC) described as "cynicism" over rational assessment. The focus had to be on what had probably, not conceivably, caused the scarring.

216. It was imperative for decision-makers to bear in mind the importance of COI for what light it shed on likely causes of scarring. In the Sri Lankan context, there was evidence that the Sri Lankan authorities used particular methods of torture the second most common of which was scarring by hot metal instruments. There was no basis therefore for speculation about SIBP "torture factories"; the "torture factories" were to be found in the detention centres run by the Sri Lankan authorities! If a judge has evidence that torture often takes the form of scarring by branding and that a claimant bears burn scars, then he or she ought to accept the claimant has been a victim of torture. She highlighted a number of passages from the COIS report, paragraphs 8.33, 8.35, 8.47 in particular.

217. Like Mr Yeo, Ms Jegarajah sought support for the position advanced by the HBF from the ECtHR case of R.C. v Sweden. This established, she submitted, that if a claimant submitted a medical report, that established a prima facie case and it was for the government to dispel any doubts about that. Once the appellant discharges the burden of proof, the onus shifted to the government. That stood in stark contrast to the position of the Secretary of State which appeared to be that the claimant had to disprove an outlandish alternative to the one identified by the medical report. The fact that there might be other possible causes should not matter if there was strong medical evidence that torture was the probable cause.

218. Ms Jegarajah reiterated points made by Mr Yeo in relation to the evidence given by Mr Rhys Jones and the medical witnesses. She urged the Tribunal not to surmise whether it was likely the appellant's scars would have become infected which might have been expected to make their outline less regular. It was difficult clinically to identify whether there had been infection retrospectively.

219. Like Ms Bayati, Mr Paramjorthy on behalf of the appellant associated himself with the submissions made by Counsel for the HBF. It was highly significant to the assessment to be made of the medical evidence that the Home Office OGN for July 2013 itself contained references to hot metal instruments being a common form of torture used by the Sri Lankan authorities.

220. In response to questions from the Tribunal, Mr Duffy for the respondent said he accepted that if a decision-maker formed the view that there was potentially no other explanation, he or she should put that concern to the claimant. However, on the principles set out a [11] of AJ (Cameroon), a decision-maker was entitled to conclude a claimant had not proved his claim to have been tortured without having to make a specific finding on whether the scars were the result of SIBP.

221. In an email of 19 March Mr Duffy drew attention to the answer given by Dr Allam to a sixth question, which seemed he said, "to point to the appellant's profound unconsciousness in response to the initial burn as being contrary to this anaesthetist's experience". He submitted that this was a factor which the panel should take into consideration when assessing the credibility of the appellant's claim to have passed out and been unconscious throughout the whole burning experience.

DISCUSSION

Istanbul Protocol (IP)

222. The HBF submitted that the Tribunal should regard the IP as having attained the status of customary international law, based on a statement by Dean Claudio Grossman (current Chair of the Committee against Torture), "The normative value of the Istanbul Protocol", in S Kjaer and A Kjaerum (eds), Shedding light on a dark practice: Using the Istanbul Protocol to document torture (International Rehabilitation Council for Torture Victims (IRCT)), 2009. Bearing in mind the requirements for the creation of customary international law, as set out by the International Court of Justice in North Sea Continental Shelf Cases, 20 February 1969, ICR Rep.1969, 3 paragraphs 70-74, such a submission is fraught with difficulties. As analysed by Wallace and Wylie in "The Reception of Expert Medical Evidence in Refugee Status Determination", IJRL, Vol 25, No.4 pp755, these range from the fact that the IP does not itself purport to impose legal standards to the fact that the UN Committee against Torture has noted that there is a lack of knowledge about the Protocol and "very few" countries were using it. Even in the context of European state practice the EU institutions chose in 2011 not to proceed with an amendment to the recast Procedures Directive, which would have required the IP to be one of the instruments that should inform the "national measures dealing with identification and documentation of symptoms and signs of torture or other serious acts of physical or mental violence, including acts of sexual violence, in procedures covered by [the] Directive". We find that the case for regarding the IP as having the status of customary international law has not been made out.

223. At the same time, the fact that the IP was mentioned in the draft recast of the Procedures Directive, coupled with the endorsement given to the IP by the ECtHR in cases such as Bati and Others v Turkey App nos. 33097/96 and 57834/00, 3 June 2004, are just two of a number of indices showing that the IP is becoming more embedded in the framework of international protection. As stated by Wallace and Wylie:

> "…irrespective of legal uncertainties as to the normative status of the Istanbul Protocol, it undoubtedly does represent a global consensus as to standards and principles for the investigation and documentation of torture".

224. In the UK recognition of its central role has come both from the Upper Tribunal, the courts and the Home Office. Accurately encapsulating this, the Home Office Policy Instructions (which we consider it useful to append: see Annex A) state at 3.3 that:

> "The Protocol, the central importance of which is accepted by the UK courts in the asylum context, makes clear that reports which document and evaluate a claim of torture for asylum proceedings need only provide 'a relatively low level of proof of torture [or serious harm]'.Therefore, the [FFT and HBF] report in support of the applicant's claim of torture or serious harm cannot be dismissed or little or no weight attached to them when the overall assessment of the credibility of the claim is made."

The Tribunal's questions

225. To the three questions we posed at the case management stage it can be seen from our earlier summary of the evidence that the answers given by the medical experts were as follows:-

Distinguishability between scars inflicted by torture and scars inflicted by SIBP

226. In answer to the first question ("whether it is possible to differentiate by any known means of physical examination or invitation between burns scarring caused by hot rods or wires or similar heated instruments including cigarettes that has been brought about by torture from scarring caused by the above methods that has come about at the invitation of the person affected"), the medical witnesses were unanimous that there was no clinical way of differentiating between scars inflicted by torture and scars inflicted by SIBP. Mr Rhys Jones's evidence made a similar point when he said that the medical literature was clear that there was no scientific way of detecting the "hand behind the [implement of] torture". (Whether we accept this answer as wholly correct is a matter we will need to address separately in due course.)

Evidence of medical intervention/palliative care

227. The second question asked by the Tribunal was "whether it is possible to determine from the nature of the scarring itself what if any medical intervention or palliative care has been provided to enable recovery?"

228. As we understand it, the answer given by the medical experts to this question was that unless there was evidence of surgical intervention, e.g. the existence of a site elsewhere on the patient's body used for a skin graft, or unless the medical examination was a very short time after the alleged torture (when for example it might still be possible to detect the presence of drugs in a person's bloodstream), it was not possible to tell whether there had been medical intervention or palliative care.

Dating of scarring

229. The third question was whether it is possible to diagnose with any precision with reference to the nature of the scarring when it occurred. It is clear from the substantial evidence we heard on this subject that there is no scientific consensus as to the precise date beyond which it becomes impossible to tell how old the scarring is, but there was agreement amongst the representatives that in the context of assessment of scarring said by claimants to be the result of torture it was only possible ordinarily to assess the age of scarring – by reference to various features such as the colouring, elevation, hyperpigmentation etc. - within the first 6-12 months. The evidence of Dr Odili, who brought the perspective of a plastic surgeon with specialism in burns, indicates that it may sometimes be possible to date scarring up to 2 years old depending on the particular medical context. That is lent some support by Dr Zapata-Bravo's observation that in some skin types bruises can lead to hyperpigmentation which may last for several years: see above paragraph 127.

Other questions

230. We have also had helpful answers to two other medical issues that arose, both of which also have a possible bearing on the appellant's case.

Effect of infections on fresh burn scarring wounds

231. Those medical experts who commented on the matter appear to agree that, unless treated, fresh wounds caused by burn scarring are prone to infection, although whether that occurs will depend on a range of factors such as the general health of the victim, age, hygiene, physical surroundings, etc.

Effect of infections on appearance of scars

232. The experts were also in agreement with the possibility that if burn scars were the subject of infection this could affect the eventual contours of the scars, making their edges or outlines less precise for example.

Résumé

233. We will have cause to discuss the answer to the first question later, but at a general level the answers given to all five questions illustrate the present limits of medical expertise and underline the point that medical reports, although of great importance as types of evidence in asylum cases, may not necessarily be able to resolve key questions regarding causation. Generally speaking, they are not like DNA test results which can furnish near certainty one way or the other. Put another way, taken as they stand the medical answers to all five of the above questions only take us so far, and they do not fully resolve what has always been the central issue raised by this case, namely whether SIBP is a possible cause that doctors should consider when preparing medico-legal reports in asylum cases. To resolve that issue we need to consider the medical evidence and submissions in their entirety and in the light of established case law.

SIBP

234. The HBF submissions on the issue of SIPB had several strands. In its preliminary skeleton argument the HBF submitted that:

> "In terms of the IP, the reason why SIBP claims should not be given any legitimacy is that these claims are anathema to proper and lawful refugee determination. If such claims continue it will become legitimate for some Tribunals to find that an Appellant has self-harmed deliberately in circumstances where it is difficult to reconcile a strong report with an adverse assessment of credibility. Or worse, an expert is required to address the degree to which scarring arises as a result of SIBP as a matter of course, thereby requiring an expert to go beyond the scope of the Istanbul Protocol…The upshot is that there will be an additional threshold that an asylum applicant will have to cross when demonstrating his asylum claim, namely that his torture was not caused by himself…"

235. In their skeleton argument, the HBF position was summarised as being that the Foundation "maintains that the alleged issue of self-infliction by proxy is not in fact

an issue, either evidentially or legally. Medical professionals should not be required by the tribunal to attempt to prove a negative. "

236. In the concluding part of their preliminary skeleton argument the HBF submission was that "[t]he suggestion of SIBP reflects aberrant behaviour rather than the norm. If such a claim is made, it must be particularised with care and sufficient notice must be given...As a matter of principle such claims ought to be rare."

237. In their oral submissions Counsel for the HBF emphasised that medical experts were concerned with what was reasonably likely not just what was possible.

238. The different strands to the HBF submissions can be identified as: (i) SIBP should be rejected *a priori* as a possible cause; (ii) SIBP was not a possibility doctors should routinely consider; (iii) unless SIBP was a reasonable likelihood or real possibility in a case, it should be eliminated from consideration. We shall address each in turn.

A priori rejection of SIBP as a possibility

239. We do not find the suggestion that SIBP as a possible cause should be simply excluded *a priori* - as seems to be implied by HBF's references to it being "illegitimate" and "anathema" to proper refugee determination - to be at all helpful. There are a number of reasons for this.

240. First, it is a suggestion which is not reconcilable with other parts of HBF's submissions, asserting that "such claims ought to be rare" - a submission which logically accepts they can sometimes, albeit rarely, arise.

241. Second, it is at odds with at least one of the medical witnesses called by HBF to support the appellant's case, Dr Zapata-Bravo. In his main report the latter stated at paragraph 65 that although he had not seen any example or seen reference to one in epidemiological studies, nevertheless "the possibility should be contemplated and Peel et al (2005) have stated, 'Very rarely an accomplice might be asked to cause a wound in a place the person cannot reach'". In some parts of his evidence Dr Arnold said much the same.

242. Third, it is at odds with the report prepared on this appellant by Professor Lingam on which the appellant's representatives also rely. From Professor Lingam's report it is clear that his methodology when dealing with possible causes was to address, not just torture but also both self-infliction and "if these were caused deliberately to mislead". The Tribunal was informed that as a matter of course, Professor Lingam who provides a number of reports on Tamils asylum seekers considers both possibilities without being specifically instructed to do so.

243. Fourth, it is contrary to IP methodology. In our view the terms of paragraph 187 embody the concern of the IP's authors to base their methodology on a scientific method so as to ensure doctors stay within the parameters of their clinical expertise. At the purely logical or scientific level, it is clear that the possible causes of scarring can only arise in a finite number of ways. If we understand the medical literature put before us correctly, either they will have arisen through a bodily reaction (e.g. a skin disease); through natural phenomena (e.g. falling debris,

molten lava); the patient having (deliberately or by accident) inflicted them on himself; or they having been inflicted on him or her (deliberately or by accident) by a third party (or parties). Within the category of third party, the crucial distinction is between an actor who does it against the patient's will and an actor who does it with the consent of the patient (which is what the HBF understands by the acronym SIBP). Reflective of this concern to adhere to scientific principles, the IP methodology treats ascertaining causation as a matter of eliminating as far as possible causes other than torture.

244. In accord with this scientific method, it must be incumbent on the doctor to consider just that - all possible causes. Furthermore, if consideration of all possible causes were not to include consideration of SIBP that would also undermine one other component of the IP methodology which, as the witnesses were anxious to remind us, requires doctors to consider false allegations of torture. If a patient has scarring but is found to be making a false allegation of torture, then that means that it may very well have had an alternative causation.

245. Obviously that does not in itself entail that the alternative causation must have been SIBP; and indeed the dangers of jumping to that kind of conclusion are strongly underscored by the analysis set out in the 2009 publication, Shedding light on a dark practice: Using the Istanbul Protocol to document torture when commenting on the fact that paragraph 187 specifies that one of the findings that can be made is "not consistent" (defined to mean that "the lesion could not have been caused by the trauma described"). As the authors properly warn at p.16, whilst a finding of "not consistent" "generally leads to the assumption that a person is fabricating or embellishing an account of torture", that does not necessarily mean such a finding demonstrates fabrication. But by dint of the same reasoning, a finding of "not consistent" or of a "false allegation of torture" cannot be said to exclude SIBP as a possible cause.

246. Fifth, the need for a medical expert to approach matters in terms of possible causes is well-established by case law, as illustrated by the case of BN (psychiatric evidence – discrepancies) Albania [2010] UKUT 279 (IAC) in which the Tribunal considered that the doctor had failed to approach his task according to a proper method, stating at [44]:

> "That is not to say however that there were not proper and powerful criticisms which could be made of Professor Prasher's reports: it was Professor Prasher who pointed out that there were three possible explanations, alone or in combination for the symptoms described and seen: medication, malingering, and genuine illness. He took steps to eliminate the first. But he never returned to the second in either report, whether to say that no view could be formed or that he had concluded, and if so why, that the symptoms were or might be genuine or not. That is not satisfactory."

247. On the other hand, in similar fashion to IP methodology, the Tribunal in that case was anxious to highlight in the following paragraph the limited value of a finding which merely fails to exclude one of the possible explanations:

> "But for all that, she [the tribunal judge] had to deal with the report which did express a view, and the fact, which we accept, that the possibility of malingering

> could not be ruled out, did not prove that it was present. She did reach the view that the appellant was feigning his symptoms but in reaching that view, she had to grapple with what Dr Van Woerkom actually did say, giving proper reasons for rejecting it, even though he did not elaborate the basis for his conclusion on what Professor Prasher had left open."

248. Sixth, (as Dr Zapata-Bravo acknowledged) it clashes with the guidance given in the Medical Investigation Handbook written by Peel and others in 2005, which at pages 37-38 clearly does not rule out such a phenomenon:

> "Sometimes a patient will say that an injury was caused by torture when clearly that is not the case" (p.37)…It is sometimes suggested that scars and other lesions might be self-inflicted. True self-inflicted wounds are of two main types. One is where a person is deliberately harming him or herself to support a false claim of assault. Such wounds are generally superficial and within easy reach of the dominant hand. Very rarely an accomplice might be asked to cause a wound in a place the person cannot reach, such as in the middle of the back… (p. 38)".

249. If we take the answer given by the medical experts to the first of the three questions posed by the Tribunal as they stand, it could also be said that it reinforces the need to leave open the possibility at least of SIBP. To this question the experts were united in replying that there was no scientific method which would enable a doctor to differentiate between scarring inflicted by torture and SIBP. That surely entails that at the level of clinical inquiry into possible causes it must always be kept in mind that scarring could either be inflicted by torture or by SIBP. The exercise of trying to reduce uncertainty is said to be unable clinically to eliminate one as opposed to the other. However, as for reasons we shall come to shortly we think the evidence provided by more than one of the medical experts conveyed a somewhat different answer, we only mention this point to highlight internal inconsistencies in the argument that the possibility of SIBP can be rejected a priori.

SIBP and routine consideration

250. A separate strand of the HBF submission – which in combination with the third strand, we take to be more reflective of their submission as a whole -- is that doctors should not routinely consider SIBP - because the job of a medico-legal expert is to focus on what is reasonably likely and not on mere or theoretical possibilities and they are adamant that SIBP is either non-existent or rare.

251. We respectfully cannot endorse this strand either.

252. It is worthwhile pausing to consider what factors might warrant declining to consider SIBP routinely in a medical report in this area of law.

253. One such factor might be if it were outside of human experience. Another might be if it is contradicted by medical experience. We will examine each of these in turn.

SIBP and human experience

254. One possible feature of SIBP that might conceivably be said to show that it was outside human experience is the unwillingness of a person to consent to a

procedure that causes him or her pain either at the time of its infliction or afterwards. However, no one could seriously suggest that human beings lack the capacity sometimes to undergo or risk severe pain voluntarily, as a means to a desired end. Further, human experience encompasses a multiplicity of cultures and historical settings. And, if we limit ourselves for a moment to our particular area of law, everyone agrees that when dealing with asylum claims decision-makers must be wary of applying western norms to the likelihood of events or behaviour. It would be wholly naïve therefore for doctors to consider that just because patients are asylum-seekers, they should not be considered routinely as never being likely to consent to the infliction of pain (on themselves either directly or by proxy) as a means to an end.

255. We must also bear in mind that it is not as if SIBP would always necessarily involve experiencing severe pain. As the medical experts have reminded us, there are a range of palliative steps that may theoretically be taken at least to significantly reduce pain both at the time of infliction and afterwards, ranging from full anaesthetisation, acupuncture, morphine, heroin, analgesics, alcohol etc., and if the scars are not inflicted on the patient's face there are not necessarily any cosmetic concerns.

256. Another possible feature of SIBP that might justify treating it as outside human experience would be if there were no known examples of it. But that is plainly not the case. Under questioning the medical experts all agreed (more or less) that within the category of SIBP one would have to include such practices as ritual or tribal scarring. That entails that if a doctor is dealing with patients from certain African (or New Guinean) tribes, it would not necessarily be at all rare to see ritual or tribal scarring. Indeed, Dr Zapata-Bravo in his oral evidence said that he had come across tribal scarring "many times": see paragraph 145**.** In the context of medical examination of asylum-seekers, who by definition are from countries other than England/the UK, Dr Arnold's invocation of Occam's Razor through the metaphor of not looking for zebras in an "English field" strikes us as decidedly unfortunate**.**

257. Dr Arnold accepted that he had seen cases of ritual or tribal scarring, but said that none of them had been cases of burn scarring. Even assuming ritual or tribal scarring never or only rarely employs burn scarring, that already shows that it would be erroneous to classify the category SIBP as rare or uncharted in the literature. What must then be meant is a sub-category of SIPB – SIBP confined to the context of burn scarring.

258. The danger of seeking in this way to refine the category is that one would be at risk of constructing categories around just one type of scarring – burn scarring - and also at risk of shutting out possible further examples of SIBP (other than ritual or tribal scarring), such as tattoo scarring. As regards the latter, the experts were not able to tell us much except to say that it was rare, although interestingly Dr Zapata-Bravo did include tattoos as one of the possible causes he considered in his written report on the appellant. One would also be at risk of ignoring known historical examples, e.g. (going back just a few centuries and considering even only Western history), ignoring accounts that sometimes young men would inflict cuts on

themselves or have friends do so, so they could then pass them off as "duelling scars", which were regarded as a badge of honour. We certainly did not have a full enough body of evidence regarding human experience and history before us to show that doctors in their medical reports could clinically disregard the possibility of SIBP except in a clearly defined subcategories of cases.

SIBP and medical experience

259. Even if – in order to get round the fact that as regards the category of SIBP as such the medical experts have experience of it in the form of tribal or ritual scarring and much more rarely tattoo scarring - we confine ourselves to the sub-category of scarring SIBP for the purposes of manufacturing an asylum claim, we cannot see that medical experience is able to negate it as a possibility.

260. In order to explain why, it will assist first to address the more general question of whether doctors can say anything about torture methods by drawing on their medical experience.

261. In general terms, we concur with Mr Rhys Jones that it would be wrong to regard the medical expertise of doctors, certainly those connected to bodies such as the HBF and FFT or who have relevant field experience, as being confined to purely clinical expertise. Medical experience may enable a doctor to become familiar with the specific types and methods of torture used by torturers in specific locations and time periods. In the IP at paragraph 162, albeit in the context of dealing with detainees, it is stated that clinicians "should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned …"

262. We would emphasise, however, that such medical experience is not to be confused with doctors' non-medical knowledge based on COI or other background data (we will address that separately below).

263. In general terms, then, we would accept that medical experience can shed light on evaluation of scarring in certain circumstances.

264. Reference was made to an article written by Dr Arnold in May 2013 in which he stated that "[a] colleague has carefully searched the world medical and legal literature on factitious torture. So have I. We have found a tiny number of cases, none of them connected with asylum or Sri Lanka. Absent hard evidence, in the specific case, self-torture by proxy is simply not a rational argument".

265. We see value in being told about the state of the medical literature, but Dr Arnold's summary of it can scarcely be said to provide a sound factual foundation for excluding SIBP from being a possible cause of scarring - if for no other reason than that if it is a phenomenon that does occur (at least in the context of deliberate infliction for the purposes of improving an asylum claim), it is one which would be clandestine. If the phenomenon of SIBP did occur in this context it is unlikely to be one that individuals would undertake in public or advertise and, if they have done it in order to fabricate a false allegation of torture, it is unlikely they would volunteer that information to an examining doctor. Just as one cannot infer from

absence of evidence about torture taking place in secret prisons in a country that it does not take place, so one cannot infer from absence of evidence of SIBT that it does not occur. This observation is not for one moment intended to suggest the two phenomena are at all comparable; only to underline the basic point that, certainly in the context of practices which are intentionally clandestine, absence of evidence is not evidence of absence.

266. Nor are we filled with confidence when we look at the reasons given by Dr Arnold for considering SIBP to be something doctors should not routinely consider. In this same article his reasons presuppose that SIBP is something asylum seekers would only do prior to leaving their country of origin ("From extensive experience of inflicting pain as a surgeon and suffering it as a patient I am certain that the answer is that no one could hold still for such harms without a general anaesthetic (which is and was almost certainly unavailable to detainees in displaced persons camps in Sri Lanka)". Two obvious questions this gives rise to are: "why must STBP take place prior to departure?" and "on what basis can one assert that a general anaesthetic would not potentially be available to persons intent on SIBP?"

267. Nor do we find convincing Dr Arnold's attempt to reduce the question of whether the phenomenon of SIBP (in the context of fabrication of an asylum claim) exists to a question about whether there is any evidence of "torture factories". His analysis presupposes that the existence or non-existence of the latter is something doctors would be more likely to know about than, say, investigative journalists. Given that, as noted already, if SIBP exists it will be clandestine, we fail to see why this should be so. Unsurprisingly, when seeking in this way to go beyond their medical expertise, doctors risk criticism for failing to consider all relevant possibilities. Why for example would the phenomenon of SIBP only be possible in the context of a "torture factory"? Why could it not occur by a person seeking the services of an ex-nurse or "quack" doctor for example to undertake it? We emphasise this point not to suggest any possession of knowledge on our part of the existence of SIBP practices in the asylum-seeking context but simply to emphasise that for all involved in this very difficult area we must be wary of going beyond what we know and if the position is that doctors do not know then that is all they can – and should – say.

268. In short, whilst the medical experts tell us that SIBP (at least in the asylum-seeking context) is non-existent or rare, what they principally mean by that turns out to be simply that it is not a phenomenon which they have come across or have been able or have sought to identify, i.e. in general terms it is outside their knowledge and experience.

Self-inflicted harm

269. Doctors do not consider the same to be true of self-inflicted scarring. The medical witnesses, supported by other medical publications, tell us that it is the experience of clinicians that self-inflicted scarring is relatively easy to detect. Mr Rhys Jones' written evidence made reference to an undated statement made by David Alton MP which he had obtained from Professor Bernard Knight who had 41 years' experience as a Home Office pathologist:

> "The professor says that although it is impossible always to be certain about a single injury, most self-inflicted injuries are instantly recognisable by an experienced medical observer…Self-inflicted injury tends to be repetitive, superficial and places in areas easily accessible and usually avoids vital structures."

270. In relation to psychological harm/mental illness, the IP notes at paragraphs 290 that "[t]he clinician should keep in mind…that such fabrication requires detailed knowledge about trauma-related symptoms that individual rarely possess". In similar vein Professor Katona was clear that whilst both the psychiatric history and mental state examination are potentially liable to being "faked", that was difficult and, as paragraph 290 of the IP emphasises that "t]he clinician should bear in mind …that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess".

271. Drawing together what has been said so far, it seems to us therefore that in order to remain faithful to the IP methodology doctors cannot routinely exclude SIBP from their consideration of possible causes - certainly not if the reason for doing so arises out of a set of assertions which on their face are outside the limits of their medical expertise.

SIBP and reasonable likelihood/real possibility

272. A third strand we glean from the HBF submissions and the medical evidence was the proposition that doctors should only be expected or required to consider SIBP as a possible cause when it is reasonably likely or is a real possibility.

273. We use the expression "reasonably likely or is a real possibility" because in some places counsel for HBF appeared to rely on the former proposition, in other places the latter.

274. Whilst in key respects the difference between these two terminologies may not be of particular significance, the difficulty with the first in this case is that it was coupled in the submissions with the somewhat different proposition that medical reports supportive of an appellant's claim to have been tortured *of themselves* established that that claim was reasonably likely to be true and so meet the lower standard of proof applied in asylum cases: see e.g. paragraph 216 above**.**

275. It is first necessary to explain why this latter proposition finds no support in the IP. To do so throws into sharp relief one key aspect of IP methodology dealing with causation of scarring (to which we already alluded at paragraphs 15-20 above**).**

SIBP and reasonable likelihood

276. What we have in mind is that the IP does not anywhere talk in terms of what is reasonably likely. At paragraph 187 the IP sets out a causation hierarchy which identifies four rising degrees of consistency between scars and causes attributable to torture: "consistent", "highly consistent", "typical of" and "diagnostic of "[2] (see also paragraph 121(d)). But:

[2] We agree with Professor Katona that it is not entirely clear that the definition given by the IP of "typical of" conveys, as it must have been meant to, a higher degree of consistency. It is at least odd that whereas

(a) as already noted, it does so by reference to a concept of "possible causes" (see in particular paragraph 121(e)); and

(b) even when talking about "degrees of consistency" (e.g. Annex IV XII.1.C, 2A), it makes no reference as such to reasonable likelihood.

277. The closest the IP comes to such language is at Annex 1 6(b) (iv) wherein a written report is enjoined to include "Opinion: interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment…" Whilst a doctor trying to use this hierarchy is engaged in what Dr Arnold aptly called "a process of reducing uncertainty", it is clear that it is envisaged that medical reports may come to a *range* of different conclusions as to the degree of consistency, some of which will reduce uncertainty but some of which will not: see e.g. Annex IV. XII. 2A, XIII.1. As observed at 169, "[a]ll complaints made by a torture survivor are significant. Although there may be no correlation with the physical findings, they should be reported".

278. A possible suggestion to the contrary might appear to arise at paragraph 92 where the IP notes that evaluations of torture can arise in different contexts and that "[f]or example, an investigation culminating in the trial of an alleged perpetrator will require the highest level of proof, whereas a report supporting an application for political asylum in a third country need provide only a relatively low level of proof of torture", but we take that to be a comment about the resulting effect of a good medical report, not about the scientific method reports should follow.

279. Counsel for the appellant and HBF have emphasised that the IP methodology is not limited to assessing the paragraph 187 hierarchy of causation but also extends to making an "overall evaluation of all lesions" under paragraph 188 and that other paragraphs instruct doctors to make an overall assessment of physical and psychological *sequelae* (paragraph 83(c); paragraph 104). As regards paragraph 188, that seems to us to be intended to ensure no more than that evaluation should not just be made scar by individual scar, but should involve a consideration of the scarring in the round. Making sure to address both physical and psychological *sequelae* says nothing of itself about the likelihood of their causation.

280. We would accept, however, that the IP encourages doctors not just to undertake a psychological as well as a physical examination, but to try and address the likelihood of possible causes in more detail. Thus, if the doctor considers that the scarring is "highly consistent" with the patient's attribution, it may be possible for the doctor to say, of the other possible causes - e.g. sports injuries, battle injuries, work-related injuries, torture injuries - that they are less likely.

281. Likewise, established case law emphasises the importance of considering possibilities by reference not just to possible but "everyday" explanations and also

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the lesser level of "highly consistent" limits the number of alternative causes ("…there are few other possible causes") the higher "typical of" level does not: ("…but there are other possible causes"). It also strikes us that the definition given of "highly consistent" is not easily described as conveying a high degree of consistency, since it leaves open there are other possible causes without requiring it to be indicated whether they are less consistent.

by reference to the patient's own life experiences. As observed by the Court of Appeal in SA(Somalia) at [44]:

> "In the case of marks or 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 complaint more or less likely"

282. In RT (Medical reports-causation of scarring) Sri Lanka [2008] UKAIT 00009 the Tribunal stated that "It is of particular importance that the report specifically examines [other possible causes] to gauge how likely they are, bearing in mind what is known about the individual's life history and experiences".

283. However, it is equally clear that the IP methodology places a very important caveat on this type of evaluation, which is that assessment of causation must be made according to clinical expertise. As stated at paragraph 162 of the IP, "[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 expertise". It follows that (with one caveat) doctors should only try and assess the likelihood of other possible causes if they are able to bring to bear some clinical or other medical expertise. Thus for example they may be able to say whether the nature and type of scarring could have been caused by sporting injuries or occupational injuries or battle injuries because they have medical experience of what sporting or occupational injuries or particular battle injuries look like and the range of circumstances in which they can or cannot arise. Thus in the 2005 Handbook by Peel et al (Medical Investigation and Documentation of Torture: A Handbook for Health Professionals) it is noted at p.36 that "a sportsperson may have many scars on his or her legs, and it is impossible to say which were caused by contact sports and which, if any, were caused by being kicked by soldiers in detention. A stab wound on the trunk, however, is not going to have been caused by sporting activities". At p.51 when describing the uses of medical documentation, the example is given of a case where the survivor of torture alleges that a lesion was caused by being beaten, but the defence lawyers suggest that it was a sporting injury. "[A]n experienced health professional", it is explained, "might be able to say which of the two attributions was more likely". Similarly, if a doctor has experience of dealing with patients wounded in particular war zones in which special types of landmines are used, he or she may well be able to say whether the scars or lesions could have been inflicted by someone in the vicinity of that war zone.

284. The dilemma posed by SIBP is that, in contrast to how they proceed in the above examples, doctors do not appear to think they can bring to bear any relevant medical experience.

285. Mr Rhys-Jones properly referred to the overlap between the task of a medical expert and an asylum decision maker, but as the issues raised by this case illustrate, it is just as important to keep in mind the differences. Two seem of particular importance to us here. One is that whereas the latter is ordinarily obliged to reach a finding on whether a person is reasonably likely to have been tortured (he or she

cannot simply say it "may" have happened or avoid the issue), for a medical expert he or she can only go so far as is possible clinically. The other is that in the latter context it will sometimes not be possible to say more than that there are a range of possible causes: see above paragraph 277.

SIBP and real possibility

286. But the third strand of the HBF submission also contained a less tendentious proposition, which was that doctors should only be expected to consider SIBP as a possible cause when there was some basis for considering that that was a real possibility (meaning in this determination simply a possibility that is not a merely fanciful or theoretical one).

287. We consider that this proposition is a sensible one and offers the best way forward for devising a framework for dealing with the triple concerns of remaining faithful to IP methodology, not eliminating SIBP as a possible cause, but at the same time not expecting doctors to give credence to it in every case (or to raise the spectre of them, to quote from HBF submissions, "having to prove a negative"). The question is, "what is it that should make SIBP a possible cause that doctors should engage with in a meaningful way in any particular case?" In our judgment, there would need to be some presenting feature about the state of the evidence before the doctor that makes SIBP something that he or she is required to engage with.

288. It seems to us that presenting features could be of two kinds: clinical or non-clinical.

289. Dealing first with presenting evidence in a clinical context, it seems to us that the evidence provided by Dr Zapata-Bravo and Dr Allam (which was not contradicted by the other medical experts) affords a specific example of a case in which features were identified which meant that SIBP should have been seen to change from being a mere possibility to being a real possibility. On their evidence, if a person has been burnt with hot metal instruments that had been applied several times over a period of some 10 minutes and as a result has scarring with precise edges, it would be necessary for that person to have been unconscious throughout the procedure, and that was likely to have required anaesthetisation. Therefore, faced with a patient who claims to have fainted on the first application of a hot metal instrument and remained unconscious throughout several further applications, it is incumbent on an examining doctor to consider whether the torture claim is clinically plausible. (We deal more fully with the medical evidence relating to this aspect of the appellant's case below).

290. Trying to reformulate this and similar examples given by the medical experts in more general terms, it would appear that such a feature arises when there is a tension or mismatch between what is revealed by a physical examination of the scarring and the patient's account of how he came to have it. We see no reason why the possibility of a false allegation in the form of SIBP could not fall within this category in certain circumstances.

291. Turning to non-clinical presenting features, whilst we would not seek to define these exhaustively either, they would arise when there was a clear mismatch

between the claimant's account of when and where and how he was tortured and the established facts. One example would be where the claimant stated that he was tortured in his country of origin in a particular month and year but it was incontrovertible that at the relevant time he was in the UK.

292. We hasten to add that in both these examples of presenting features, it will always be necessary to consider whether matters are quite what they seem, e.g. (in relation to the first example) whether the failure to wake up from having fainted when there were further applications of a hot metal instrument to the subject's body could have been caused by poor physical condition) or whether (in relation to the second example) the claimant could have been explicably confused about the period of time he said he was in his country of origin. At the same time, once they have taken such possible explanations into account, decision makers are entitled to make findings and draw reasonable inferences.

293. From what we have just elaborated it will now be clear why we do not consider that the negative answer given by the medical experts to the first question posed by the Tribunal at the case management stage (whether it was possible to differentiate between scars inflicted by torture and scars inflicted by SIBP) accords with the medical evidence furnished by two of them. We recognise that in seeking to answer this question the medical experts appear to have principally had in mind the incontrovertible point that clinical examination cannot identify the "hand behind the (instrument of) torture". They also appear to have wanted to underscore the different view they have as to the distinguishability of scars inflicted by torture and scars inflicted by someone self-harming: the latter they find to be relatively easy to "detect". At the same time, given that it turns out, from the medical evidence we had in this case, that clinical examination can shed light on whether it is plausible that scars were inflicted in the manner claimed, we think that a more nuanced answer should have been given to the first question.

294. For completeness we need to clarify what doctors should do or say about the SIBP possibility when there are no presenting features to suggest it. We only mean here to identify what we as judges consider as best practice in respect of preparation of medico-legal reports for use in asylum cases. It follows from our earlier conclusion - that SIBP cannot be excluded as a possible cause, either *a priori* or routinely - that (i) doctors should indicate in their assessment that SIBP as a possible cause has been considered (in the same way as Professor Katona said it was best practice for doctors to consider feigning generally as a possible cause; and in the same way that Dr Zapata-Bravo considered whether the appellant's scarring could have been caused by tattooing); but (ii) if there is an absence of any presenting feature giving rise to a concern about a "false allegation of torture" of this type, then all the doctor need do is state that whilst SIBP as a possible cause has been considered, there is no presenting feature making it more than a mere or remote possibility .

295. So far as decision-makers are concerned (primary or judicial), it should not be thought that our analysis requires them to make any definitive finding of whether scarring is the result of SIBP. If the evidence strongly points to such a finding we do think it is necessary to say that SIBP is a real possibility. In this regard we do not agree with Mr Duffy that it is enough simply to say that the burden of proof in

asylum cases rests on the appellant and that if he has failed to demonstrate that his scarring was the result of torture, then he has not established his claim. That does not in itself make intelligible to the reader why the decision maker has engaged with SIBP as a real possibility. When there is at least one presenting feature of the case that makes SIBP a real possibility and, after consideration of the state of the evidence as a whole there is no other real possibility, that should be said. To state as much is entirely consistent with the guidance given to decision-makers in Karanakaran [2000] EWCA Civ 11, [2000] Imm.AR. 271. But to go further would risk violating the cardinal principle of holistic assessment. In the context of a holistic assessment, where for example a claimant has given a strongly consistent and plausible account of his claim to have been tortured, but the medical evidence points against this, a decision maker might properly conclude that the claimant has nevertheless made out his claim to the lower standard.

Procedural fairness

296. As regards the procedures used by *doctors* when preparing medico-legal reports, we have had evidence regarding how they operate at the HBF and we are aware from the background documentation of how they historically operated at the former Medical Foundation. We have no reason to think there are any procedural fairness issues that arise at this level, certainly not such as are relevant to asylum appeals.

297. As regards *first-instance decision makers*, from the Policy Instructions cited earlier, it seems to us that the Home Office takes sufficient steps to ensure procedural fairness in respect of claimants who allege they have suffered torture: e.g. at 2.1 it is stated that "Where an account of torture or serious harm is given during the interview, the caseworker should suggest that the applicant may wish to approach one of the Foundations for care and treatment." (See also 2.8.2).

298. So far as concerns *tribunal judges* dealing with appeals, we consider that the head note in RR recognises the importance, in order to guarantee a fair hearing, of ensuring that an appellant has an opportunity to deal with allegations that an injury has been "not caused in the way alleged by the appellant but by a different mechanism".

299. However, we do not consider that RR can be taken as authority for the proposition that the respondent should not put an allegation of SIBP unless she has background evidence of its existence. We do not think the Tribunal in that case meant to say, for example, that if the medical report relied on raised serious concerns about whether the scarring could have been caused in the way claimed (because it had presenting features such as described earlier), that even then the respondent should not pursue the point.

300. We do not exclude either, subject to the parties being given proper opportunity to address the matter, that a tribunal might want to explore with a claimant and the parties the possibility of SIBP of its own motion. It follows from what we have said earlier that this is not something a tribunal should do lightly: it would require there to be some presenting feature, as described earlier.

Medical reports and background COI

301. We noted earlier that when preparing medical reports doctors might also have before them non-medical evidence in the form of COI relating to known methods of torture.

302. Of course, such non-medical evidence may be of varying kinds. It is well-established that doctors preparing reports in asylum cases should have regard to evidence other than that within their own medical expertise or experience. Indeed in JL the Tribunal summarised the effect of case law on this point as being that:

> "Those writing medical reports are to ensure where possible that before forming their opinions they study any assessments that have already been made of the appellant's credibility by the immigration authorities and/or a tribunal judge ("It is essential that those who are asked to provide expert reports, be they medical or otherwise, are provided with the documents relevant to the matters they are asked to consider. Failure to do so is bound to lead to the critical scrutiny of the expert's report, and may lead to the rejection of the opinions expressed in that report…." (SS (Sri Lanka) [2012] EWCA Civ 155 [30]; BN (psychiatric evidence discrepancies) Albania [2010] UKUT 279 (IAC) at [49], [53])). "

303. In BN the Tribunal was highly critical of the fact that the psychiatrists had either not read the interview records, statement and letters or had not evaluated them in reaching their conclusions. At [54] it added:

> "The solicitors provided no material to suggest that they had had any difficulty in taking instructions or preparing the statement after the screening interview, or in writing the letter after the substantive interview. Neither statement nor letter suggests any difficulty on the appellant's part at all in remembering either the events described at interview or the interviews themselves. The purpose was to correct answers, which suggest that he remembered events quite clearly, the answers given, and what he thought was wrong with them. The first explanation for inconsistency was the malice of the interpreter which was withdrawn after some time. When depression was first raised it was not to explain inconsistency, but just to correct the omission by the appellant to say that he was depressed. None of this is mentioned or evaluated by Professor Prasher or Dr Van Woerkom. We would not have thought it possible to give any weight to their views on inconsistency being caused by depression."

304. Materials as identified in such cases will sometimes include COI, often as summarised in the respondent's reasons for refusal letter or in the tribunal judge's determination. We can see no basis for excluding COI from the materials a doctor can be expected to look at by this route.

305. However, it is equally clear that there are at least three caveats to doctors drawing on COI materials.

306. The first is that unless the COI has some specific relevance to the clinical assessment of the cause of torture (e.g. it deals with the most common methods of torture used in a particular country of origin) doctors should not go searching for such materials themselves – and indeed doctors are not and should not purport to be country experts.

307. Linked to the first, a second caveat is that even when they do draw on COI materials, doctors should make clear that they are not in a position to say what the overall state of the COI is, only to say what they have been made aware of: once again, they are not country experts who can be expected to have a comprehensive picture of COI.

308. A third caveat is that in the context of a medical report the doctor's task is to assist the asylum decision-maker by bringing to bear his or her medical expertise. He or she is not conducting a free-ranging assessment of the credibility of the claimant's story. This point is equally reinforced by established case law. As pointed out in JL, " [w]here the materials before the doctor include previous determinations by a judge, they should not conduct a running commentary on the reasoning of the judge who has made such findings, but should concentrate on describing and evaluating the medical evidence (IY (Turkey) [2012] EWCA Civ 1560 [37]."

309. In this regard we do voice slight concern about the tenor of some of the evidence given by Mr Rhys Jones in his supplementary statement, especially what is said at paragraphs 23-25: see above paragraph 104**.** It may be that within organisations such as HBF there are persons such as Mr Rhys Jones who through their lengthy case work experience are in a position to identify poor quality reasoning on the part of an asylum case worker in the reasons for refusal or even on the part of a tribunal judge. But the forum for ventilating such concerns is not that of a medico-legal report written by a doctor. Contrary to what is suggested in one part of his supplementary statement, the focus of an MLR should not be to "unpick" the reasons given by the respondent for finding a claimant not credible unless the doctor's clinical expertise can shed light on deficiencies in such reasons. As experts, doctors should never do anything to suggest they have an advocacy role: see Secretary of State for Home Department v MN and KY [2014] UKSC at [55]. To reinforce the point made by the Court of Appeal in IY (Turkey), doctors in their reports should concentrate on describing and evaluating the medical evidence and drawing on their medical expertise. In order to focus on, in Dr Arnold's phrase, "clinical plausibility", there must be a clinical basis for doing so. We would add the observation that the more doctors stray beyond their clinical expertise, the greater the risk they run that judges will not attach significant weight to their reports.

Medical reports and veracity

310. As is clear from a number of authorities, whilst it is not the role of a medical expert to assess the credibility of a patient's asylum claim, it is part of their role to assess (once again, to use Dr Arnold's term) clinical plausibility. Principally the latter is (or should be) a matter of examining the physical and psychological *sequelae* of the claimed ill-treatment and reaching a conclusion as to causation in accordance with the IP hierarchy. Counsel for the HBF have sought to emphasise that the conclusions represent the result of a critical evaluation by the doctor; they are not based uncritically on the patient's narrative. They have highlighted the fact that the IP at paragraphs 143 and 209 requires the medical examiner to consider inconsistencies. We are sure that is a fair description of what a *model* medical report should consist of, but whether reports always fit that description is a different matter, although if they properly apply IP methodology and best practice as

identified by the HBF and the FFT, that should be the result. (An example of a doctor relying uncritically on a patient's report can be found in Professor Lingam's report. He rejected several possibilities of the causes of the appellant's scarring relating to accident, wounds from training with the LTTE or childhood injuries because "the patient denied any wounds or accidents other than the injuries caused by torture": see above paragraph 84.)

311. But even then the notion of critical evaluation thus formulated must be kept in its rightful context. The primary duty of a doctor is to "promote the patient's best interest" (Peel et al, 19). According to the IP, doctors owe "a clear duty of care to any patient they examine or treat" (paragraph 67); the doctor-patient relationship in both contexts is based on trust (paragraph 164); and, in the context of a psychiatric interview, Professor Katona likewise ventured that it was "crucial…to establish and maintain rapport and to be non-judgmental". He also referred in this context to paragraphs 143, 262 and 290 of the IP.

312. That is some considerable remove from the assessment of the evidence which must be undertaken by the decision-maker in a legal context in which the burden of proof rests on the claimant and when one of the purposes of questioning is to test the claimant's evidence so as to decide whether (to the lower standard) it is credible.

Evidential burden of proof

313. By reference to R.C v Sweden counsel for the appellant and the HBF have sought to argue that once a claimant has sought and obtained a medical report supporting their claim (whether or not IP-compliant) to have suffered torture then that should be treated as *prima facie* evidence which it is for the government to rebut. We note that the Tribunal has dealt with the approach to documentary evidence taken by the ECtHR in MJ (Singh v Belgium: Tanveer Ahmed unaffected) Afghanistan [2013] UKUT 253 (IAC) and NA (UT rule 45: Singh v Belgium) Iran [2014] UKUT 00205 (IAC) and we see no reason to deviate from the guidance given therein.

314. In any event, in relation to the approach we must take there are a number of decisions of the Court of Appeal that are binding on us and in none of them has it been accepted that production of a favourable medical report creates a shift in the evidential burden of proof. Certainly we would agree with counsel for the HBF that a medical report is capable of being probative of an asylum claim. As noted by Sir Mark Potter at [27] in SA (Somalia) [2006] EWCA Civ 1302 one of the "tasks" a medical report can be " tendered to perform" is "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". But that falls well short of endorsing the proposition advanced by HBF in its preliminary skeleton argument that "medical evidence of torture raises a strong likelihood that the Appellant has been tortured". Such a position not only overlooks that the weight to be given to medical evidence of torture will depend on a holistic assessment and will vary depending on the contents of that report, it is also inconsistent with IP methodology which envisages that medical reports can furnish a range of assessments, not all of which could be said to establish a strong likelihood: see above paragraphs 277, 285.

315. Consistent with this, one of the findings the IP states it is open to a doctor to make in a medical report is that a person's scarring is "consistent with" torture. This only amounts, according to the IP, to a relatively weak finding that "the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes".

316. Courts and tribunals greatly value medical reports in asylum cases, but we cannot accord them some hallowed status; and the weight they possess is very much a function of the extent to which the clinical evidence enables them to make positive findings about causation of injuries, as well the individual quality they possess.

Psychological evidence

317. From our summary of the submissions it will be apparent that counsel for the HBF were anxious to highlight the fact that the IP requires medical reports to deal with both the physical and psychological *sequelae* of torture. They pointed to paragraphs 83(c) and 104, the latter of which states that "[a] psychological appraisal of the alleged torture victim is always necessary and may be part of the physical examination or where there are not physical signs be performed by itself".

318. They wished to underscore as well that medical reports that dealt with only one of these two types of *sequelae* should not necessarily be seen as having less weight for that reason alone. It is perhaps as well that they coupled these two submissions together because none of the reports we had from the medical experts who gave evidence dealt directly with the appellant's psychological condition – not even Dr Zapata-Bravo who of course was the only doctor apart from Dr Odili to examine the appellant and who is a Consultant Psychiatrist. In that respect their reports did not strictly comport with paragraph 104 of the IP. The only doctor who did deal directly with the appellant's psychological condition was Professor Lingam whose medical report as we have observed above had been prepared for the First-tier Tribunal.

319. Nonetheless we have no difficulty accepting both of these submissions as valid. As the Home Office Policy Instructions also recognise, the fact that a person who has physical scars does not have any psychological *sequelae* does not in itself indicate that the physical scars were not caused by torture.

ASSESSMENT OF THE APPELLANT'S APPEAL

General aspects

320. In the light of Mr Duffy maintaining the challenge to the appellant's credibility, we need to make findings of fact in order to assess what risks there are if returned. We do so on the lower standard and assess therefore whether the account the appellant relies on is reasonably likely to have occurred or (putting it another way), whether there is a real possibility that the events claimed happened. Our findings are based on all the evidence, medical and non-medical, taken in the round and without compartmentalising one or the other. We apply, so far as it is relevant, the country

guidance set out in GJ (post-civil war: returnees) Sri Lanka CG (Rev 1) [2013] UKUT 319 (IAC) (5 July 2013).

321. We bear in mind when assessing the appellant's credibility that we now know from the background COI as set out at paragraphs 186-9 above that one of the reasons given by the respondent in her letter for considering that his asylum claim was not credible was erroneous. The decision letter counted wrongly against him that there was no evidence that the Sri Lankan authorities use burn scarring as a method of torture. Nevertheless we are required to assess the appellant's credibility for ourselves in the light of the much larger body of evidence now before us.

322. We count in the appellant's favour that in his various accounts of his experiences in Sri Lanka there are a number of matters about which he has given been broadly consistent evidence and that, in relation to his claimed experiences in detention, he has been able to give a significant amount of detail, albeit much of that has emerged during the appeal process. Albeit they were family members, the evidence of his witnesses also broadly corroborated his claim. It is also in his favour that he sought and obtained medical evidence to support his claim, a medical report from Professor Lingam being prepared for use at his hearing before the First-tier Tribunal and reports by two doctors who examined him (Drs Zapata-Bravo and Odili) being prepared for use in the present hearing. It is also now confirmed that when he visited his GP in April 2011 he did show the doctor scarring on his back (although there is no mention of scarring on his arm). Whilst the three reports from doctors who examined him focused on examination of his physical scarring, Professor Lingam's does address (albeit very briefly) his psychological condition and found that he was severely depressed and Mr Duffy has not sought to challenge that finding. Accordingly we apply the Joint Presidential Guidance Note No 2 of 2013 on Child, Vulnerable Adult and Sensitive Appellant Guidance and have thus given particular consideration throughout to whether any discrepancies in his evidence could be satisfactorily explained by his psychological history .

323. We note that the respondent considered that the appellant gave discrepant evidence in relation to when he first started working for the LTTE, having said at one point 2002 and in another 2003. We are prepared to accept, however, that this difference arose from the appellant's misunderstanding as to whether he was being asked about his father or himself. We are also prepared to accept that although the appellant gave different dates as to when he last worked as a jeweller, this can be explained in terms of the ad hoc nature of the jewellery and gold-related work he did in Colombo and then in Vanni.

324. However, there are other aspects of the account that trouble us. It is difficult to accept that the appellant, who is educated and no doubt aware of the risks of being involved with LTTE members, would decide to travel publicly within less than 48 hours of a major terrorist attack at the airport on 25 March 2007 in Colombo. This is particularly so in the light of the reason he gave for his flight, i.e. the arrest of one of the two LTTE members he lived with the day before. If indeed there had been interest in the LTTE member who travelled with him, which appears to have been the case because of his evidence that he learnt later that there had been an army visit to his house, it is significant that the appellant and his LTTE member

housemate, despite travelling together, did not encounter any difficulties in making their way through Sri Lanka to the LTTE area. We do not have any evidence before us that deals with the immediate consequences of the bombing of the airport. We note however that it has been a consistently mentioned in UKBA COI reports on Sri Lanka and other major country reports that in 2006 (the year preceding the year when the airport bombing took place and the appellant said he left Colombo (in May 2007), there had been an increase in the number of checkpoints and roadblocks in the capital city and there were road closures to the A-9 Kandy to Jaffna highway restricting the movement of passengers and supplies through the LTTE-controlled Vanni region and on roads leading in and out of the city; and that the Sri Lankan authorities were applying a heightened level of vigilance through checks and controls on freedom of movement: see e.g. COI report on Sri Lanka, dated 2007, paragraphs 28.01- 28.12. The appellant's representatives said nothing to suggest they considered the situation to be otherwise. Up until the hearing before us there was no mention by the appellant of the two of them meeting with any check. At the hearing before us the appellant mentioned for the first time that the bus they travelled on had been stopped and that he had to show his ID card, but, in addition to finding it surprising he had made no mention of this previously, we find it most implausible there was no point at which he and his friend were questioned. To reiterate, on his account one of his housemates had been arrested the day before in connection with the airport bombing and very shortly after the authorities had visited his house looking for him.

325. The ease with which the appellant was able to travel with an LTTE member and his failure to mention previously that the bus he was on had been the subject of any stop or search at checkpoints does not accord with the COI. Although the appellant said that he felt he had to attempt the journey even though it was risky to do so, we note that he did not describe himself as considering less risky options such as going to stay with friends or seeking an agent in Colombo to try and arrange for him to leave the country (as he did some two years later). At that point he had lived in Colombo for a number of years, so would have had friends and contacts he could have tried.

326. It is also significant that despite having helped the LTTE in Trincomalee and, latterly in Colombo, through the medium of the jewellery business, there is a complete absence of any account of difficulties encountered by the appellant either prior to coming to Colombo in 2003 or during his time in that city. There was no evidence of any prior interest in his LTTE member house mates either. Despite therefore his claim to have worked for the LTTE and to having accommodated two of their members, it is significant that the appellant has given no account of adverse encounters or prior interest from the authorities in any of them.

327. On the assumption that the appellant did leave Colombo as claimed and worked in a LTTE controlled area without becoming a member but nevertheless had dealings with them, our attention turns to his account of being taken on surrender into an army detention camp in 2009. Being held there for so long needs to be considered against the country information. It is clear from the COI reports dated June 2009 and November 2011 (e.g. at 4.36-4.38) and other contemporary country reports that during this period many people were being detained for lengthy periods and so

there is nothing in itself implausible about the appellant's claim to have been detained for some 21 months.

328. Against that background, we turn to what the appellant has said happened to him in detention.

329. As to the time line of these events in detention, according to his first witness statement he signed a confession 5 days after being taken into detention. He was identified by PLOTE/EPDP a week thereafter. At the hearing he explained his belief that the EPDP members in the camp must have told the army that he had been assisting the LTTE with the gold. The appellant could not be expected to know the detail of when this information was passed on but it seems highly unlikely that they would have delayed for over two months (between late May and August) before seeing fit to torture him in order to find out where the LTTE had stored their gold.

330. Although it is wrong to look for rationality by torturers, it is also difficult to see why the army would put so much effort into ill-treating the appellant over such an extended period of time if, apart from the issue over the gold, their interest was solely in him identifying where the LTTE leaders were hiding to which he could give no answer and there must have been a point when they realised he was not a member. His evidence is that he was "burned" during just one session of torture in August 2009. Furthermore, the decision to burn the appellant appears to have been taken without any particular triggering event: on the appellant's evidence the authorities were reasonably likely to have known of his work as a goldsmith well before then. The appellant gave no evidence that he revealed or was in a position to know where the LTTE had stored their gold or what they had done with it. There must have also come a time when the authorities knew that they were getting nowhere and that must have been soon on in the detention. The only explanation for the continuing ill treatment was a desire to inflict sadistic and cruel harm. Having regard to the well documented claims of serious abuse by the Sri Lanka forces we do not rule out this possibility, but equally we find it very difficult to accept that the authorities would invest so much effort in ill-treating him on a daily or almost daily basis and to do so over a very extended period (21 months).

331. We should mention that we do not think the appellant's representatives helped the cause of clarity by submitting at one point that we should consider there was no regular pattern to the appellant's ill-treatment. Given that on his own account beatings were daily or almost daily, the pattern was of regular and frequent ill-treatment. Nevertheless we do not consider this is a point that goes to the substance of what we have to decide in this case.

332. The appellant's account of how he was able to negotiate his way out of detention does not stand close scrutiny. If he was of such interest that he was held in a cell and escorted to a lavatory, it is questionable how he was able to strike up a conversation with a non-prisoner who put in hand arrangements for his escape and would have been permitted to load things on to trucks. That escape indicates lax security and this is difficult to reconcile with the closely guarded conditions under which the appellant claims he was kept. We accept that the background evidence

shows that the EDPD were complicit in helping detainees escape, but that evidence does not indicate they were able to do this in relation to persons who were closely guarded and subjected to daily or almost daily beatings. We note also that he gave quite different accounts of the numbers of persons with whom he shared a cell, and, although he sought to explain that in terms of the numbers varying over time, we do not see why he did not explain that in his asylum interview.

333. Given the brutality of the treatment which the appellant says was meted out to him daily or almost daily over a period of some 21 months (and leaving to one side whether he had suffered burn scarring), we consider it extraordinary that he was able to fly so soon after his release in February 2011 and arrive in the UK not suffering any injuries requiring immediate treatment. We note that he did not seek any medical help in the UK from his arrival on 24 February 2011 until 10 April the same year and when he did so his main presenting problem was confined to his knees and he was merely given a combination of topical and oral analgesia. He did not attend the surgery after that time.

334. As regards the evidence from family members, we have given it close consideration notwithstanding that being family members none of them could be described as independent witnesses. The appellant's brothers were curiously reticent and gave short accounts that they did not know what had happened to him following the mass surrender in 2009. The appellant's account of how the family came to know of him going to Vanni has been put in an odd way. If indeed relatives travelled to Trincomalee (where the brothers were living) to explain how he had sought refuge in Vanni, it is odd they did not have more detail available. It is also curious that they had not sought to find out what happened to their uncle who was the LTTE member despite their uncle with whom they live in the United Kingdom being aware that he is safe. It was not explored how it is known that he is safe.

335. The uncle's (VS's) account of how he was unable to leave Colombo when he made his visit in 2013 does not stand up to scrutiny. Given the evidence he gave about what he knew had happened to close members of his family, it is difficult to believe that he did not have his own safety concerns about undertaking a trip along with his family *before* he left and felt them only on arrival, particularly in the light of his evidence that he had been aware prior to that journey that in 2012 his brother-in-law had been tortured. We find contrived the account that the appellant's mother brought his brother-in-law and sister in the middle of the night to Colombo for them to meet him.

336. We also find it very difficult to understand how it was that the Sri Lankan authorities had not arrested and detained the appellant's father. On the information the appellant said he gave to his torturers, he had been working in his father's shop as an assistant to his father. They suspected him of helping the LTTE with melting down and valuing their gold. Why the authorities would arrest and detain the shop assistant but not the shopowner is difficult to comprehend, especially given the great effort stretching over more than 18 months during which the authorities ill-treated the appellant in order to find out more about what had taken place in this man's shop. If his father had been arrested and/or detained we would most certainly have heard about it since, on the appellant's account and that of his

witnesses, his father had made contact with him on at least one occasion and there had been indirect contact with other family members.

Medical aspects

337. We turn to address the medical evidence relating to his scarring which has informed our overall assessment. If the appellant's scarring was caused by torture in detention then the possibility of the appellant's account being true, notwithstanding the identified shortcomings, becomes a real one.

338. The appellant has scarring which having regard to its appearance was clearly not the result of an accident or sports injury or work-related injury, as the experts have all agreed. The medical evidence was not entirely clear-cut regarding whether the appellant's scarring could have been caused by military training. Dr Odili said that clinically she could not tell whether it had; Professor Lingam said he ruled it out but the only reason he gave was that the appellant had denied any causation other than torture. However, all the medical experts agreed that his scars were deliberately inflicted and there was no evidence to suggest that military training with the LTTE has ever involved deliberate infliction of burn scarring. Hence (leaving aside what we consider it indicates about SIBP) we take the medical evidence as a whole to point strongly against military training being a cause.

339. There is a slight difference between the three doctors who examined the appellant (Professor Lingam, Dr Zapata Bravo and Dr Odili) regarding the number of scars the appellant has, but we attach no significance to that as all three were agreed about what they were describing. The medical evidence is also not entirely clear as to whether the appellant's burn scars, at the time they were inflicted, would have been open wounds or ones which did not bleed. In his evidence Dr Zapata-Bravo appeared to proceed on the basis that when inflicted the appellant's scars were "open wounds", whereas Dr Odili appears to have proceeded on the opposite basis and Dr Arnold said he thought the burns concerned were "partial thickness burns", i.e. ones that left some of the epidermis intact. This evidence is not easily reconciled with the appellant's account – he said that when cellmates helped him take his T-shirt off the next day it was blood-encrusted – but in the absence of more detailed medical consideration of this possible difference, we take no point against the appellant regarding it.

340. Notably, none of the medical witnesses bar one made a specific finding in accordance with paragraph 187 of the IP that the appellant's account was either "typical of" or "highly consistent" with his account of being tortured. Indeed Professor Lingam's conclusion was limited to a finding of mere consistency. Despite being specifically requested to make a finding about the causation of the scarring in relation to the appellant's attribution, in accordance with the Istanbul Protocol, Dr Odili confined herself to making findings as to the causative link between the scars and the type of instrument used and the technical circumstances in which the scarring came about. Her findings cannot on any reading be treated as findings that the appellant's scarring was "diagnostic of", "typical of" or "highly consistent with" the appellant's attribution (torture). That is not a criticism of Dr Odili. Indeed we consider it a proper clinical response to the limited evidence that

she had and the principal focus of it. Dr Arnold and Professor Katona did not examine the appellant and very properly confined their reports to the implications of the appellant's case for broader issues relating to SIBP and the proper preparation of medical reports in the context of asylum cases. Even though Mr Rhys Jones purported to argue at a general level that BF doctors were entitled to "unpick" Secretary of State decisions, his written and oral evidence (quite properly) did not seek to do that in the appellant's case. The only doctor who made a specific finding that the appellant's scarring was "highly consistent" with his attribution was Dr Zapata-Bravo. We will deal with his findings below.

341. Of the medical witnesses, we prefer the evidence given by Dr Odili and Dr Zapata-Bravo as to the technical circumstances in which the scarring may have come about. Unlike Dr Arnold and Professor Katona, both examined the appellant. As noted above, Professor's Lingam's finding was limited to one of mere consistency and such a finding does not entail more than a conclusion that torture was one among other possible causes. Whilst we have commented favourably on certain aspects of Professor Lingam's methodology, we find little assistance in his application of this to the appellant's case in relation to other possible causes, as he appears to have decided to eliminate some possible causes simply because they were not consistent with the appellant's narrative.

342. All the medical experts agreed that that there was no inconsistency between the date the appellant said he was subject to burn scarring (August 2009) and the appearance of his scars as shown first to his GP and then photographed in April/May 2011. They were all agreed as well that, from the fact that the scarring on the appellant's back had precise edges and patterning, he would have needed to be unconscious throughout as otherwise, even with restraint or his being held still, his muscles' involuntary reflex would have caused the edges to be blurred. The time involved is also a relevant factor here. Dr Zapata-Bravo, without contradiction by the other experts, estimated that for the scars to have been inflicted on the appellant's back there must have been several more applications of a heated metal instrument: he considered that was likely to have taken 10 minutes.

343. We have already observed that in our judgment the medical evidence we received raised a significant presenting difficulty for the appellant's account. On his account, it must be recalled, he was first burnt on the upper right arm and the pain from that burn caused him to fall unconscious. If it was clinically likely that someone could be burnt once, then fall unconscious yet not wake up, even when there were more applications of a hot metal instrument, there was nothing to be concerned about. But if on the clinical evidence that scenario was unlikely, then the appellant's account was clearly problematic. This issue was addressed by Dr Zapata-Bravo in his oral evidence, but given that his answer then was that he considered it unlikely that a person who had fainted would remain unconscious upon fresh infliction of pain, that was a matter that should have been apparent to him at the stage when he was examining the appellant and preparing his written report. We find it difficult to follow why in the end he said the appellant's account of remaining unconscious was plausible. Both he and Dr Odili were entitled to treat as one relevant factor the appellant's poor physical condition, but on the medical evidence as a whole, that was an unlikely explanation of the fact that he had not woken up. The evidence Dr

Zapata-Bravo gave to the effect that shock-induced fainting was not sufficient for unconsciousness over the relevant period (approx. 10 minutes) was subsequently confirmed by Dr Allam, an anaesthetist. (We are also surprised that neither Professor Lingam nor Dr Zapata-Bravo explored more closely with the appellant the claimed severity of the beatings he received almost daily for 21 months, given that they found no other physical ill-effects except for knee problems).

344. At all events, we consider that the medical evidence as now before us discloses a presenting difficulty for the appellant. If his account is correct – and he was given ample opportunity to correct or qualify it – then he was able to remain unconscious despite several repeated inflictions of burn scarring which clinically was an unlikely hypothesis.

345. Dr Allam has described a sedation scale beyond which there is no response to painful stimulus. Her evidence about the way in which opoid analgesics or alcohol can achieve states of unconsciousness is not relevant to the claim as it is not the appellant's case that these were used. As to fainting (which is the appellant's case), she considers that a faint can be caused by any painful stimulus but that, following lying down, consciousness is regained very quickly as observed in her own patients, "usually within seconds". She refers also to other factors such as health/physical state that could affect the speed of recovery but does not suggest such factors could have caused him to remain unconscious even when the hot metal rods were re-applied.

346. It is not the appellant's case that he was lying down and he demonstrated that the burns were applied when he was in a kneeling position throughout which he was restrained. It seems to us highly unlikely that had the appellant fainted he would have remained kneeling and is likely to have slumped. There would be no need for his captors to hold him in the kneeling position which would have required his cooperation and the rods could have been as effectively applied if he were lying on his front.

347. **A** further aspect of the clinical picture in the appellant's case was that on his account he had not experienced any significant infection as a result of the episode of burn scarring (apart from suffering from a fever for a short period) notwithstanding that (i) he was in a poor physical state; (ii) the conditions in his cell were unhygienic and his wounds were not dressed; (iii) straight after he was burnt he had petrol poured over his body; (iv) when he went back to his cell he said his surface skin around and over the wounds peeled off; and (v) he continued to be beaten all over the body including on his back on a daily basis or at least every two or three days. There was consensus amongst the medical experts that if burn scarring wounds become infected, that can affect the eventual contours of the scars, making their edges or outlines less precise for example. We note that Dr Zapata-Bravo and Dr Odili considered that the odds of the appellant's scarring becoming infected may have been reduced by the fact that (on his account) he had been allowed to bathe the day after and was given a clean shirt. At the same time, both clearly considered that even so he was "very lucky" to escape infection. Whilst the medical evidence regarding this aspect of his claim was not definitive, we think it is another indicator that the account he has given is not credible.

348. It follows from the above that we do not consider that Dr Zapata-Bravo's conclusion that the appellant's scarring was "highly consistent" with his account of having been tortured is justified when account is taken of the doctor's own evidence indicating (i) it was clinically unlikely, given their precise edging, that his scarring could have been inflicted unless he was unconscious; and (ii) that it was clinically unlikely a person could remain unconscious throughout multiple applications of hot metal rods to his arms and back, unless he was anaesthetised; immobilisation or restraint short of anaesthetisation would have caused his muscle reflexes involuntarily to cause movement.

349. Yet a further aspect of the clinical picture was that the appellant was found by Professor Lingam to be severely depressed. However, the treatment of this aspect of the appellant's claim by the Professor was extremely cursory and he did not recommend any particular treatment for the appellant's psychological condition. Nor we observe had the appellant's GP who saw him in April 2011 referred to any psychological problems. As already noted, we find it surprising that despite considerable efforts being taken by the appellant's representatives to obtain medical evidence to support his claim, no further steps were taken to confirm Professor Lingam's psychological diagnosis or to ascertain whether his psychological condition had a specific linkage with his burn scarring and experiences of other kinds of ill treatment, particularly since Professor Katona in his evidence expressed willingness to provide such a report. Nevertheless, we bear in mind that Professor Katona and Mr Rhys-Jones, in common with the IP guidelines, have emphasised that lack of psychological symptoms does not necessarily demonstrate that a person has not been the victim of torture. Overall, we find the evidence regarding the appellant's psychological condition does not materially assist his claim.

350. To summarise we find that the lack of correlation between the appellant's account of how he was tortured and the resulting nature of the scarring, counts against the credibility of that account.

The evidence of Mr Vinayagamoorthy

351. In reaching our conclusions on the appellant's account and in particular whether he was burned in detention in the manner claimed, we have examined the COI, including the report by Appathurai Vinayagamoorthy at page 85 of the appellant's bundle. He was instructed on behalf of the appellant to prepare a report in relation to various aspects of issues relating to torture in Sri Lanka. He describes himself as an Attorney and he sets out his political background of involvement with various Tamil political groups. He is an MP, belonging to the Tamil National Alliance.

352. He describes the political and human rights situation in Sri Lanka, and we return to that assessment in due course. In "Appendix two" Mr Vinayagamoorthy refers to his having handled torture cases in his capacity as a lawyer. Under the sub-heading "The Use of Torture and Other Cruel, Inhumane, or Degrading Treatment as Interrogation Devices in Sri Lanka" there is what appears to be an extract from a document which is not identified, and which concerns the use of torture in Sri

Lanka. It is in italics, unlike the majority of the report. It starts with the statement that :

> "Sri Lanka is infamous for its record of systematic torture and branding, which goes back to 1948".

353. Mr Vinayagamoorthy's report refers to the various methods of torture which it is stated include burning with heated metal rods. In a paragraph that commences "Fact from Sunday Time" giving a web address, some examples of cases of torture are given. Mr Vinayagamoorthy's report continues in stating that in the overwhelming majority of "torture survivors" referred to him, 99% bear the marks of torture on their bodies. He gives a limited number of examples, with names and other details included. He states on page 13 of the report that the torture is done to cause permanent damage and scars "because this will put them in danger of prosecution again."

354. In the "Conclusion" paragraph he states that in his opinion:

> "burning with hot metal objects (branding) is the second most common method of torture among the above, which I see on a regular basis."

355. He concludes by stating that this particular method of torture is used for a number of reasons, in summary: as an easy way to cause pain, it leaves permanent scarring which is used as a method of identification by the authorities, to humiliate the victim, prevents the victim from escaping from detention because the scarring is permanent and visible. He states that he has seen approximately 1,500 of his clients who were burned in a way that left permanent marks.

356. He goes further and states that although the size and number of the burns differ from person to person "these marks resemble the tiger stripes", and that it is widely said that the police deliberately brand the victim with tiger stripes so that they can identify him in the future.

357. Such injuries are not properly documented by doctors in Sri Lanka, he states, mainly because judicial medical officers do not want to get into trouble with the security forces by recording "the real causation". The report goes on to state that on the other hand in some cases medical experts have concluded that these scars were consistent with torture and the medical experts could not find any other alternative method of causation. He "personally [does] not have any reason to believe that these branding scars could have caused (sic) by any other means."

358. We are prepared to accept that one of the methods of torture used by the security forces is burning with a heated rod or similar instrument and that this causes scarring. That much is evident from other documentary material to which we have referred, for example the USSDR. We are however, sceptical about Mr Vinayagamoorthy's claim that "burning with hot metal rods (branding)" is the "second most common" method of torture. At the very least, it is difficult to ascertain from his report which, of the 24 "documented methods" he lists on p.10 are the first or third or fourth etc most common. Despite his own reference to

having seen 1,500 "clients" with permanent burn scarring, his report does no more than provide several illustrations.

359. As regards his claim that such scarring is inflicted because the authorities want to make it easy to identify the victim in the future and to prevent the victim from escaping, although something similar was said by FFT in a November 2011 report (see above paragraph 187), in a letter of 5 January 2012 the British High Commission stated that whilst scarring had been used in the past to identify suspects this practice has either ceased or is used less frequently. We note further that in GJ the Tribunal found that the procedure applied by the Sri Lankan authorities at the airport in respect of returnees was now benign; there is questioning but no detention facilities and that the regime no longer relied on checkpoints and searches; rather its approach is intelligence-led (see GJ, paragraphs 347-354). Even if we had considered that the regime continued to rely significantly on checkpoints and searches, we would still have regarded Mr Vinayagamoorthy's claim as far-fetched, since scarring for identification purposes would surely only apply if the burns were in a place where they could be seen, such as the face, or perhaps arms or legs if not covered by clothing. In this appellant's case, on his account he was able to escape despite the burns; they were on his back. There is nothing to suggest in his report that "tiger-branding" is inflicted on the face or forearms.

360. Furthermore, the background material put before us which includes details of the methods of torture does not indicate that any particular method of torture is more prevalent than any other. None of that material refers to "tiger stripes" branding as being a significant phenomenon.

361. Importantly, and as a general observation on the report of Mr Vinayagamoorthy, we are of the view that he cannot be considered as an impartial expert on the matters contained within his report. We note his political background. We also detect in the report a lack of impartiality. That is perhaps understandable if he has had dealings with many people who have been subjected to torture and taking into account his political background. Understandable or not, it does affect the extent to which his report can be relied on as impartial expert evidence.

362. A specific example of the emotive, overstated and tendentious nature of his evidence can be seen in the following paragraph on page 6 which we quote in full:

> "Impunity like malignant cells causes cancer and ultimately kills its host. It is invasive and pervasive and victimises even its one-time practitioner-beneficiaries, as the fate of Gen. Fonseka demonstrates. The rulers of Sri Lanka profited from impunity during the war. Their appetite for it remains undiminished. The attacks on the media is a clear warning to every dissenter in Sri Lanka, be it General Fonseka a political opponent or a critical journalist-no one will [escape] the wrath of the Rajapaksa regime."

363. We observe that however critical the major country reports on Sri Lanka have been, none go anywhere near as far as saying that "no-one" will escape persecution. We do not consider that the evidence of Mr Vinayagamoorthy advances the appellant's case in any significant respect in any event. We have already accepted on the basis

of more objective sources that many Tamils were arrested and held in detention camps during the 2009-2011 period and that the authorities in those camps used torture, burning with hot metal rods being one of the methods of torture they employed. Where his evidence concurs with such sources we are prepared to accept it, but his evidence does not establish that such a method of torture is any more prevalent than any other or that the security forces 'brand' detainees in the manner of so-called tiger stripes.

Conclusion

364. Considering the evidence as a whole, including the background country evidence, the evidence of the appellant and his witnesses and the medical evidence, we are not satisfied, even on the lower standard, that he has made out his claim. There is evidence of wide-scale detention of Tamils in Sri Lanka in 2009-2011 and of torture involving burns in Sri Lanka. However in our judgment, these facts are not enough even on the lower standard to persuade us that the appellant was detained in the way that he described or at all or that he was burned and acquired the scars he has in the manner claimed. In addition to certain discrepancies, his story has too many implausible and inadequately explained aspects. In relation to the medical evidence, we have found that whilst it assisted in eliminating some possible causes, it left us with only two that were real possibilities: that the appellant was tortured as claimed; that his scarring was SIBP. Of these two real possibilities, we have found, on analysis, that the former claim does not withstand scrutiny. Certainly we cannot say in his case that the evidence inexorably points to SIBP, but given that we have concluded it is left as the only real possibility that we have not been able to discount, taking the evidence as a whole, we are satisfied that he has not shown his account is reasonably likely to be true.

365. Taking all the evidence in the round we do not accept that the appellant had to flee Colombo for Vanni, that he provided services as a goldsmith to the LTTE or that he was detained on the cessation of hostilities. We find that after 2003 he lived and remained in Colombo and at no stage then or thereafter did he come to the adverse attention of the army or police before coming to the UK. He can safely return to Sri Lanka without fear as there is nothing in his past apart from his ethnicity that would cause the authorities to show any interest. The absence of any anti government activity pre and post flight will mean that any enquiry will not crystallise into concern about the appellant being a security risk.

366. To conclude, even though there is evidence of torture involving burns in Sri Lanka, and notwithstanding that we apply the lower standard of proof, that is not enough to persuade us that the appellant was burned and acquired the scars he has in the manner claimed.

367. In reaching this conclusion we have considered the appellant's case in accordance with the current guidance as set out in GJ and are satisfied that he would be of no interest to the authorities as he would not be perceived to be a risk to the state. In particular we are satisfied that the appellant is not on either a "stop" or "watch" list. The absence of problems before he left coupled with the nature of the limited activity he has undertaken in the United Kingdom (attending Nullivakail

remembrance days in May 2012 and 2013 and Heroes' Day in November 2011 and 2012) means that he does not have the profile of someone who will be regarded as a threat or of adverse interest. Any intelligence led enquiry would not indicate that the appellant is a Tamil activist nor does he have any intention of becoming such an activist on return. We do not consider that the appellant's case falls within any of the current categories of risk identified by the Tribunal in GJ nor under any other categories discernible from available evidence.

368. For the above reasons:

The First-tier Tribunal was found to have erred in law and its decision was set aside.

The decision we re-make is to dismiss the appellant's appeal on asylum and human rights grounds. The appellant is not entitled to a grant of humanitarian protection.

Signed:

Upper Tribunal Judge Hugo Storey

APPENDIX A: Error of law decision

DECISION AND DIRECTIONS BY UTJ DAWSON OF 7 SEPTEMBER 2012

1. This appeal comes before me pursuant to a transfer order dated 4 September 2012 having been previously listed before UTJ Waumsley and myself on 12 September 2011. The appellant, a national of Sri Lanka born 17 August 1982, appeals with permission the decision of First-tier Tribunal Judge Jhirad who dismissed his appeal against the decision to remove him as an illegal entrant on 31 March 2011. The appellant had arrived in the United Kingdom unlawfully and applied for asylum on 14 March 2011 based on a fear from the authorities because of his previous support as a Tamil for the LTTE. This had led to his detention following the surrender of many LTTE supporters in May 2009. The appellant was taken to Pambamadu detention camp where he was tortured and held until his escape with the assistance of a member of the EPDP who smuggled him out of the camp concealed in a lorry in February 2011. The appellant relies on scarring as evidence of that detention and torture. According to Professor S Lingam, an Executive Medical Director of Medical Express Clinic based in Harley Street London, the scars on his back and right shoulder were caused by heated metal rods (although it is the appellant's account they were caused by heated wires).

2. As to the appellant's account, in summary, his father was a jeweller in Trincomalee. The appellant's father helped the LTTE through his business in 2002. The appellant started working for the LTTE in 2003 by valuing their jewellery they brought to him and he also helped dig bunkers and transport food. He started work as a jeweller in 2007 (the precise chronology is uncertain). In addition to this work the appellant pursued a course of study in Colombo where he lived in a house owned by his parents together with two LTTE members although their reason for being in Colombo is not clear. The appellant had previously made three unsuccessful applications for entry clearance to come to the United Kingdom as a student on 6 October 2006, 13 October 2006 and earlier on 27 June 2005. His case is that in the aftermath of an LTTE attack on Colombo Airport on 25 March 2007, one of the Tamils with whom he lived was arrested and the other had received a message from Vanni for him to return (it appears from the LTTE). The appellant decided to accompany him as he knew the authorities would be after him. There was no evidence of the appellant having previously encountered any difficulties from the authorities. On arrival in Vanni, the appellant stayed with his father's brother who was an LTTE member and started to help them. He ceased helping them in 2008. His arrest, as described above, followed on 10 May 2009 leading to his detention in Pambamadu. The EPDP member who facilitated his escape (called Sasi) had made contact with the appellant's parents. On his escape, the appellant was provided with a false Sri Lankan ID card in the name of a Muslim. He journeyed to Negombo where he was given a French passport and was accompanied by the agent through checks at the airport and who informed him not to claim asylum in France. He claims to have arrived in the United Kingdom on 24 February 2011. The agent called his uncle in the United Kingdom and after he was dropped off,

that uncle made an appointment with the Home Office for the appellant to claim asylum. The appellant's mother's two brothers are also in the United Kingdom.

3. The First-tier Tribunal judge did not believe the appellant giving these reasons:

    (i) The appellant had given no credible reason why he would want to return to Vanni with a known Tiger member and thus risk the authorities' adverse interest in him.

    (ii) No reasonable explanation had been given why his parents who owned a house in Colombo would risk allowing their son and two known Tiger members to occupy that property.

    (iii) There was no reasonable explanation why it had taken the appellant's parents one and a half years to facilitate their son's release from detention. If Sasi, the EPDP member, had been able to get in touch with the appellant's parents, the judge considered she had no explanation why the parents could not have taken steps earlier to find out where the appellant was detained. His father, a businessman had supported the Tigers and it is likely he would have known whom to approach.

    (iv) It was significant the appellant had attempted on three previous occasions to enter the United Kingdom as a student.

    (v) Although the appellant's father had apparently been arrested no subsequent adverse interest had been shown in him by the authorities. There is no evidence that those authorities had issued an arrest warrant for the appellant.

    (vi) Professor Lingam had not tested the appellant's account but accepted it at face value. In his finding that he could not scientifically differentiate between wounds inflicted deliberately from wounds inflicted from torture, he had not stated what scientific tests or other means he had used to establish this opinion.

    (vii) There must be a method by which injuries capable of being inflicted on the appellant by invitation to a third party to do so and injuries caused by third parties as a result of torture and detention could be differentiated.

4. After addressing the risk categories identified in *TK* the judge decided the appellant would not be at risk if returned and would be safe in Colombo.

5. At the hearing before me I heard submissions from Mr Paramjorthy on the grounds of application and responses where appropriate from Mr Wilding. I say this as on 12 September 2011, Mr Jarvis on behalf of the Secretary of State accepted the judge had made an error of law. Unfortunately no decision was then promulgated by the Tribunal and following Judge Waumsley's retirement the need for the transfer order referred to above came about.

6. In essence, the appellant relies on four grounds. The first is that the judge had failed to engage with the appellant's oral evidence why he would return to Vanni from Colombo. Mr Paramjorthy made only limited submissions on this ground and I accept Mr Wilding's argument that there was no clear explanation from the appellant why he decided to go to Vanni except for a fear from the authorities. That fear however needed to be considered in the absence of any evidence of previous difficulties by the appellant. The evidence before the judge was that one of the Tamil members had been arrested on 27 March 2007 but in the absence of evidence of any adverse interest in the appellant, the finding of the judge on this aspect was one that was open to her on the evidence.

7. The second ground relates to the plausibility of the appellant's parents permitting him and two LTTE members to occupy their property in Colombo. It is stated in the application that the appellant had provided oral evidence that he had not registered their presence with the authorities. The judge does not refer to this in her determination. It is not immediately apparent from the judge's record of proceedings whether this specific point was put in cross-examination. The appellant had been tendered for cross-examination adopting his statement but even on the assumption it had not been raised, it was arguably open to the judge to be concerned about the likelihood of the appellant's father putting himself personally at risk by permitting occupation of his house by LTTE members in Colombo.

8. The third ground relates to the judge's conclusion that there was no explanation why the appellant's parents had not located him earlier following his detention. This ground argues that it was not the appellant's parents who made contact with the EPDP member but that he had made contact with them. I do not accept Mr Paramjorthy's argument that the judge was confused. What she stated was, "the appellant's father is a businessman who supported the Tigers and it is likely he would have known whom to approach in order to put enquiries in motion as to the whereabouts of the appellant". It was not the case that the judge had misunderstood the evidence. It is an unusual view taken by the judge that the LTTE would be in a position to disclose the whereabouts of the appellant but nevertheless it is not one which of itself discloses an error of law.

9. There is however merit in the fourth ground which relates to the judge's assessment of the medical evidence. There was no evidence before the judge to support her view that there must be a method by which there could be a differential identification of the cause of injuries of the kind suffered by the appellant. She was in error in rejecting the evidence of Professor Lingam for this reason and furthermore, because of her view that he had not tested the appellant's evidence.

10. Professor Lingam's report does raise potential difficulties. Unsatisfactorily, he explains that in Tamil the word *cambi* can mean both metal wires and metal rods. He is not a language expert. He explains in his report that he spoke to the appellant in Tamil as he is conversant in that language. He does not explain the extent of his language competence. His report explains, *inter alia,* that: "I have ruled that, no way I could scientifically differentiate between the wounds inflicted deliberately from the wounds inflicted from the said torture". He does not explain

why he is unable to do so. Further, he states, " I considered if these were caused by a medical condition or a surgical procedure, I have ruled that, no medical condition would have caused the scarring described in this report". He does not explain what methodology he used to come to this conclusion despite earlier concluding that he was unable to scientifically differentiate wounds caused deliberately from those brought about by torture. He does not answer the second limb of this question whether the scars were caused by surgical procedure.

11. As accepted by Mr Wilding, the judge clearly erred in her approach to this important evidence that had the potential to meet the credibility concerns which led her to disbelieve the appellant's account as a whole. My view is that the error is sufficiently material for her decision to be set aside and remade. If the appellant is able to establish that the scarring came about as a result of his detention, there is a real possibility that his account therefore is true.

12. Mr Wilding did not accept that if the Tribunal were to find that the scarring was caused in detention it would be determinative of his claim. This is a position he was entitled to take but Mr Paramjorthy was correct in reminding me of the weight to be given to evidence of previous ill-treatment in assessing future risk with reference to the *QD*.

13. The Tribunal is often confronted with the difficulty of deciding the cause of particular scarring. The respondent in her reasons for refusal letter of 31 March 2011 did not accept the appellant had been tortured by the Sri Lankan authorities. Whatever shortcomings there are in the report by Professor Lingam, it is clear from what he observed that the appellant does have significant scars which, although not visible wearing a short sleeve short would, were the appellant required to strip, be sufficient to raise enquiries in the mind of an observer.

14. The appellant's case is that the scarring was inflicted by hot wires and specifically on that both Mr Wilding and Mr Paramjorthy agreed there is merit in there being general guidance by the Tribunal on:

    (i) whether it is possible to differentiate between burn scarring caused by hot rods or wires or similar heated instruments that has been self inflicted or inflicted with consent, and burn scarring caused by torture of the kind described by the appellant as having occurred during detention.

    (ii) whether it is possible to determine from the nature of such scarring if someone has had any form of medical intervention or treatment and if so of what kind;

    (iii) whether it is possible and with any precision, to age such scarring by any means.

15. The case will be listed for a case management review four weeks hence by when the parties will have had the opportunity of considering the nature of expert evidence required to deal with the issues in paragraph 14 above, in particular whether that evidence needs both a dermatologist and a trauma consultant. It will also be an opportunity to re-categorise, add to or vary the three areas of enquiry described

above. The parties are directed to liaise on this and to identify a joint expert(s) - details of their identities and qualifications will need to be made available to the Tribunal at the case management review.

16. In summary therefore I am satisfied that the First-tier Tribunal made a material error of law requiring the decision to be set aside and remade. None of the findings of the First tier Tribunal is preserved. The appeal will be heard substantively on a date convenient to the parties after the case management review before a panel of judges of the Upper Tribunal.

Signed Date 7 September 2012

Upper Tribunal Judge Dawson

APPENDIX B: Home Office Policy Instructions on Medico-Legal reports, January 2014

Asylum Policy Instruction

Medico-Legal Reports from the Helen Bamber Foundation and the Medical Foundation Medico-Legal Report Service

Version 3.0

17 January 2014

Contents

Section 1: Introduction

1.1 Purpose of instruction

This guidance explains how caseworkers should process and consider asylum claims involving allegations of torture or serious harm where a Medico-Legal Report (MLR) from the 'Medical Foundation Medico-Legal Report Service' at Freedom from Torture or the Helen Bamber Foundation forms part of the evidence. There is separate guidance for medical (or expert) reports submitted by other individuals or organisations in Medical Evidence (Non Medical Foundation cases), and where a report is submitted in relation to an Age Dispute case.

This is a supplementary instruction and **must** be read in conjunction with other relevant guidance when considering the claim, including:

- Considering the Asylum Claim and Assessing Credibility;
- Humanitarian Protection;
- Gender Issues in the Asylum Claim;
- Internal Relocation;
- Victims of Trafficking (Guide for Competent Authorities);
- Appendix FM (Family Life) and Long Residence and Private Life;
- Discretionary Leave (DL);
- Human Rights claims on medical grounds.

1.2 Background

Torture, trauma and ill treatment can form part of any asylum and/or human rights claim and victims and survivors may have difficulties in recounting details because of the traumatic and sensitive nature of those experiences. Nevertheless, where an applicant claims to have been tortured or the victim of other forms of serious ill-treatment, caseworkers are required to consider any information about when, where, how, and by whom the torture or serious harm was inflicted. This may involve considering MLRs submitted as evidence to support the claim.

This guidance is for caseworkers processing cases where either the Medical Foundation Medico Legal Report Service or the Helen Bamber Foundation (the Foundations) has registered an interest in the case and specifically, where either organisation has provided an MLR as part of the evidence of ill treatment. Further details about both organisations can be found in Annex B.

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1.3 Policy intention behind considering MLRs

The underlying policy objective when processing claims involving allegations of torture or serious harm and considering MLRs in the context of an asylum claim is to:

- ensure all asylum claims are properly considered in a timely and sensitive manner on an individual, objective and impartial basis;
- ensure all cases are managed effectively throughout the asylum process to avoid unnecessary delay;
- ensure all relevant medico-legal (and any other) evidence provided by the Foundations in support of the claim is properly considered and given appropriate weight.

1.4 Application in respect of children

Children can be victims of torture and in certain circumstances the Foundations will accept referral of cases involving unaccompanied and accompanied children. As with adults who allege torture or serious harm, referral of a child to one of the Foundations for an MLR comes via their legal representatives. Referrals for treatment services may also be made by GPs, teachers or social workers. In respect of claims involving torture or serious harm, Medical Foundation and the Helen Bamber Foundation MLRs relating to children must be considered in the same way as those relating to adults.

Specially trained caseworkers deal with asylum claims from children, including cases where torture or serious harm is alleged. The Foundations' MLRs may occasionally provide evidence relevant to the age of the child. If age is in dispute, this evidence must be considered alongside all other relevant evidence on age. Where the MLR contains more information which raises credibility issues around the claim, wherever possible, this should be put to the child (if this is being done in person, this must be in the presence of a responsible adult) to give them an opportunity to explain or clarify the credibility point in question.

Evidence provided in the MLR must not be given 'no weight' in the overall consideration of the claim. Further guidance on weighing up conflicting evidence on age is given in the Asylum Instruction Assessing age.

Caseworkers must also be aware of our obligations under Section 55 of the Borders, Citizenship and Immigration Act 2009. Further guidance is available at Section 55 Children's Duty Guidance.

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Section 2: Process and case management

2.1 Referrals to the Foundations

For asylum claimants who allege torture, referral to one of the Foundations usually comes via their legal representatives, but it can also be made by GPs, other health professionals, frontline refugee agencies or, in the case of children, teachers or social workers. This second type of referral can also lead to an internal referral for an MLR.

Where an account of torture or serious harm is given during the interview, the caseworker should suggest that the applicant may wish to approach one of the Foundations for care and treatment. However, it is for the applicant or their representative to decide whether to seek an appointment with one of the Foundations. Where a caseworker suggests a referral, this does not necessarily mean that the claim of torture has been accepted at this point.

2.2 Children

The Foundations will accept referral of cases involving unaccompanied and accompanied children. Claims from children who have provided evidence that they are awaiting an appointment with the Foundations must be dealt with in the same way as those from adults, although caseworkers should be aware that the Foundations have limited clinical resources in this area which may lead to delays. See also section 1.4 above.

2.3 Pre-Assessment procedure by the Foundations

Once the applicant has been referred to one of the Foundations, from whatever source, for an MLR, the referral is assessed by the Foundation and, on the basis of the information contained in it; a decision will be made to:

- Reject the request without an appointment or;
- Invite the applicant to attend a 'pre-assessment' interview; or
- Move directly to an appointment with a clinician.

Although this varies between the Foundations, only approximately 30 per cent of applications are accepted for pre-assessment. The decision not to invite an applicant for an assessment does not necessarily reflect upon the applicant's credibility. This decision may be taken on a number of grounds, including instances where the case does not fall within the remit of the Foundation, where another clinician may be better placed to document the evidence, where there is nothing to document physically or psychologically or where injuries have already been documented and the Foundation has nothing to add. Caseworkers must not draw adverse inferences regarding the credibility of the asylum claim from the Foundations decision not to invite the applicant for an

assessment or not to proceed with an MLR after a pre-assessment.

Paragraph 161 of the Istanbul Protocol states that:

> The absence of 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.

Similarly paragraph 236 of the Protocol states:

> It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However many victims experience profound emotional reactions and psychological symptoms.

Paragraph 234 of the Protocol though makes clear that:

> The psychological consequences of torture, however, occur in the context of personal attribution of meaning, personality development and social, political and cultural factors.

In cases where applicants are not accepted for an appointment with a clinician or other health care professional, the Foundation will promptly inform them of the reason, usually through their legal representative, who should, where the Home Office is awaiting the outcome of the referral, promptly inform the caseworker to ensure the case is not unnecessarily delayed.

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2.4 Cases accepted for a pre-assessment

When the caseworker is informed in writing by the applicant's legal representative that the case has been accepted for a pre-assessment appointment, they should normally suspend the substantive decision if they are not minded to grant any leave (see section 2.8 below). If the caseworker is informed by phone, the legal representative should be asked to provide written confirmation and a copy of the letter from the Foundation (which should be available).

However, there may be cases where the applicant's account of events, including incidents of torture, is accepted but this does not give rise to a need for international protection where, for example, the country situation has changed or there is sufficiency of protection. In such cases the caseworker may proceed to decision without waiting for the MLR but should first contact the legal representatives and give them an opportunity to provide representations as to why the decision should be suspended to wait for the MLR. Caseworkers should discuss a decision to proceed with a Senior Case worker.

Where it is decided to delay the decision pending receipt of the MLR, caseworkers should confirm that the decision has been suspended in writing to the applicant and legal representative (if represented). A template letter is available at Annex A.

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2.5 Assessment timescales

The Foundations aim to produce a full MLR within five months[1] of the date that the legal representative or applicant has been notified in writing that the case has been placed on hold by the Home Office. However, flexibility is required when considering whether to delay cases beyond the five month target as there may be exceptional reasons for delay. Caseworkers must consider any reasons for the delay provided by the legal representative and act reasonably in deciding whether to allow more time.

There are several factors that may lead to a delay in the completion of an MLR, and which may warrant the grant of extra time. These include, but are not limited to:

- a high level of trauma and/or a long history of torture and/or multiple injuries requiring additional clinical sessions;
- the need to match the applicant with a particular specialist;
- missed appointments due to travel disruption;
- a decision not to release the applicant from detention; or
- illness on the part of the applicant or Foundation clinician or interpreter.
- In children's cases, securing the appropriate clinical resources and expertise.

However, the Home Office are unable to delay a decision indefinitely whilst awaiting receipt of an MLR and is entitled to set a reasonable time limit for the receipt of additional evidence after which the case will be decided. It is not possible to state a rigid time limit which would be appropriate for all cases where provision of an MLR has not been possible within the 5 month timeframe. Therefore, a reasonable time limit should be set on a case-by-case basis, in consultation with a Senior Caseworker who must consider any correspondence from the legal representative regarding the reasons for the delay.

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2.6 Case management

When deciding whether or not to delay consideration of a case pending receipt of an MLR from either Foundation, the guiding principle is that the caseworker must act reasonably. The decision to delay must be made on a case-by-case basis. Caseworkers should assess the importance and relevance of the evidence to the claim, and seek advice from a Senior Caseworker if in doubt.

Cases must be actively managed whilst any report is being produced. Caseworkers must ensure regular contact with the applicant's legal representative (where they are represented) is maintained to minimise any delays in either the production of the MLR or the existence of other factors that could reasonably be expected to delay the decision more than is necessary.

[1] The Foundations have significantly reduced the timescales for provision of MLRs from 12-18 months to 5 months in the majority of cases following a pilot in 2011-12 to improve internal processes.

Caseworkers must clearly document on the Home Office file all communication with the applicant's legal representative, including any failure to provide updates on the progress of the case when requested to do so. If there is no indication from the applicant's legal representatives as to why the case has been delayed, consideration must be given to proceeding to a substantive decision. Caseworkers must ensure that every effort has been made to discuss the progress of the case with the legal representative before proceeding to make a decision.

Where repeated attempts to contact the legal representative are unsuccessful, caseworkers can write directly to the Foundations, who will follow up directly with the legal representative to avoid unnecessary delay. The Foundations' are experts instructed by the legal representative on behalf of the applicant so direct communication between the Foundations and the Home Office will normally be inappropriate. However, in the absence of a legal representative the caseworker may contact the Foundation direct and vice versa.

Where a request for permission to take up employment is received whist the case is on hold, this must be considered in accordance with the guidance on 'Permission to Work'.

2.7 Granting leave without the need for an MLR

If caseworkers are minded to grant asylum, Humanitarian Protection, leave under Appendix FM (Family Life) or Paragraphs 276ADE to 276 DH (Private Life) or Discretionary Leave they may do so without waiting for an MLR, even where the case has already been referred to the Foundations.

The legal representative must be informed promptly, especially if, for any reason, the decision will not be served immediately so that they can advise the Foundation which will be able to reallocate an assessment appointment if appropriate (where asylum is refused but another form of leave is granted, an MLR may still be needed for any appeal of the decision to refuse asylum under Section 83 of the Nationality, Immigration and Asylum Act 2002).

2.8 Case handling at the substantive interview stage

2.8.1 Request received before the substantive interview date

The asylum interview should not be delayed pending receipt of an MLR unless there is evidence that a medical condition may prevent the applicant from attending or participating fully with the interview process. Any letter from the Foundation provided in support, must clearly state why the applicant is unable to participate in the interview.

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2.8.2 Dealing with torture claims at the substantive interview

Caseworkers must check the Home Office file prior to interview as part of their preparation to see whether:

- evidence has been submitted indicating that the applicant intends to submit a medico-legal report;
- the applicant has approached a medical practitioner;
- the applicant may require particular care during the interview;
- the Screening Interview Record notes any previous mention of a medical condition, medication, other treatment or other relevant information.

See the Asylum Instruction, '[Conducting the Asylum Interview]'.

Where an account of torture or serious harm is given during the interview, the caseworker should suggest that the applicant may wish to approach one of the Foundations for care and treatment. If during the interview, an applicant indicates that they or their legal representative has approached one of the Foundations, the caseworker must make a note of this on the interview record, photocopy any evidence of a medical appointment, and place this on file.

Where evidence of a medical appointment is not available at the interview the caseworker should request that a copy is provided within **5 working days**. The interview should, where possible, establish the relevance of the MLR to the claim because evidence provided during an interview may be sufficient for the caseworker to accept an account of torture or serious harm without the need for an MLR. Caseworkers must be aware that in some cases the applicant may not be aware that the legal representative has referred the case to one of the Foundations for initial assessment.

It should be made clear to the applicant that the report must be submitted as soon as possible and that without an explanation for any subsequent delay, a decision will not necessarily be delayed beyond any agreed date. The applicant and/or legal representative should be informed by email or letter the agreed deadline for receipt of the MLR, following consultation with a Senior Caseworker.

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2.8.3 Dealing with cases that have not been referred

Applicants who inform caseworkers that they **intend** to seek referral to one of the Foundations, but have not yet done so, are not entitled to have consideration of their claim suspended pending confirmation that they have actually been referred. In such instances, caseworkers must advise applicants of this fact, but inform them that, if a letter confirming a Foundation appointment is received before a decision is made, the case may be placed on hold to await any further evidence from the Foundation before deciding the claim. Where the applicant is represented, caseworkers should contact the legal representative to confirm if a referral has been made before proceeding with a decision.

Interviews should not be suspended or cancelled on the basis that an applicant has informed the Home Office that they intend to approach one of the Foundations. See 'Conducting the asylum interview' for guidance on the circumstances in which it may be appropriate to suspend or cancel the interview.

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2.9 Interim Reports

The Helen Bamber Foundation (and sometimes the Medical Foundation) may produce an interim report. This may be because although the clinician cannot yet be as comprehensive as he or she might in a full report or because a full history has not yet been obtained (for clinical reasons) there are nevertheless significant factors to report. Often there are cogent psychological reasons why it has not been possible to take a full history but those reasons may, of themselves, be worthwhile discussing in an Interim Report.

Where an interim report has been completed, it will depend entirely on the individual facts of the case and the content of the report as to whether it would be appropriate to proceed to a decision. In cases where an interim report **does** provide sufficient evidence to justify a grant of leave there is no need to wait for the full MLR. The principles set out in Section 3: Considering the content of MLRs should be applied.

2.10 Cases where referral does not lead to an MLR

The Foundations may decide not to write a report for a number of reasons and the absence of a report should not be taken as a reason for refusal. The reasons they may decline to write a report Include (for example):

- Where nationality is in dispute;
- Where they cannot match the testimony to the injury:
- Where there is no apparent physical scarring or psychological consequences of torture or serious harm to document.

Caseworkers must be aware that some methods of torture do not produce scarring and the absence of scarring does not necessarily mean that the torture did not take place; it could mean that there is simply nothing physical to document to the requisite standard. Similarly, some survivors of torture are highly resilient and do not have ongoing psychological problems capable of being documented. Where torture or serious harm is not in dispute or is sufficiently well documented by others of appropriate expertise, the Foundations may also decline to write a report.

Agencies other than the Medical Foundation and the Helen Bamber Foundation prepare MLRs and, on occasion, the Foundations will refer the legal representatives to those other agencies.

This may be because of geographical location or particular expertise, a pre-existing relationship with the client/patient, or a temporary lack of resource in a particular field.

2.11 Detained Fast Track processes

Applicants routed into the Detained Fast Track (DFT) can be referred to the Foundations by legal representatives in the same way as other applicants who are not detained. If either Foundation agrees to accept an applicant for pre-assessment before a substantive decision is made, the applicant will be taken out of the DFT process providing confirmation of the appointment is received. The referral is usually accepted within 24 hours. It is Home Office policy to remove from DFT processes any applicant who is accepted by the Foundations for a pre-assessment appointment. In such cases, unless there are other reasons for the applicant to remain detained he or she should usually be released and the case transferred to the Asylum Casework Directorate (ACD) who will take responsibility for the case management and decision making process.

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Section 3: Considering the content of MLRs

3.1 Introduction

Both Foundations are accepted by the Home Office as having recognised expertise in the assessment of the physical, psychological, psychiatric and social effects of torture. Clinicians and other health care professionals from the Foundations are objective and unbiased. Reports prepared by the Foundations should be accepted as having been compiled by qualified, experienced and suitably trained clinicians and health care professionals.

Reports may also be compiled by other experts with extensive experience in this field and should be accepted providing details of their qualifications, training and experience have been provided and it is clear that the report has been compiled using the standards and terms employed by, for example, the **Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations, 2004)**. No report or its contents should be given little weight on the grounds that the writer, whether a GP, Consultant, other clinician or health care professional is not sufficiently qualified to write it. In particular, in relation to mental health conditions, the report will be accepted by the Home Office whether completed by a GP, clinical psychologist, consultant psychiatrist, other health care professional or other expert with extensive experience in this field.

If a caseworker considers the writer of a report compiled by another expert on behalf of one of the Foundations is not apparently qualified to write the report, they **must** first refer it back to the legal representative. The concerns regarding the qualifications must be clearly set out so that the legal representative – as commissioner of the report – can raise these concerns with the relevant Foundation before a decision is made on the asylum claim.

Agencies other than the Foundations prepare MLRs and, on occasion, the Foundations will refer the legal representatives to those other agencies. This may be due to geographical location or particular expertise, a pre-existing relationship with the client/patient, or a temporary lack of resource in a particular field. Where the subsequent report is not prepared by the Foundations, caseworkers should ask the legal representative to confirm that the report has been prepared following the Foundations own processes. If the report has not been prepared using the Foundations processes, the Home Office instructions regarding the Foundations do not apply and caseworkers should instead refer to guidance on handling medical reports from providers other than the Foundations. See Medical Evidence (Non Medical Foundation cases).

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3.2 Interviewing

The traumatic nature of torture means that particular care and sensitivity is **required** when interviewing applicants who claim to be victims of torture. Caseworkers must ensure that they are familiar with guidance on interviewing alleged victims of torture in the Asylum Instruction, 'Conducting the Asylum Interview'. Caseworkers should note that not all forms of torture necessarily result in physical scars or injuries that are identifiable during a medical examination or are visible to an interviewing officer.

A torture victim's potential shame, distress, embarrassment and humiliation about recounting their experiences are difficulties which may need to be overcome. Many find this particularly difficult in the atmosphere of an official process. Those who have suffered at the hands of their own authorities may distrust officials here, despite travelling to this country to seek refuge. In many ways, this is an intractable problem but common sense, awareness and sensitivity can reduce its influence. All Home Office staff are expected to treat people with respect and must adopt a professional and sensitive approach during the interview process.

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3.3 Considering MLRs as part of the decision making process

It is important that reports prepared by the Foundations are understood fully and given proper weight in the consideration process. MLRs are expert evidence, not simply a report on the credibility of a claim of torture. The report may provide additional information that the applicant was unable to convey at interview but was able to disclose during sessions with the clinician. Caseworkers must take great care when assessing expert medical evidence. Due consideration must be given to the opinion of the medical expert on the degree of consistency between the clinical findings and the account of torture or serious harm, on the understanding that this does not impinge on the caseworkers duty to make an overall finding on credibility.

Foundation clinicians can be assumed to have considered the possibility of 'a false allegation' of torture in forming a clinical view as this is required by the Istanbul Protocol: Paragraphs 105(f) and 287(vi) require the report writer to consider whether the clinical picture suggests a false allegation of torture.

It is **not** the role of caseworkers to dispute the clinical findings in the report or purport to make clinical judgements of their own about medical evidence or medical matters generally. Examples of clinical judgements that are inappropriate for the caseworker to make include:

- what in the caseworkers opinion ought to be physically possible or survivable;
- speculation as to alternative causation of physical or psychological injuries;
- questioning the accuracy of a diagnosis (based on selective quoting of the diagnostic criteria);
- substitution of the caseworkers own opinion on late disclosure or discrepancies in

the testimony when a clinical explanation has been provided in the MLR or

- speculation with regard to the amount of detail with which a particular traumatic event ought to be remembered.

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

- the use of information obtained via the internet about diagnostic criteria or medication;
- the use of statements made by an applicant at interview that they 'feel well' to subsequently dispute medical problems identified and documented by the Foundation;
- selective quoting from the MLR to challenge representations made by the claimant that the report supports when read properly and in its entirety.

This is not exhaustive and if caseworkers are in doubt as to whether a finding is a clinical judgement, they should discuss the case with a Senior Case worker who may consult Asylum Operational Policy where necessary.

Where further particulars relating to the content of the report are required, requests should be made to the legal representatives if the applicant is represented. If there is no response to requests for further information from the legal representative, caseworkers can write directly to the Foundations. The Foundations will liaise with the legal representative to progress the case and will not provide information directly to the Home Office as this would be inappropriate given the Foundations' role as an expert instructed by the legal representative for the applicant).

Caseworkers are required to consider all evidence in the round; including expert medical evidence and a conclusion on the overall credibility of an account of past events must not be reached without careful consideration of the contents of the Foundation's MLR. Caseworkers must have in mind the approach to assessing the credibility of past events set out in the Karanakaran judgment, which emphasises that evidence should not be excluded where some weight may be attached to it. They also need to bear in mind that the standard of proof is that of a 'reasonable degree of likelihood' which is lower than 'the balance of probabilities'. See Considering the asylum claim and assessing credibility for further guidance. The Foundations will not produce reports unless there is clinical evidence that is at least 'consistent with' the claimant's account of torture or serious harm according to the terms used in the Istanbul Protocol.

The Protocol, the central importance of which is accepted by the UK courts in the asylum context, makes clear that reports which document and evaluate a claim of torture for asylum proceedings need only provide 'a relatively low level of proof of torture [or serious harm]'. Therefore, the Foundations' report in support of the applicant's claim of torture or serious harm cannot be dismissed or little or no weight attached to them when the overall assessment

of the credibility of the claim is made.

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If a report has been produced in support of an allegation of torture or serious harm and, having considered the findings, the caseworker is minded to reject the claim to have been tortured for the reasons ascribed by the applicant because there is significant evidence that outweighs the MLR evidence in support of credibility, the case must be discussed with a Senior Case worker.

If it is decided to refuse the claim the Reasons for Refusal Letter (RFRL) must address the contents of the report and explain what weight has been given to the medical evidence and why this do not outweigh other grounds for not accepting the applicant's account of events.

Caseworkers should not argue that no weight can be applied to the report. If the allegation of torture or serious harm has been rejected, the RFRL must state clearly the reasoning behind the rejection of the claim.

Paragraph 339K of the Immigration Rules makes it clear that the fact that a person has been subject to persecution or serious harm, or to direct threats of such persecution or harm, will be regarded as a serious indication of the person's well founded fear of persecution or of a real risk of their suffering serious harm, unless there are good reasons to consider that such persecution or serious harm will not be repeated.

However, the existence of a medical report and/or the acceptance of past persecution and/or torture will not necessarily justify a grant of asylum or Humanitarian Protection on that basis alone. For example, a grant of leave may not be appropriate if there are significant and enduring improvements in conditions in the country such that past mistreatment does not give rise to a future fear of persecution or if internal relocation is reasonable. The RFRL must explain why there is no reasonable likelihood that the applicant will be at risk in the future.

If caseworkers have concerns about the content of any medical aspect of an MLR prepared by the Foundations, they should discuss those concerns with Asylum Operational Policy via a Senior Caseworker. The Senior Caseworker will then refer the matter, if necessary, to the legal representative - outlining the reasons for the concern - before reaching a final decision on the asylum claim. The decision should be put on hold pending the outcome of that discussion.

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3.4 Assessing the overall claim

Where an MLR is submitted in support of a claim, the claim must still be considered in its entirety and not solely on the findings set out in the MLR, whilst always giving due weight to the report. As with all claims, caseworkers must assess according to the appropriate standard of proof whether:

- there is a well-founded fear of future persecution (which may include torture or serious harm) for a reason covered by the 1951 Convention (in which case the person will normally qualify to be recognised as a refugee – see the Asylum Instruction Considering

the Protection (asylum) Claim and assessing credibility) ; or if not;

- there are substantial grounds for believing that, if removed, there is a real risk of the applicant being subjected to torture or to cruel, inhuman or degrading treatment or punishment (in which case Humanitarian Protection should normally be granted. (Please refer to the Asylum Instruction on Humanitarian Protection.)

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3.5 MLRs submitted following refusal of asylum

In cases where an MLR is submitted after the claim has been refused, the case should be reviewed before any appeal. The report should be carefully considered taking all evidence into account in accordance with the principles set out above. It is important to fully consider the MLR in the context of the evidence as a whole to properly assess whether such evidence may have resulted in a different overall assessment of credibility and evaluation of future risk had it been available before the initial decision. It is not sufficient to maintain, without clear explanation, that previous adverse credibility findings mean the MLR makes no difference to those findings.

Having considered the report it may be appropriate to withdraw the decision only if it is clear that a grant of Asylum, Humanitarian Protection or Discretionary Leave is appropriate. If the refusal is to be maintained it may be appropriate to provide a supplementary RFRL setting out how the report has been considered and why the decision is to be maintained. Caseworkers must ensure that the legal representative is provided with a copy of any supplementary refusal letter prior to the appeal to ensure that the appeal can proceed without delay.

3.6 Preparing case files for appeal hearings

If there is evidence that an applicant has been in contact with one of the Foundations, whenever possible Presenting Officers should contact the applicants' legal representatives to confirm whether an MLR has been received by them or is in preparation and, if so, they should request a copy in advance of the appeal hearing in order to review the case.

If, however, the representatives confirm that the applicant is still waiting for a report, then the officer should use their discretion on the basis of the information that is already on file, together with any information given by the representative as to the likely timescale for the production of any report, and in the appeal bundle to decide whether or not to take any further action, bearing in mind the need to avoid unnecessary appeals.

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Section 4: Miscellaneous

4.1 Difficulties with the Foundations

Asylum Operational Policy should be informed if Senior Caseworkers believe that an MLR appears to depart considerably from the Foundations' own guidelines. If appropriate, Asylum Operational Policy will bring any concerns to the attention of the relevant legal representative.

4.2 Reporting

When establishing a reporting regime, caseworkers must bear in mind current contact management policy in relation to certified Foundation cases and take into account the implications that any future appointments or ongoing treatment with one of the Foundations could have on an applicant's ability to fulfil a reporting regime.

According to Home Office contact management policy, where there is certified evidence that the applicant is a client of either of the Foundations, they should attract a low reporting frequency. See Contact Management Policy for further information.

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Annex A – Template Letter

Template Letter: Advising Legal Representative that the case is on hold

RE: [**Case Reference** (include legal representative and Foundation reference if known) – **Applicants name**]

As you will be aware your client, [name of applicant] has been accepted by the [Helen Bamber Foundation or Medical Foundation for the care of victims of torture] for a pre-assessment appointment regarding their claim to have been tortured or ill-treated. I have therefore placed the case on hold.

We wish to take into account any relevant evidence provided by the Foundation in either an interim report or a full medico-legal report as soon as it is available. This is to enable us to proceed to a decision on the merits of your client's claim as quickly as possible. You are therefore required to provide updates to the Home Office whenever a request on your clients' progress with the Foundation is made and no less frequently than every 28 days. We will not normally keep the case on hold for more than 5 months from the date of this letter so you must provide reasons for any delay beyond the 5 month target. It would be helpful if you could provide details of alternative arrangements to cover any absences to ensure updates can be provided as requested. We reserve the right to contact the Foundation directly if you do not respond to update requests.

You should also inform the Home Office immediately (and certainly within 72 hours) once you are made aware that:

- The Foundation has decided to take no further action in your client's case;
- Your client has been accepted for a full assessment;
- The Foundation has provided a Medico-Legal Report on your client.

I would be grateful if you would also inform the Foundation that the case has been placed on hold pending receipt of a Medico-Legal Report or confirmation that no further action is to be taken.

Instances of legal representatives failing to comply with these requirements will be reported to the Legal Aid Agency.

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Annex B: Background information

Freedom from Torture

The following information about Freedom from Torture (www.freedomfromtorture.org) has been provided by the organisation:

'Freedom from Torture is a national charity which was established in 1985. It is the only organisation in the UK dedicated solely to the treatment of survivors of torture and organised violence. The main treatment centre is in London, with further centres in Manchester covering the North West of England, Newcastle covering the North East of England, Birmingham covering the West Midlands and Glasgow covering the whole of Scotland.

Prior to 17 June 2011, Freedom from Torture was known as the Medical Foundation for the Care of Victims of Torture. The Medical Foundation for the Care of Victims of Torture continues to be its name in legal and financial dealings. This Asylum Instruction relates to Freedom from Torture's Medico-Legal Report service which continues to be known as the 'Medical Foundation Medico Legal Report Service'.

Freedom from Torture offers medical, psychiatric and psychological consultation, assessment and treatment, short and long term rehabilitation through social care, casework and counselling, psychotherapy, physiotherapy, complementary therapies, group and family work, small financial grants to individuals as well as practical assistance with accommodation and welfare agencies. The Medical Foundation Medico Legal Report Service also accepts instructions for the preparation of forensic MLRs documenting physical and psychological evidence of torture and organised violence'.

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Helen Bamber Foundation

The following information about the Helen Bamber Foundation (www.helenbamber.org) has been provided by the organisation:

'The Helen Bamber Foundation was founded in 2005 and works with survivors of torture (whether sponsored by the State or others), war, genocide, human trafficking for sexual exploitation or labour (slavery), gender based violence (including violence on the basis of one's sexuality) and extreme domestic violence. Many of our clients fall outside the remit of other organisations.

The Foundation's understanding of the traumatic impact of such experiences is based on 60 years direct clinical experience that began with concentration camp survivors after WWII. The methodology for assessing and treating victims incorporates current research on trauma.

Prolonged and repeated exposure to catastrophic experiences (such as when the victim is in a state of captivity, unable to flee, and/or under the control of the perpetrator) can result in

trauma that is complex and enduring. Such trauma often results in the victim feeling permanently damaged, the loss of previously held belief systems, social withdrawal, the feeling of being constantly threatened, an inability to relate to others and a fundamental change to the individual's previous personality. Impairment to memory and capacity to articulate traumatic experiences are often observed within this population. Examples of the conditions in which such trauma is likely to occur include prisons, concentration camps, slave labour camps, as well as in brothels, other institutions of organized exploitation and within some families in which the perpetrator creates a relationship of coercive control.

New diagnostic categories are emerging to better account for the full range of symptom constellations that can result from multiple and chronic traumatisation. Conventional psychiatric classifications can 'reduce' the survivor to a category of symptoms, often discounting the individuality of the experience, as well as its social and political context. The Foundation considers that the complex, human dimension of an individual's response to these experiences must be given proper consideration.

All clinical assessments are carried out by one of the Foundation's senior clinicians, often involving members of the multidisciplinary team, prior to implementation of a care plan. Each clinical assessment uses a range of internationally recognised assessment schedules (Harvard Trauma Questionnaire, Hopkins symptoms checklist etc)'.

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Section 5: Change record

Version	Author(s)	Date	Change References
1.0	SL	20/03/2007	New web style implemented
2.0	JL	27/10/2009	Children's duty paragraph added
3.0	OPRU	17/01/2014	Updated following MLR Pilot

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