Encountering victims of torture in a GP’s surgery

This case was written by Dr Frank Arnold, Clare Shortall, Jack Tasker and Chris Venables, Medact (United Kingdom). It was edited by Charlotte Butler, Project Consultant. The case is intended to be used as the basis for group work and class discussion rather than to illustrate either effective or ineffective handling of a Medical Peace Work situation.

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PART ONE

London, England

10th October 2014

At the end of a long working day Dr. Talbot sat at his desk and watched as Peace Abilowale and her friend Mrs. Jones entered the room.

“Good afternoon, how can I help?” he asked them.

In fact, his question was just a formality, part of a routine he had refined over the years. He knew full well why they were there. Only a few hours earlier there had been a commotion in his small surgery when Mrs. Jones, one of the practice’s long-term patients, had demanded that Julie Strong, the practice manager, register Peace Abilowale as a patient and arrange an appointment for her to be seen by Dr Talbot that afternoon. Ms. Strong had refused because Peace Abilowale could produce no proof of address or identification, and informed the curious crowd in the reception area that Ms. Abilowale was, “probably an illegal immigrant!”. At that, Mrs Jones had set her jaw, and refused to leave the waiting room without an appointment.

“As I told you earlier, Dr Talbot”, Mrs Jones began in a strong, clear voice. “Peace arrived in the UK last year from Uganda and has become a member of our congregation. As a Christian, I feel it is my duty - our duty - to have her registered here and attended to by yourself. She hasn’t been well since she arrived in the country from Uganda, and I’m concerned about her health.”

“Okay. Please, take a seat”, said Charles in a deliberately pleasant tone. “Well, as I said earlier when you turned my entire afternoon into chaos - it’s pretty unheard of to register someone without proof of address or ID, but –” he looked at Peace. “- we will make an exception on this occasion as the word of Mrs. Jones carries more weight than gold in some circles - or so it seems.”

Peace looked down at her hands and mumbled in a soft, low voice, “Thank you, Doctor”. Dr Talbot strained to listen. It was the first time he’d heard her speak.

“My dear, tell the doctor what the problem is,” Mrs. Jones urged Peace.

“Since I have been here...” she spoke slowly, trying to remember the handful of English words that she knew. “I have been... coughing blood. I do not sleep. I lose my body.”

“Lose your body?” Dr Talbot questioned. “Body.” she clasped her waist.

“Weight loss, possible insomnia...haemoptysis.” Dr Talbot spoke to himself as he wrote a note. Then he looked across his desk at the two women sitting opposite and smiled. “Let’s see what we can do then.”
Over the next ten minutes Dr Talbot battled with Peace’s limited English and Mrs. Jones’s interruptions as he tried to conduct as full an assessment as possible. It was apparent that since leaving Uganda she’d been suffering, but on examination Charles couldn’t find an anomaly to account for all her symptoms. Having written a referral for a chest X-Ray and taken samples of her sputum to send to the lab, he told Peace he would see her again in two weeks’ time when the results were back.

The two women said thank you and left, arm in arm. Dr Talbot thought about the situation, how there was obviously so much more going on beneath the surface. But Peace’s reluctance to talk and her lack of English had made it difficult to work out what it was. Tired and hungry at the end of a long day there was little else he could do until he saw her again. Once the results of the samples were back they’d take it from there. He switched off his computer and grabbed his papers.

31st October 2014

It was several weeks before Dr Talbot saw Peace again. To try and keep on top of all the developments he kept a diary of hurried notes that documented his time with the Ugandan woman. Peace was once again accompanied by Mrs Jones, who, despite Charles’s best efforts to speak directly to his patient, kept on interrupting.

Charles informed Peace that the sputum results came back positive for TB and that he would be referring her to a chest clinic. He tried to comfort her by letting her know that all the other tests had come back negative, and that the TB was completely treatable. Peace went on to complain about severe insomnia and cold sweats, but Charles was pressed for time, and decided that the TB was the most pressing issue to address, for now.

“I’m sorry, we will have to talk about those things at our next appointment, and, who knows, perhaps when your chest clears up, those things will all go. Why don’t you come back in three weeks? I may well be away on holiday at that point, but my colleague, Dr. Qureshi, should be able to see you. Speak to Mrs. Strong on your way out. Take care.”

22nd November 2014

Several weeks later, Peace arrived for her third appointment – this time with Dr Qureshi, a new registrar who was taking on some of Dr Talbot’s case-load while he was away. This time Peace was accompanied by the Reverend Williams, the vicar of the church she attended. However he did not want to stay for the consultation.

“Hello Mrs Abilowale, what’s brought you here today? I see from Dr Talbot’s notes that you’ve not been sleeping well and have been suffering from general body pains.”
“Yes, my body hurts everywhere”, Peace responded. Dr Qureshi tried to make eye contact and waited for her to say more. “I also have problem...down there.” Peace tapped her hand between her legs. “I am leaking white water”.

Dr Qureshi explained that as well as a general check-up she needed to conduct a gynaecological examination. When she described what this would entail Peace seemed distressed, but said she understood that it was necessary and consented. Dr Querishi’s examination revealed a slightly bulky uterus, a creamy discharge and mild pelvic tenderness. Dr Qureshi also noticed scars on her inner thighs and lower abdomen.

After the examination, Dr Qureshi explained to Peace that she had a genital infection which was causing the itchiness, discomfort and creamy discharge and then, speaking very gently said, “You’ve come this far, so you might as well tell me what exactly happened to you.”

“They took me. They hurt me.” Peace looked down. She was trembling.

“Where was this?” Dr Qureshi spoke very deliberately.

“Back home. In the prison. In Uganda.”

“And what did they do to you?”

“They raped me. They hurt me. They - ”

Peace’s words broke off. After a long pause, Dr Qureshi walked round to her side and gently squeezed her shoulder. “It must have been hard to tell me this. Have you told anyone else about it?” Peace shook her head.

“Why were you in prison?” the doctor asked.

“It is a long story. My husband Tom was close to the leader of the opposition. I used to help him, by designing and printing t-shirts for the movement, going on demonstrations. A couple of times I even spoke at them. We got arrested. I don’t know exactly what they did to him but Tom died.” Peace stopped, sighed and then continued in a resigned tone:

“I told them at the interview. I don’t think they believed me. Every time I tried to describe anything about all that, they changed the subject.”

“What interview?” Peace pointed upwards, “Them. The Home Office. My interview so that I can stay here. It was last week. No sleep since then.”
PART TWO

3rd January 2015

In late August Dr Talbot received a letter from the legal firm Paine Mendes LLP requesting Peace’s medical records. The letter said that they were immigration lawyers working on Peace’s behalf. Enclosed was a letter from Peace Abilowale herself giving her consent to release her documentation and asking for Charles to write a covering letter explaining how the medical evidence supports the claim that she had survived torture and had a “well founded fear” of further abuse if she was forced to return to Uganda. The letter ended with a small note informing Dr Talbot that she would be relocated to the north of England as part of the Home Office ‘Dispersal Policy’. Dr Talbot was unsure exactly how to respond, and what to include, but drafted a response that he ran past to Dr Qureshi before sending.

Letter from Dr Talbot to Paine Mendes LLP

Brick Lane Practice
ChB DRCOG
London Exxx 555
DCHM RCPsych
MB BS MFOH

To whom it may concern,

Re:  Ms. Peace Abilowale
DoB: 14/08/1990

This woman, who is a patient of our practice, gives a history of rape and torture during a three-month period of imprisonment in the Uganda. She presented with symptoms of pulmonary tuberculosis and completed a course of standard anti-tuberculosis chemotherapy.

She gives a history of having been tortured and imprisoned while in prison, and has scars on her thighs which accord with this account. She also displays symptoms consistent with severe depression.

If further information would assist, please do not hesitate to contact me.

Yours sincerely,
Dr. Charles Talbot
16th June 2015

It was six months before Dr Talbot heard about Peace Abilowale again. Early one Monday morning Ms Strong knocked on his office door and passed him a letter with a postal mark from the Teeside – in the North East of England. He immediately thought of Peace and waited for Mrs Strong to leave before opening it:

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**Letter from South Tees Mental Health Unit to Dr Talbot**

South Tees Mental Health NHS Trust
Dockside Buildings
Middlesborough MI13 1TR

16/06/2015

Dear Dr Talbot,

Re: Ms. BA
DoB 14/08/1990

I am writing to you regarding Ms. Peace Abilowale who (according to health service records) is currently registered at your GP surgery in London.

Ms. Abilowale was admitted to Chaffinch Ward of South Tees Mental Health NHS Trust on 25/05/2015 under section for assessment of her confusional state. She had removed her clothes and was kneeling in prayer outside St. John’s Church when Cleveland Police found her – members of the public had alerted them.

Our working diagnosis is of a severe depressive illness - it is likely that she has been suffering from this for some time. It also seems probable that the incident outside the church was triggered by a recent rejected asylum application; she was holding a Home Office letter stating that her claim to political asylum had been rejected at the time of being found by the police. Peace consented to sharing this with you. [EXHIBIT ONE]

In view of the history she gives of violent abuse in Uganda, and her status as an asylum seeker, we have referred her for counselling and to a London-based charity for a more expert assessment of her case. It is my understanding that a Dr Elaine Forrester has been assigned to work on her case - she may well be in touch to ask for Ms. Abilowale’s records.

Yours sincerely,
Dr. Janet Norris
Registrar to Dr. David Pollinghurst

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**MPW3-15-10**
Dr Talbot put the letter down and exhaled. He felt disturbed by what he read and couldn’t help but feel that he could’ve done more to prevent this from happening. He knew she would be forced to move away from London but didn’t realise how desperate her situation had become.

PART THREE

16th February 2016 (Six months later)

“So, tell me everything. What is the news?” Dr Talbot asked urgently.

“She’s fine, everything is fine.” Mrs Jones responded, smiling.

Dr Talbot had asked Mrs Jones if she could drop by the GP surgery one evening after work. He wanted to know the latest news of Peace Abilowale. It had been three months since Dr Forrester from the Helen Bamber Foundation had contacted him requesting Peace’s medical records.

“Has she been granted asylum?” Dr Talbot was keen to know the news.

“Let me start from the beginning, but, yes, everything is good.” Mrs Jones paused, then began the story “As we both know, after Peace was relocated by the Home Office, she went through a very tough time. I am ashamed to say I could only make it north once to see her, in the whole time she was there. But, my church friends up there told me she struggled with the money and travelling, and then, out of the blue, the Home Office officially rejected her asylum claim. I’ve brought a copy of that letter.”

“That’s when the police found her. It was early one morning; she was walking half naked through the middle of town. The doctors said she was depressed, and prescribed medication. This is when I went to see her. It was horrible, seeing her there, shattered and confused. But, the team up there were incredible – they worked with lawyers and others to make sure she received a proper medical examination to document what happened to her in Uganda... it’s awful, truly awful – as you know.”

“But, even with that report and the expertise of Dr Forrester, her barrister told me that they tried to dismiss the asylum claim on the grounds that she was a GP and not qualified to assess evidence of torture. However, the sheer amount of work that Dr. Forrester had done with the Foundation spoke for itself and I believe the Judge looked favorably on her findings.” [EXHIBIT TWO]

“Anyway, the bottom-line is that Peace now has leave to stay her for five years. There’s so much to do, but we’re going to help her as much as we can. We will make sure to drop into the practice soon to say hello I know that Peace wants to thank you for your help.”
It was another Monday morning, and Dr Talbot was sitting at his desk before the first patient arrived. His mind was still busy thinking about the conversation he’d had yesterday with Mrs Jones. He decided to get a quick breath of fresh air before the day began, and walked into the already busy waiting-area of his surgery. At the reception desk, a young man was having a heated discussion with the receptionist, Mrs Stong.

“I must see a doctor. I have no papers, I have no ID. But I need help, I am ill.”

Dr. Talbot looked at the young man and thought of Peace. He thought of all she had been through before she arrived in the UK, and wondered what this man might have seen and experienced. He considered what to do: should he intervene with the reception again?
Exhibit 1

Home office rejection letter

Eaton House
581 Staines Road
Hounslow
Middlesex

TW4 5DL
Tel 020 8814 5242
Fax 0870 336 9249
Email
Web www.gov.uk/uk-visas-immigration

Ms. Peace Abilowale  
Our ref: A157006

Date of Birth: 14/08/1990  
Your ref: xxxxxx

Nationality: Ugandan  
Date 22/05/2014

The factual accuracy of statements recorded in this letter has been assessed for immigration purposes only

Dear Miss Abilowale,

REASONS FOR REFUSAL

Legal Framework

1. You have applied for asylum in the United Kingdom and asked to be recognised as a refugee under the 1951 Convention relating to the Status of Refugees (the Convention) on the basis that it would be contrary to the UK’s obligations under the Convention for you to be removed from or required to leave the UK. You claim to have a well-founded fear of persecution in Uganda. A person is refugee where, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, that person is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable, or owing to such a fear, is unwilling to return to it and is not excluded from the protection of the Convention.

2. Your application has not been considered by the Secretary of State personally, but by an official acting on behalf of the Secretary of State.
3. Considering has also been given to whether or not you qualify for a grant of Humanitarian Protection in accordance with paragraph 339C of the Immigration Rules. A person will be granted Humanitarian Protection if the Secretary of State is satisfied that:

- the person is in the UK or has arrived at a port of entry in the UK;
- the person does not qualify as a refugee as defined in regulation 2 of The Refugee or Person in Need of International Protection (Qualification) Regulations 2006;
- substantial grounds have been shown for believing that the person concerned, if the person returned to the country of return, would face a real risk of suffering serious harm and is unable, or, owing to such risk, unwilling to avail him or herself of the protection of that country;

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**Decision**

25. Your claim has been considered, but for the reasons given below it has been concluded that you do not qualify for asylum or Humanitarian Protection. It has also been concluded for the reasons given below that you do not qualify for limited leave to enter or remain in the UK in accordance with the published Asylum Instruction on Discretionary Leave.

26. In considering your claim the objective evidence contained within the Country of Origin Information Report for Uganda, dated 15th March 2013, has been considered.

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**Consideration of Claim**

29. Your claim has been considered following the guidance in Karanakaran. The material facts of your claim have been examined and either rejected, accepted, or left in doubt. If any aspects of your claim are left in doubt these have been considered in conjunction with Section 8 of the 2004 Treatment of Claimants Acts, 339L and 339N of the immigration rules.

30. Any documents that you have submitted have been considered where appropriate within the consideration of the material fact of your claim to which they relate. They have also been considered inline with the case-law of Tanveer Ahmed\[2002\] UKIAT 00439 STARRED. This case states that:

“In asylum and human rights cases it is for an individual claimant to show that a document on which he seeks to rely can be relied on.” (Para 38.1)

“A document should not be viewed in isolation. The decision maker should look at the evidence as a whole or in the round (which is the same thing).” (Para 3)
Detention Rape and Torture in Uganda

35. You state that you were arrested and imprisoned because of your activities on behalf of the women's section of the Forum for Democratic Change. However, from your description of your role in that organisation, it is clear that at most you would have been seen as a low level activist. There is no reason to believe that you would have been of any interest to the authorities and it is therefore not accepted that you were imprisoned.

36. You have not produced any medical evidence in the form of a body map, compliant with the Istanbul Protocol showing that any injuries you may have are consistent with or could only have been caused by torture.

37. It is therefore not accepted that you were tortured or raped.
Exhibit 2

Peace Abilowale Medico legal report

Name: Ms. BA
Date of Birth: 14/08/1990
Nationality: Uganda
Religion: Christian
Languages: English, Luganda
Interpreter: Not required

Examination by Dr. Elaine Forrest on 30/07/2015

Documents Read: Dates
Screening interview 20/03/2014
Asylum interview 07/08/2014
Reasons for Refusal 22/05/2015
 Witness statement, Ms. A 15/06/2015

Instructed by: Paine Mendes llp

PREAMBLE:
This is the account of Ms. PA’s history as related to me, and of my findings on examination. Where her demeanour changed during this account, I have recorded this. Direct quotes are recorded in quotation marks. The history recorded is restricted to those aspects I consider relevant to physical or psychological findings. The absence of reference to an incident in this report does not necessarily mean that it was not related to me, and nothing in my summary of Ms. A’s history should be taken as a finding of fact in relation to her asylum claim.

In formulating my opinion I draw upon my experience as set out in my biography and other appropriate sources. I have read the Immigration and Asylum Chambers of the First-tier Tribunal (Immigration and Asylum Chamber) and the Upper Tribunal (Immigration and Asylum Chamber) Practice Directions as they relate to expert evidence. I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that
the opinions I have expressed represent my true and complete professional opinion.

**HISTORY:**

H1) Ms. A states that she was born and brought up in Kampala, Uganda. Her parents are secondary school teachers. She has a younger brother and an older sister. She attended primary and secondary school, before starting a course in Computer Sciences in Makindye.

H2) In her first year at university, she formed a relationship with a postgraduate student of economics, who was a parliamentary candidate for the opposition party, the Forum for Democratic Change (FDC) in the national elections of 2006.

H3) In the run up to the election, she took part in demonstrations, some of which were violently broken up by the authorities, but was not injured at that time.

H4) After graduation, she took up employment with a local telecommunications company, and continued her activities for the FDC, becoming chair of the women’s section of her local branch. On two occasions, she was interviewed on national radio.

H5) In 2008 she married her partner in a traditional ceremony.

H6) On 07/02/2011 In the run-up to the elections later that month, she was arrested from their home, along with her husband by five armed police officers. She denies any injuries to herself during the arrest itself, but witnessed her husband being hit on the head and knocked unconscious. She was handcuffed, put in a vehicle and driven to a local police station. This was the last she saw of her husband.

H7) Here she was interrogated about her and her partner’s political activities, the names of their close colleagues and plans for a forthcoming demonstration. When she refused to name colleagues, she was beaten with batons.

H8) She was put in a cell in solitary confinement, where she was held for five days, and allowed only water and dry bread once per day. She had to sleep on the ground and use a bucket for a toilet.

H9) On the last night, three officers entered her cell, ripped off her clothing and raped her at knife-point. She sustained lacerations on her thighs from the blade and to her breasts from their fingernails.

H10) The next day, she was transferred to Luzira women’s prison, where she was held for a further two weeks. The cell held about 20 women and
was too small for them to all lie down at once. Prisoners were escorted to toilets at the whim of guards. Food consisted mainly of rice and beans, provided twice a day.

H11) Shortly after the election, she was released without charge. She obtained painkillers from a local clinic.

H12) The following day, she was visited by a senior police officer accompanied by two members of his staff. They warned her to have no further dealings with the opposition movement, and that if she did, things would go badly for her and her family.

H13) She returned to work and spent the next few months looking, without success, for information about her husband’s whereabouts. She also continued her activities for the FDC.

H14) In late 2011 she started receiving anonymous threatening phone calls. Her husband’s wedding ring was found in a parcel on the doorstep, along with a photograph of his dead body. Attached to it was the message “You’re next.”

H15) She fled to the UK arriving in March 2013.

**CURRENT MEDICAL PROBLEMS:**

**M1** Prior to her arrest she was fit and well, and had sustained no significant injuries which left scars or other visible marks (except as cited above and below) nor major illnesses or treatment. I specifically enquired for, and she denied, any previous history of automotive, sporting, domestic or occupational accidents causing lasting scarring or damage, or any life-threatening experiences other than those cited above.

As is my standard practice I first invited her to list any medical symptoms of which she was currently aware.

She spontaneously described sleep disturbance, nightmares, hearing voices, and pelvic and low back pain.

I then proceeded to a full assessment of her physical and organic symptomatology using a standard systems approach, which yielded the following concerns:

**M2 Respiratory:** She was diagnosed with tuberculosis in 2014 in the UK but is now symptom-free having completed a course of standard anti-tuberculosis chemotherapy.
M3 Alimentary: Her appetite is poor; she has lost about 7kg in weight over the past year. She is subject to sharp upper abdominal pain after meals and episodes of nausea and vomiting which she related to stress.

M4 Urogenital: Her menstrual periods were previously normal but have become irregular, heavy and painful since her detention in Uganda.

M5 Central nervous: No abnormality disclosed.

M6 Cardiovascular: episodes of palpitations, accompanied by shortness of breath, tremor and sweating; these are brought on by intrusions (see below).

M7 Musculoskeletal: She has low back pain, without radiation to the legs; this impairs her ability to lift heavier objects.

M8 Psychological:
   a) Her sleep is limited to about four hours on a typical night. She is kept awake by thoughts about what happened to her in prison and is woken by nightmares about being raped and about the beating of her husband. During the day she is subject to intrusive memories of and visual, flashbacks to those events. She is subject to bouts of unprovoked anger.
   b) These intrusions are triggered by the sight of violence on television and loud noises, which she tries to avoid. She prefers to be alone, but when in company, she has been witnessed to become absent and unresponsive.
   c) Her mood is “sad”. She can not envisage a future for herself and has been troubled by thoughts of suicide, but has made no attempts to kill herself.
   d) Her short term memory is impaired – she frequently mislays everyday objects and misses appointments. Her concentration is impaired (for example, while reading she has to return to the beginning of paragraphs again and again because she loses the thread.

M9 She is registered with a general practitioner. She was admitted as an involuntary patient for assessment during an episode of severe mental illness in early 2015, but appears improved as compared with her behaviour as described by the hospital at that time. She is currently prescribed olanzapine (an atypical anti-psychotic agent) and citalopram (an anti-depressant). These drugs are commonly used for both depression and post-traumatic stress disorder.

ON EXAMINATION:
Physical findings

E1) On the right breast there are two vertical linear pale scars (S1,2) both 3mm wide, one 8 and one 10 cm in length. On the left breast there are four lesions (S3-6) of similar appearance and width; these range from 7-12cm in length. Palpation of the scars reveals a moderate degree of stiffening of the underling skin as compared with surrounding normal tissues.

E2) On the inside of the left thigh there are three narrow linear scars. The upper one (S7) is transverse in orientation and measures some 3x0.2 cm. A similar scar (S8) is seen just beneath it. The lower (S9) is oblique and is some 7x0.2 cm. Both show more marked fibrosis than S1-6.

E3) There is a small ovoid scar over the left knee cap (S10). It measures 0.8 x 0.6 cm in maximum dimensions.

E4) All of the above scars are quiescent.

E5) The external genitals were normal to inspection.

E6) The tendon reflexes are grossly hyper-dynamic.

E7) Psychological findings - Mental state examination (MSE):

MSE1 Appearance and behaviour: appropriately groomed and dressed. No tics or overtly abnormal activity.

MSE2 Speech: normal in tone and content except when describing the rape; during this time she broke off all eye contact and became tearful and very quiet.

MSE3 Mood: low

MSE4 Thought: no current evidence of thought disorder

MSE5 Perceptions: although she can recall command hallucinations around the time of her hospitalisation

MSE6 Cognition: Alert and orientated for time, person and place

MSE7 Insight: intact

MSE8 Risk: I would assess her current risk of suicide as low and her risk to others as minimal.

OPINION: (for a definition of underlined terms, please see notes below)

O1) Scar E1-6 have the appearances following laceration of the breasts with human finger nails. It is difficult to imagine any other circumstance which could have left lesions of this kind at these sites. No medically plausible form of injury (whether occupational, domestic, sporting or transport would be expected to create such a result. Nor is this a common site or mechanism for self harm. These scars are typical of the cause she averred.

O2) Scars E7-9 are the results of cuts with a sharp object such as a blade. The deeper scarring (as compared with E1-6) accord with this causation. Young women rarely sustain three such lacerations to the inner thigh from any benign sort of injury. These scars are typical of stab wounds (E7,8) and slashing (E9), and are located as would be expected during a sexual assault, aimed at forcing her to open her legs.
O3) The quiescent nature of the above scars indicates that the causative injuries occurred at least one year before my examination. There currently exists no method of medical examination or scientific investigation by which the ages of scars resulting from injuries more than one year prior to assessment can be established with confidence.

O4) The normal genital examination does not exclude rape – only about 5% of women examined more than one month after such an event show injuries to the genitals themselves. However, her scars are those to be expected after sexual assault of the kind described. Her demeanour was that I have witnessed among other torture survivors whose experiences were accepted by the courts.

Psychological formulation:

O5) I base my diagnostic conclusions on my objective clinical observations of her behaviour, speech and demeanour and not merely on the symptoms she described to me, as explained above. According the criteria of the International Classification of Diseases (10th edition - ICD10) there are five criteria for the diagnosis of Post-traumatic stress disorder (PTSD). Although there are subtle differences between ICD-10, the Diagnostic Statistic Manual (version V) and those of the UK Department of Work and Pensions, these all rely on the following five features:

a) Exposure to the stressor(s)
b) Onset and persistence on symptoms
c) Hyper-arousal
d) Avoidance of reminder stimuli
e) Emotional numbing or blunting

I base my diagnosis of PTSD on the presence of the following clinical features:

She gives a history of having experienced relevant stressors (rape and beating).
She has intrusion phenomena (flashbacks and nightmares). She has avoidance related behaviour in the form of avoiding reminder stimuli such as the sight of violence on TV. She has negative alterations in cognitions and mood in the form of depressed mood and numbing. She has alterations in arousal and reactivity of which the hyper-dynamic reflexes are evidence – these are not under voluntary control. The duration of her symptoms has been more than a month. Her symptoms have functional significance to the extent of interfering with activities of daily life. There is no evidence that her core PTSD symptoms are attributable to medication, substance misuse or other illness. PTSD can result from any life threatening experience over which the subject has no control. The list of common causes includes torture, warfare, natural disasters, industrial and automotive accidents, rape, and child abuse. I explicitly enquired about, and she denied, any such experience other
than those described in the history above. She also displays features of depression, which is often found to accompany PTSD. The Istanbul Protocol requires rapporteurs to explicitly consider the possibility that examinees may have inaccurately described, or even confected parts or all of the history given. In the present case, all of the clinical finding accords with the history of abuse that she described and none is in conflict with it. It is noted that she did not recall any cause for scar S10 and made no attempt to pass it off as due to torture or abuse. The Istanbul protocol requires a medical rapporteur to make an overall evaluation of the likelihood that some or all of their clinical findings are due to torture. In the present case, this is as follows: It would be unusual for a woman to show the extent and types of pathology seen in this case she had not survived organised violence of the kind she described. The medical evidence makes it more likely than not that she has indeed been harmed in the ways she described and has severe physical and psychological damage as a result.

Notes:
From the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, P35  
“...(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.....  
187. Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.”
Accessed 22/3/2006

ICD-10 diagnostic criteria for PTSD at:
http://www.who.int/classifications/apps/icd/icd10online/ 
“It is sometimes important for legal purposes to be able to estimate the time since a particular wound was inflicted. Having discussed the matter with many eminent members of the ETRS and WHS, I have reached the conclusion that it is only possible to distinguish approximately between the various appearances...
Fresh wound: 1-3 days old
Early healing: 3-10 days
Later healing: 10-21 days
Early maturing: 21-42 days
Intermediate maturing: 42-180 days
Mature: 180 days-1 year
Quiescent: > 1 year"
Appendices

International and regional law

There are a multitude of national, regional and international legal and regulatory frameworks that prohibit the use of torture – there are no exceptions. It is important that health professionals know of the existence of these frameworks given the likelihood of encountering survivors of torture in the course of their work.

Despite the legal prohibition, torture continues to affect millions of people across the world today - often by persons acting on behalf of a state. Due to the continued prevalence of torture, efforts continue to ensure that all countries respect, protect and fulfil the right of their people to be free from torture, inhuman or degrading treatment. The major regional and international treaties prohibiting torture are detailed below. However the prohibition of torture is also a rule of customary law therefore all countries are legally prohibited from carrying out or allowing torture even if they have not signed any of the relevant treaties.

International Law

Universal Declaration of Human Rights (1948)

Article 5 – “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”

Geneva Conventions (1949)

Common Article 3(1)(a) – during armed conflict not of an international character, “violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture” are prohibited against persons taking no active part in the hostilities.

International Covenant on Civil and Political Rights (1966)

Article 7 – “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”

Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)


Article 7(1)(f) defines widespread or systematic torture as a crime against humanity.

Article 8(2)(a)(ii) defines torture as part of a plan, policy or large scale commission as a war crime.
Article 55(b) persons being investigated “Shall not be subjected to any form of coercion, duress or threat, to torture or to any other form of cruel, inhuman or degrading treatment or punishment.”

**Regional Law**

**European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)**

Article 3 – “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”

**European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987)**

**American Convention on Human Rights (1969)**

Article 5(2) – “No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment.”

**Inter-American Convention to Prevent and Punish Torture (1985)**

**African Charter on Human and Peoples’ Rights (1981)**

Article 5 – “...All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.”

**Arab Charter on Human Rights (2004)**

Article 8(1) – “No one shall be subjected to physical or psychological torture or to cruel, degrading, humiliating or inhuman treatment.”

*There are no regional Asian human rights treaties.*