PROJECT REPORT

COMMON FORENSIC STANDARDS FOR THE MEDICAL EXAMINATION IN THE ASYLUM PROCEDURE

ARTICLE 18 DIRECTIVE 2013/32/EU.

A GENUINE CONTRIBUTION TO DECISION-MAKING

Co-funded by the European Union

IN THIS AMIF-PROJECT, IMMO (NETHERLANDS), CORDELIA FOUNDATION (HUNGARY) AND PARCOURS D'EXIL (FRANCE) DEVELOPED, IN LIGHT OF ARTICLE 18 MEDICAL EXAMINATION (DIRECTIVE 2013/32/EU), A FORMAT AND GUIDELINE FOR A MEDICAL EXAMINATION IN ORDER TO SUPPORT AND STRENGTHEN THE DEVELOPMENT OF AN EFFECTIVE EUROPEAN ASYLUM PROCEDURE.

iMMO

PARCOURS d'exil

CORDELIA FOUNDATION

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Common standards for the medical examination in the asylum procedure.
Article 18 Directive 2013/32/EU.
A genuine contribution to decision-making,
Co-funded by the European Union

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INTRODUCTION

20 July 2015 marks an important day in the standardization of the European Asylum Procedure: a medical examination in the asylum procedure was introduced.

In Article 18 medical examination of Directive 2013/32/EU on common procedures for granting and withdrawing international protection, it is stipulated that 'Where the determining authority deems it relevant for the assessment of an application for international protection in accordance with Article 4 of Directive 2011/95/EU, Member States shall, subject to the applicant's consent, arrange for a medical examination of the applicant concerning signs that might indicate past persecution or serious harm (Article 18.1). Alternatively, Member States may provide that the applicant arranges for such a medical examination (Article 18.2). The medical examinations referred to in the first subparagraph shall be carried out by qualified medical professionals and the result thereof shall be submitted to the determining authority as soon as possible (Article 18.3).'

Member states may designate the medical professionals who may carry out such medical examinations. However, unlike forensic medical expertise in other legal areas, a standardized examination and official training of the medical professionals as such does not exist. In most European countries, medical doctors and psychologists who deliver medico-legal reports (MLRs) within the asylum procedure are trained within NGOs. They all developed their own methods, standards and reports. What some of them have in common is that they are likely to make use of the Istanbul Protocol. This protocol, adopted by the United Nations, sets out international standards for health and legal professionals on the investigation and documentation of allegations of torture and other ill treatment. It is the Istanbul Protocol that is mentioned as such in precondition 31 of the Asylum Procedure Directive 2013/32/EU. In addition, it is the Istanbul Protocol that works as the principal guideline along which the medical examinations take place in the three participating countries in this project. By detailing the process of documenting medico-legal evidence, the Istanbul Protocol's objective is to contribute to achieving justice and to fight against impunity in cases of alleged torture and other ill treatment. The systematic documentation of allegations of torture according to the Istanbul Protocol can also provide a foundation for both the asylum claim itself and for the rehabilitation of the victim.

Producing a full MLR based on the Istanbul Protocol to be included in an asylum procedure as medical evidence is different to a procedure where the MLR serves as evidence against a perpetuator of torture and violence. However, it has to be stressed here that the medical professionals conducting the examinations will either way be confronted with the same medical findings as a result of shocking human rights violations. That is exactly why the UN-endorsed Istanbul Protocol was developed and serves as a result of multi-professional international consensus as to how physical and psychological evidence of torture and other forms of violence should be gathered and evaluated in an encompassing MLR. As outlined in the Istanbul Protocol, the precise and careful medical considerations have to be carried out by medical experts, experienced clinicians who are trained to deliver an objective and unbiased report.

1 > OUTLINE OF THE PROJECT PLAN

In this AMIF project, iMMO (Netherlands), Cordelia Foundation (Hungary) and Parcours d'exil (France) planned, in light of Article 18 Medical Examination (Directive 2013/32/EU), to develop a guideline and training material for a medical examination according to the Istanbul Protocol in order to support and strengthen the development of an effective European asylum procedure.

The original project plan included the following.
The common European asylum system requires international consensus among experienced health professionals. The project will initiate a standardized medical examination focused on user (medical professionals and immigration officers) needs, training, development of common and standard tools, exchange of good practices, as well as peer mentoring.

Together with international experts, this project will lead to development of the standards for this specific medical examination, of the qualifications of the medical health professional who performs these examinations and of a manual including the necessary training. Since it is the difficult task of the asylum decision makers, lawyers and judges to use the content of the MLRs in their decision-making, also a manual on how to interpret the MLRs is developed.

This tool will enhance the skills of health professionals while simultaneously increasing the usefulness of MLRs in asylum decision-making. The ultimate goal is, therefore, to create a shared, piloted and approved methodology for the MLR in asylum settings in Europe.

In each country, 25 medical examinations and the training material have been piloted and discussed with the relevant parties in meetings. Attention was also given to the further development of a forensic photo library to train and enhance the expertise of health professionals.

The guideline and training material were reviewed by the three countries of the project during the pilot; the outcomes of the pilot will be used to adjust and enhance the guideline and training material where needed.

The outcome of this project will be published in an article in an international (forensic) medical journal and distributed to international and national forensic organizations and institutes, the European Asylum Support Office (EASO), national immigration services, immigration lawyers and judges.

2 > COURSE OF THE PROJECT

During a first international meeting (1 and 2 February 2016), the three partners (iMMO, Cordelia and Parcours d'Exil) came together with a group of experts in the field of (medical examination in) the asylum procedure. [1]
All relevant elements concerning a medical examination in the asylum procedure were discussed. The questions included in § 105 [2] of the Istanbul Protocol were leading in the discussion concerning the medical examination in the asylum procedure. During this first meeting, the question of relevance – when should an immigration officer decide to ask for a medical examination – was also addressed.

A second international meeting was organized on 18–20 May 2016. With a wider group of experts, the important aspects of a medical examination in the asylum procedure, e.g. relevance, were discussed. Several presentations were given about the topic 'Medical relevancy: what would be of help to decide whether or not to ask for a forensic medical examination in the asylum procedure?'. [3] Marije Giesberts discussed the question of relevancy in the Dutch practice, Professor Duarte Nuno Vieira elaborated on the use of the Istanbul Protocol and Dr Jane Herlihy focused on the psychological aspects.

The session on 20 May 2016 focused on the physical aspects of the examination: how to assess lesions from alleged torture.
A digital-photo library developed by iMMO was demonstrated.

During the year following these meetings, a format, guideline and a manual, based on the Istanbul Protocol, for legal workers and health professionals were developed and piloted. Each of the three countries trained health professionals on how to examine asylum seekers for evidence of persecution and serious harm and how to write a robust MLR using the guideline.

[1] *Juliet Cohen, MD, head of doctors, Medico-Legal Reports Service, Freedom from Torture, United Kingdom, Önder Özkalipçi, MD, Associate Professor of Forensic Medicine, Switzerland, Riikka Peltonen, Quality and Vulnerable Groups Officer, European Asylum Support Office (EASO), Malta, and Laetitia van der Perk, Dutch Immigration and Naturalisation Service (IND), The Netherlands.*

[2] *§ 105. In formulating a clinical impression for the purpose of reporting physical and psychological evidence of torture, there are six important questions to ask:*
(a) Are the physical and psychological findings consistent with the alleged report of torture?
(b) What physical conditions contribute to the clinical picture?
(c) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
(d) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where in the course of recovery is the individual?
(e) What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.)? What impact do these issues have on the victim?
(f) Does the clinical picture suggest a false allegation of torture?

THE FIRST FORMAT INCLUDED THE FOLLOWING EXAMINATION QUESTIONS:

A. Is it likely that the lesions and/or physical symptoms are caused by the torture/abuse or other traumatic event(s) as described by the applicant in his/her asylum request? If so, what is the degree of likelihood?
B. Is it likely that the psychological symptoms are caused by the torture/abuse or other traumatic event(s) as described by the applicant in his/her asylum request? If so, what is the degree of likelihood?

During the pilot it was decided to exclude the questions from the format since the wording 'is it likely' unintentionally suggest that health professionals might have anything to say about the credibility of the asylum application itself. It remains a point of discussion whether or not and what examination questions should be included.

During the international meetings it was also discussed whether photographs taken from bodyparts or even the whole person should be included in the MLRs as evidence. Some claimed it was supportive material but others questioned this for obvious privacy reasons.

There was also discussion concerning the usefulness of diagnostic testing. It was mentioned that in this respect there exists no evidence based research material with asylum seekers. Is it possible to make use of intercultural validated tests and benefit from the extra information to validate the MLRs itself? People in favor stated that testing gives extra information if the results are used very carefully. This subject also needs further discussion.

On the use of photographs and diagnostic testing it was decided to use them optional. In France and the Netherlands photo's are added but people are not identifiable and private parts are never included in the MLRs. Only the Netherlands made use of diagnostic tests and most of the time the results were supportive during the examination and in the reports.

[3] *Marije Giesberts, senior decision officer, Dutch Immigration and Naturalisation Service (IND), the Netherlands, Duarte Nuno Vieira, MD, Professor of Forensic Medicine and Forensic Sciences, University of Coïmbra, Portugal, and Dr Jane Herlihy, Clinical Psychologist, Executive Director of the Centre for Study of Emotion and Law (CSEL), UK.*

[4] *Medical examination in the asylum procedure. Article 18 Directive 2013/32/EU. Training manual for health professionals and legal workers. See website iMMO*

During the second half of 2016 and the first months of 2017, each country conducted 25 medical examinations as a pilot, using the developed guideline and training material. At the IRCT (International Rehabilitation Council for Torture Victims) Symposium in Mexico (5–7 December 2016), a presentation on the progress of the pilot was given by the three partners.

The piloted format and guidelines are presented in a separate publication:

MEDICAL EXAMINATION IN THE ASYLUM PROCEDURE.

ARTICLE 18 DIRECTIVE 2013/32/EU.

MANUAL FOR HEALTH PROFESSIONALS AND LEGAL WORKERS.[4]

Despite the national differences, project participants and experts formulated some contextual common challenges and wishes when it comes to content and use of MLRs within the asylum procedures.

COMMON CHALLENGES:

- What standard of proof is applied for asylum applicants? Sometimes it seems to be set as: 'beyond reasonable doubt'.
- Implementation of Article 18 medical examinations as such (Hungary and France).
- The quality versus time and costs element in producing a robust MLR.
- When should authorities arrange for an MLR?
- How is the MLR valued by immigration officers? Immigration decision makers tend to make their own clinical interpretations about which they are not qualified and disregard the professional medical opinion.
- How is the MLR implemented in the decision-making process?

[4] *Medical examination in the asylum procedure. Article 18 Directive 2013/32/EU. Training manual for health professionals and legal workers. See website iMMO*

COMMON WISHES:

- A common internationally acknowledged standard for the examination of asylum seekers/ persecution and serious harm, with the Istanbul Protocol as the foundational document.
- Cooperation with the national immigration services in general, and acknowledgement and acceptance of the professional medical opinion in particular by immigration officers and judges.
- Training of legal workers on how to interpret medical conclusions.
- Ensure that the project will contribute to improved decision-making and that common standards can be found despite national differences.

In this report, the national developments during the AMIF project in the three separate countries are presented.

3 > PROJECT IN FRANCE

THE CURRENT ASYLUM PROCEDURE

In 2016, France received more than 85,000 asylum requests, and its immigration service has produced 90,000 decisions regarding asylum.

Almost 39% of the requests were 'accelerated procedures', which means an average time of decision of 98 days. The overall duration of the procedure is now 183 days.

The average admission rate to refugee status is 28.8% at the French Asylum Office (OFPRA). This increases to 38.1% after the appeal procedure (OFPRA annual report 2016).[5]

The French legal framework does not foresee the use of medical reports when examining asylum applications. However, applicants often present medical certificates from specialized centres. According to some doctors, all too often, their certificates are not taken into account, as OFPRA often dismisses them as evidence, without seeking a second opinion. The medical report is paid for by asylum seekers via the state-supported medical insurance: the 'protection universelle maladie' (PUMA) or 'aide médicale d'Etat' (AME).

On 10 April 2015, the Council of State cancelled a Cour Nationale du Droit d'Asile (CNDA; The National Court of Asylum) decision, considering that the court should have duly taken into account the medical report presented by an asylum seeker, as it was supporting his story and explaining his fears in case he would be deported back to his country of origin. From the time of this judgement, the CNDA has to take into consideration documents, such as medical reports, presenting elements relating to alleged risks and fears. The court also has to justify why it would not consider these elements as serious. This significantly strengthens the consideration of psychological and physical wounds of asylum seekers and balances the power of the CNDA compared with the asylum seeker.

[5] *https://ofpra.gouv.fr/sites/default/files/atoms/files/rapport_dactivite_ofpra_2016_1.pdf)*

[6] *Handbook of Asylum Procedures*

LEGAL IMPLEMENTATION OF THE MEDICAL EXAMINATION IN THE FRENCH ASYLUM PROCEDURE

Until 2013 and the recast directive on procedures, medical examinations were never requested by the authorities during the asylum procedure. These examinations were asked for only by asylum seekers at their own expense. For them, medical certificates could be very important and useful in the procedure. The only exception to this practice was when the Asylum Office needed a regular medical examination attesting that a girl had not been submitted to genital mutilation after being recognized as a refugee.

The European regulations (Article 18) on medical certification were transposed into the French law on asylum on 29 July 2015.

The French regulation adopted in July 2015 provides that:

- The Asylum Office 'may ask the person seeking asylum to undergo a medical examination'.
- 'The fact that the person refuses to submit to a medical examination shall not prevent the Office to decide on the application'.
- The certificates must be 'taken into account by the Asylum Office together with the other elements of the application'.
- The detailed framework of the medical certificates should be set by joint regulations of the ministers responsible for asylum and for national health. These ministries will also define the 'categories of doctors who can practice the medical examination'.

The Asylum Office also mentions that there is an opportunity created for a medical examination prior to the interviews. This is set up for asylum seekers who seem unable to verbalize their fears.[6] To our knowledge, this procedure has not been used yet.

The 'accelerated procedures' have a strong impact on the ability of torture victims to verbalize their traumatic experiences if they never had access to treatment. Thus, the use of independent medical expertise, if performed in a short time frame, appears as an interesting tool to contribute to a fair decision-making process.

6 *Handbook of Asylum Procedures*

The asylum cases received during this project were chosen by social workers or lawyers because they were confronted with 'difficult cases'. All of them were in need of a professional medico-legal report (MLR), especially concerning the psychological problems the asylum seekers presented. This means there was no random choice of people for this pilot. On the contrary, all applicants presented themselves with a massive amount of medical problems.

THE ROLE OF MLRS IN THE FRENCH ASYLUM PROCEDURE IN THE FUTURE

The French asylum office set up a working group in 2013 on torture victims. This group has conducted several internal studies on how a medical examination should be introduced into the framework of the asylum procedure.

In the French regulation, the Istanbul Protocol is not mentioned. The specific regulation mentioned in the 2015 law was never adopted, and the Asylum Office never requested an MLR. All the specificities of the certificates are still to be defined by the authority.

In the meantime, in July 2016, a special meeting was requested by Parcours d'Exil with the Executive Director of the Asylum Office. Parcours d'Exil wanted to stress the importance of using international standards such as the Istanbul Protocol. During that meeting, the French authorities expressed strong resentment to start using MLRs within their decision-making procedure because they feel it would interfere too much in their decision-making processes. On the other hand, during that same meeting, they agreed that the EU regulation on medical examinations should be introduced.

Because of this reluctant attitude of the authorities, Parcours d'Exil fears that very low standards will be adopted and that medical examinations will not be as robust as they should be. Lower standards could even mean that a medical examination becomes a disadvantage in the asylum decision-making process instead of an extra tool for asylum seekers and decision makers concerned. In France, the above reasons led to the interesting situation that many NGOs even strongly oppose the introduction of official medical examinations. They fear it will disadvantage those asylum seekers who are not suffering from physical or psychological sequelae resulting from torture or violence but are as much in need of international protection as those being tortured or violated. The NGOs fear the 'medicalization' of the asylum procedure.

TRAINING PROGRAMME FOR HEALTH PROFESSIONALS IN FRANCE

In August 2016, Parcours d'Exil organized a one-day internal training session for medical professionals. The training focused on conducting and writing an MLR according to the format and guidelines of the project. Three doctors, two psychologists and one legal professional, all working in Parcours d'Exil, attended this training session. The training also focused on all the relevant legal parts of the Istanbul Protocol. This included: the legal framework created to protect all individuals against torture and other cruel treatments; legal obligations to prevent torture; and international and national legislation such as the transposition of Article 18 of the Directive 2013/32/EU into national law.

TRAINING FOR DECISION MAKERS IN FRANCE
The training for decision makers will take place on 30 May 2017, and an invitation was sent to the network of lawyers working on asylum, the French Asylum Office and the Appeal Court for Asylum. Only lawyers and judges registered for the training session, but no one from the Asylum Office.

EVALUATION OF THE 25 MLRS IN FRANCE
Health professionals of Parcours d'Exil established 26 MLRs after they followed the training. It was decided that all staff (three doctors and two psychologists) of Parcours were to deliver the 26 MLRs for the project. All examinations and reports were supervised by Dr Pierre Duterte (director of Parcours d'Exil) and Karin Teepe. The idea was to establish Parcours d'Exil as a centre of expertise to perform these MLRs. Parcours d'Exil is now also equipped to deliver MLRs at request of the French authorities.

During the 26 examinations, no external medical professionals needed to be consulted. All examinations were always conducted by a doctor and a psychologist. Pierre Duterte supervised all MLRs.

The administrative director of Parcours d'Exil, Jérôme Boillat, carried out the organizational work. In order to select 25 persons to undergo an MLR, he contacted all the persons in the Parcours d'Exil network:

- The NGOs (France Terre d'Asile, Ligue des Droits de l'Homme), which provide housing, orientation and legal information for refugees.
- The social workers of the homes for refugees (CADA) in different towns of the Parisian suburbs and other CADAs in France with whom Parcours d'Exil has a regular working relationship.
- Hospital of St Denis (department female victims of violence).
- Lawyers working on asylum cases.
- OFPRA. The proposal to residents and hospital patients to undergo this particular medico-legal examination at Parcours d'Exil exceeded quickly the 25 examinations that Parcours d'Exil was able to provide within the AMIF project. Taking into account this situation, Parcours d'Exil did not chose on particular grounds which request for a MLR to accept but simply accepted all the first 26 propositions.

Since these particular MLRs have never been used before in France within the asylum procedure, lawyers were impressed by the quality of the reports. Those reports were quite different to the medical certificates they usually received.

Each applicant received a letter prior to the examination, explaining about the upcoming medical examination and about the time and place.

Concerning the organizational part of the project, no particular difficulties are to be noticed, except that three persons had difficulties with the date of the appointment, having not understood exactly when the second part of the examination would take place. The examination had to be postponed for 2 or 3 weeks. In another case, the asylum seeker lived in France since 2012 and had a working permit. He was waiting for the administration to decide upon his asylum

request. The medical exam had to be postponed for 4 months since he could not combine his employee demands with a medical examination that would last at least half a day.

The 26 asylum seekers:

- came from different African countries: Congo/Brazzaville, Ethiopia, Guinea-Conakry, Nigeria, Soudan, Iran, Morocco, DRC, Chechnya, Afghanistan, Bangladesh.
- were 58% men and 42% women, aged between 27 and 45 years.
- were single or married. Most of the married persons left their spouses and children behind in their home country.
- came from very different socio-cultural backgrounds. Some of the examined persons could hardly read or write and had been prevented from obtaining access to school during childhood. On the other hand, some examined persons had obtained several university degrees (Master I and II, i.e. 5 or 6 years of university studies), had been abroad in order to accomplish university studies or had family members working at European universities.
- came from very different socio-economic backgrounds. Some indicated that they had experienced extreme poverty, while others had left all their high living standards behind them: a well-paid job, regular journeys to other countries, houses with servants, cars, etc.

RESULTS CONCERNING PRACTICAL CONDITIONS OF THE MLRS

Most of the examinations lasted between 3 to 3 and a half hours. The psychologists worried about the duration of the examinations: could applicants carry on considering the themes that were still to be explored? Writing the reports took at least 4 to 4 and a half hours. It is possible to evaluate the time of a psychological examination to 7 hours at least, but more often 8 hours or a little more was required. The physician and the psychologist conducted two separated examinations and shared their conclusions as the Istanbul Protocol recommend. The duration of the whole procedure (the examination, writing, editing, photo references etc.) has been largely underestimated.

No special difficulties are to be noticed concerning the participation of the asylum seekers. They all came on time, were very respectful and participated fully during the examination.

All applicants were requested to return after a 2-week period to receive and sign the MLR. After reading the MLR, they had the opportunity to correct certain facts or mistakes. On one occasion, one person corrected a date in his story. The MLR was given only to the examined person in a sealed envelope. It was then up to them whether they wanted to use it for their asylum procedure.

The majority of the applicants spoke French or English so well that the services of an interpreter were not necessary. During other examinations, Parcours d'Exil was assisted by interpreters in Dari/Farsi, Arab, Russian and Bengali. The interpreters performed very professionally. Only once was the interpreter refused by the client. The interpreter came late and the examination had already started in quite good French. The client objected to the translator being late; the

translator became irritated by this, thus raising the question of trust. Some of the interpreters were familiar with the work of other NGOs but not with Parcours d'Exil and showed surprise and were impressed by the quality of the medical examinations. They noticed 'the patience of the examined persons, and the facility with which they explained very traumatic situations'. Interpreters even asked whether the examiner had noticed moments of dissociation. Yes, indeed, they had noticed, and yes it is not easy to conduct interviews that last several hours, even with one or two short coffee breaks.

The interpreters also made remarks about their own situation, explaining that sometimes they themselves could have difficulties after interviews that showed the trauma and suffering of the applicants.

At the very beginning of the examination, doctors and psychologists introduced themselves, explained the purpose of the MLR, explained the way the medical examination would take place and the different main themes that would be approached and informed the client that they could stop the examination at any moment and that they could refuse to answer to questions; they also indicated that refusal would not lead to the medical professional reacting angrily. The applicant was requested to sign an informed consent.
The persons examined were asked to identify themselves with an official document. All documents they brought and thought important for the understanding were photocopied; these included the legal and medical files. All medical professionals used the project guidelines during the examination and writing of the MLR. It worked well to carry out the examination with the two medical disciplines together. This made it possible to avoid going twice through the traumatic history of the applicant and still get all the information needed.
For example, when it came to the description of torture suffered, the psychologist could rely on the description already done by the physician who carried out a complete physical examination and had been asking about the origin of every scar. On the other hand, the doctor could rely on a complete anamnesis of the family history and childhood history done during the psychological examination.

Most applicants realized that the questions asked were quite different to those commonly asked and appreciated that. They felt understood, and a large majority asked 'why they had not been sent to Parcours d'Exil sooner'. Some contacted Parcours d'Exil afterwards to ask for further medical care and psychotherapy.
In one instance, a client suffered from so many psychological problems that this hindered the first medical examination too much; as a result, the client was asked to meet another medical doctor for a second examination.

For heavily traumatized persons, the psychological examination is difficult to bear. During the pilot, it became clear that it was easier to start with the actual physical examination and then carry on with the psychological examination. During this examination, it was found easier for asylum seekers to explain about traumatizing events while the medical doctor carefully examined scars and other abnormalities. This initiated a more organic relationship between the client

and the medical professional. It helped the psychologist to build on that experience and go deeper into the traumatic events.

Only in a few cases was it necessary to stop the examination temporarily because of outbursts of strong emotions, such as anger or panic. In five cases, the psychologist asked the person 2 weeks later if post-traumatic symptoms (sleep deprivation worries or negative thoughts) had increased after the examination; the answer was 'no'.

RESULTS OF THE MLRS DELIVERED

We regret not having enough time to evaluate the impact of the MLRs in the asylum procedure. Up to now, only three procedures where an MLR was provided came to a final decision; the outcome was positive in all cases.

3 > PROJECT IN HUNGARY

THE CURRENT ASYLUM PROCEDURE

Since 28 March 2017, asylum applications in Hungary can be lodged only in transit zones (at the border areas of Tompa and Röszke). Hungary admits only 10 asylum seekers per day. Asylum seekers (everybody except for unaccompanied children under 14 years of age) are de facto detained in the transit zones; the capacity of these zones is 250 each, and asylum seekers are held until a decision is reached regarding their case. Medico-legal reports (MLRs), as possible proof in the asylum procedure, can be asked for by the case officer or filed by the applicant or his/her legal counsellor. The decision-making process takes 60 days, after which, in case of rejection of the asylum claim, the judicial review has been drastically shortened to 3 days. Within this time, the preparation of an MLR is unrealistic. In case the court asks for a new procedure to be started by the Office of Immigration and Asylum, the time frame for the preparation and the submission of an MLR as a new element is again open. Asylum seekers are not offered a legal counsellor automatically. Those who have legal aid are, in the majority of the cases, clients of the Hungarian Helsinki Committee.

The Hungarian government introduced a series of measures that drastically changed its asylum laws and policies starting from 2015. The amendments have numerous outcomes, many of which have been reported in the international media. For example, a fence has been built along the southern border of Hungary; transit zones were established and the best-equipped open asylum reception centers (Debrecen, Bicske) were closed. This all contributed to a growing detention regime in the country.

On 14 February 2017, the Hungarian government submitted another package of amendments to five acts in parliament. With these amendments, Hungary yet again triggered vigorous criticism from not only human rights organizations but also EU bodies. The most widely criticized and characteristic measures describing Hungary's asylum system at the moment are as follows:[7]

[7] *Source: http://www.helsinki.hu/en/hungary-key-asylum-figures-as-of-1-may-2017/*

Currently, despite the lowering number of asylum claims filed since 2017 January, Hungary has ordered a **'state of crisis due to mass migration'**, the grounds of which were extended to include vaguely defined requirements by the latest amendments.

If any foreigner who has no right to stay in Hungary is **apprehended anywhere in the country, he/she shall be 'escorted' back by the police to the external side of the border fence** along the southern border. No registration or individual documentation of persons 'escorted' back across the fence is carried out, neither are their protection needs assessed. These measures breach the EU Returns Directive, as they make collective expulsion a norm.

Asylum applications can be submitted only in the transit zones and the number of applicants allowed to file an asylum claim has been reduced to five persons per working day in each of the two transit zones.

Vulnerable persons and unaccompanied asylum-seeking children over 14 years of age are to be detained in the transit zones as well. The Strasbourg Court has ruled against the detention of some teenagers (clients of the Hungarian Helsinki Committee) after the new law came into force. This meant that transport to the transit zones was not carried out in the case of these particular clients. As for any other unaccompanied minor above 14 years of age, however, placement into transit zones is a practice that is being carried out at the moment.

Transit zones represent de facto detention (as ruled by the Strasbourg Court), and **de facto detention of asylum seekers is indefinite,** as it lasts until the end of their asylum procedure. The deadline to seek judicial review of inadmissibility decisions and rejections of asylum applications has been drastically **shortened to 3 days.**

LEGAL PLACE OF A MEDICAL EXAMINATION IN HUNGARY

Hungary has not transposed many provisions of the Recast Reception Condition and Procedure Directives and, among them, Article 18 into its national legislation. However, MLRs are mentioned in the current asylum legislations as follows:

Asylum Act 59. § (2): if the reason for contradictions in the asylum seeker's statement according to the medical expert opinion is the psychological condition of the client, it can be assumed that they have been victims of persecution.

Asylum Act Implementing Regulation 34. § (1): if according to the opinion of a specialized medical professional, the vulnerable asylum seeker is in need of psychological or psychotherapeutic treatment, then they have the right to be treated (and their treatment is to be covered by state funds).

The asylum officer should initiate the request for a medico-legal report if this has not been done by the asylum seeker or by their legal counsellor.
As far as practice is concerned, the Cordelia Foundation is the only entity in Hungary carrying out systematic examinations of torture or trauma survivor asylum seekers. The MLRs are based

on the Istanbul Protocol. The reports issued by Cordelia are sometimes regarded as an important contribution to the asylum decision-making process; in other cases, those reports are marginalized. Cordelia's clinicians do not qualify as forensic experts based on Hungarian legislation, while at the same time they are the only ones in the country with considerable experience in issuing MLRs in asylum cases. Cases in which an official forensic expert has been asked to provide a report in an asylum procedure are extremely rare.

In Hungary, there exists no standard identification procedure for vulnerable asylum seekers. With the increasing detention measures characterizing the Hungarian asylum system, the role of MLRs in Hungarian procedures has grown. MLRs were previously issued mainly by the Cordelia Foundation to aid the asylum seeker in the asylum procedure (by documenting the sequelae of torture) or in the judicial review phase, with the same purpose. In 2016 and 2017, such reports were used increasingly to prove that a given asylum seeker belonged to the vulnerable group and, as such, they should be exempt from the re-traumatizing effects of detention and placed in an open asylum facility. In some other cases where the patient's mental health condition was critical, such reports were used as part of the attempt to stop the patient's return under the Dublin procedure to another country (in most cases Bulgaria).

The reason why MLRs were used increasingly to challenge detention orders in the case of torture survivors or otherwise psychologically vulnerable asylum seekers is because the asylum procedure in the case of detained persons is, by definition, conducted in detention. Thus, while an MLR in such instances served to lobby for more suitable reception and protection standards given the physical and psychological vulnerability of the applicant, it also served as a proof of torture or inhuman or degrading treatment in the asylum procedure. The asylum seeker's legal counsellor would file the MLR with the case officer or with the court (depending on the stage at which the asylum case was), and the relevant authority would attach it to the case file. In practice, MLRs often would look the same, but in the case where an MLR was also aimed to lobby against detention, a clause would be added that would state the harmful effect of detention on the patient and the recommendation that the applicant should be placed in a safer, open environment while their asylum claim is being evaluated.

Theoretically speaking, requests for an MLR can come (as the legal provisions above show) from the asylum officer, the client's legal counsellor or from the clients themselves. In practice, there are two most common ways in which a report is asked for. Firstly, the client's legal counsellor is the most likely to ask for such a document. When it comes to legal aid to asylum seekers, the Hungarian Helsinki Committee is the one organization providing such services for free in practically all reception and detention facilities of the country. No state-funded legal-aid program is currently functioning in the country, and private attorneys are also rarely specialized in the field of asylum. The lawyers and legal counsellors of the Helsinki Committee work in close cooperation with Cordelia's experts in all locations of the country as well as with the organization's headquarters in the capital.

The second way for an MLR to be issued is a rather unusual one, which largely reflects the lack of adequate identification and protection measures for vulnerable asylum seekers in Hungary. The request derives in these cases from Cordelia's therapeutic team. This team works in the asylum reception and detention facilities offering a low-threshold psychological counselling service.
As a result of low-threshold screening procedures in which a short assessment of the applicant's mental health condition and possible history of traumatization is made, a torture survivor or severely traumatized asylum seeker is often identified for the first time. In such cases, it is obvious that the mental health practitioner is the one initiating contact with the patient's legal counsellor – or, if the patient does not have one, to the practitioner will get in touch with a colleague from the Hungarian Helsinki Committee. An MLR is provided if this could be relevant to challenge detention orders or to assist the applicant's allegations of trauma or torture.

THE ROLE OF MLRS IN THE HUNGARIAN ASYLUM PROCEDURE.

Until the provisions of the Recast Procedures Directive (and among them Article 18) are implemented in Hungary, the role and scope of MLRs will remain linked to the provisions in Hungarian legislation currently in place. The current provisions in the Asylum Act are rarely used however. The use of MLRs is promoted largely by legal counsellors (mostly civil society entities as described above) or solicited by mental health professionals who identify the vulnerability of a given client. As invisible vulnerabilities such as traumatization are not being identified systematically in Hungary, all actors involved with the asylum seeker from the early days of reception (including the asylum officer, the legal counsellor and mental health or social care providers) have an increasing responsibility to identify such vulnerabilities. In the current framework, a judicial review after a rejection of an asylum request has to be given within 3 days. This de facto means that, if an MLR has to be issued in order to prove an otherwise unnoticed vulnerability such as the experience of torture, the time for an examination and delivering a medical report is hardly possible.

During the time the present project was running, Cordelia Foundation's members were not allowed to enter transit zones in Hungary. Access to the transit zones has been requested repeatedly but denied with no particular justification by the Hungarian Immigration and Asylum Office. With access being denied, Cordelia's reach-out to the asylum seeker population, including those suffering from mental health issues, traumatization and the sequelae of torture, is made practically impossible. Only those clients

who have not been taken to the transit zones and who are currently accommodated in one of the asylum detention centers (as all open facilities have been closed) can reach out to Cordelia. The situation on the ground changes fast from day to day, with facilities being closed suddenly and clients being transferred from facility to facility unexpectedly and without prior notification given to them. If entry to the transit zones will not be granted to Cordelia and/or if transit zones will continue to be the only form of reception for asylum seekers in Hungary, the future of the use of MLRs within the asylum procedure is difficult to predict.

There are some instances where it is still possible to issue an MLR. Until now, unaccompanied minors have been exempt from the transit zone procedures, although this is legally not the case if the minor is above 14 years of age. This is also possible for clients who already reside in Hungary with a protection status in place but where a judicial procedure is ongoing (for example, if they strive to prolong their protection status). As long as asylum seekers in transit zones have hardly any access to mental health services, let alone the possibility of an MLR, the situation is alarming. As stipulated above, at the moment, Cordelia is the sole organization with expertise in documenting the sequelae of torture and issuing MLRs in asylum cases. This pool of knowledge is increasingly available and made accessible by initiatives such as this project. Under the present circumstances, this is rather difficult to implement.

TRAINING OF HEALTH PROFESSIONALS IN HUNGARY

The Cordelia Foundation is composed by a therapeutic team of psychiatrists, psychologists and other therapists (art therapists and experts of non-verbal or group methods). Psychiatrists and psychologists are the ones responsible for issuing MLRs or psychological reports, while at the same time being responsible for the treatment of patients. An important methodological question within the current project was whether the neutrality required for an MLR and the emotional involvement naturally characterizing a therapeutic relationship mutually exclude one another. The present situation, i.e. Cordelia's unique role in being the sole mental healthcare provider and the only one issuing MLRs in Hungary, put the above question in a different light: how to manage examinations and treatment within the same organization and to what extent can other actors be involved in the process?

Training of the medical professionals in such a setting consisted of internal workshops and case discussions at Cordelia, centred around the new framework for MLRs, developed within this project.

Mental health professionals within Cordelia had to familiarize themselves with a new report framework that was partly known to them, as based on the Istanbul Protocol. However, this also required new areas of precision, as well as cooperation with other medical staff. A new and relatively unusual characteristic of the new framework to be learned was the assessment of the change in the clients' physical and mental state over time, as required by the 'Former physical and mental health status', 'Physical and mental health status during and short after the torture/abuse/traumatic events' and 'Current physical and mental health status' subjects of the MLR format. Mental health professionals found it often challenging to assess these changes in time, due mainly to characteristics in how PTSD patients' memory related to traumatic events often functions. Personality, health and life in the present versus the past are often viewed as directly opposing one another ('nothing is as it was', 'I am not the same person anymore' as patients often refer to these changes), and in such a framework, assessing the particularities of these changes is often difficult.

The documentation of physical sequelae of torture based on the allegations of the patients made it often necessary to reach out to specialized medical examinations (including but not restricted to gynaecology, urology, dermatology or ophthamology). When this was possible, Cordelia financed such examinations. However, in the detention setting where most of our clients were examined, the external medical information came from state hospital staff with whom Cordelia's medical professionals had no prior contact nor any possibility to discuss the parameters and aims of an MLR. In these cases, the external medical information had to be included in the MLR without the possibility of lengthy evaluation or consultation. In other cases, specific external examinations could not be carried out, and the report had to narrow down its conclusions to the evidence available.

Overall, a total of six psychologists and six psychiatrists were trained to use the new MLR structure within the project's framework.

TRAINING OF THE LEGAL PROFESSIONALS/ DECISION MAKERS IN HUNGARY

In November 2016, a one-day training session for legal professionals working in the field of asylum was organized within the framework of this project. The training targeted not only asylum officers, but also judges, legal counsellors and lawyers. The reason for such an attempt to mix different legal stakeholders in a single training occasion was to facilitate dialogue – not only between mental healthcare practitioners and legal experts, but also between legal experts working at different stages and in different sides of the same issue. Legal-aid providers and asylum officers, for instance, found the training an important occasion to exchange opinions on the use of different legal provisions related to vulnerable clients and to test to what extent the Recast Directives' hindered implementation in Hungary led to shortcomings in such cases. The organizers of the training as well as the legal counsellors present put increasing effort

into raising the awareness of asylum officers about the importance of asking for MLRs in the asylum procedure. This should be possible even without the facilitating provisions of Article 18 in place.

The legal and psychological definition of torture, torture methods and the sequelae of torture (recognition of symptoms and their manifestation during an interview) constituted the first part of the training. The psychological and mental health conditions emerging as a consequence of torture and the effects on memory, as well on the mental and emotional condition of applicants, followed in the second part. Then a large section was devoted to the documentation of torture in the European asylum system. The scope of the current project and the newly designed MLR framework was presented. In a long, interactive session, each and every point of the MLR was discussed. This also led to talk about the procedure following medical and psychological assessments leading to an MLR. Also, one of the discussion points related to knowledge sharing: how an MLR can support in proving torture and how that might be related to the decision to offer international protection. The training day was wrapped up by a session on vicarious trauma and burnout, an issue rarely addressed by legal professionals, and a point of connection between the two professions. This also enabled a sense of cooperation and of working for a common goal: that of the needs of survivors of torture and extreme violence to be recognized in a fair asylum procedure with adequate protection means. A total of 32 persons attended the training session.

EVALUATION OF THE 25 MLRS IN HUNGARY

The Cordelia Foundation, as Hungarian partner in the current project, has strived with the active support of the coordinating organization iMMO to involve the Hungarian Office of Immigration and Asylum in the development of a new MLR structure. The aim was to get national authorities to actively cooperate in the steps leading to the creation of a tool that suits the national asylum procedures and that could serve as a basis for the European Asylum System as such. The Hungarian Office of Immigration and Asylum was informed of the project and its goals; however, although the office assured that it would provide the necessary assistance during the pilot phase (for instance by assuring entry to asylum reception and detention locations), it declared no availability to attend meetings and delegate members in the board to be set up in the project.

Medical examinations according to the newly developed MLR format took place in Hungary in the second half of 2016 and the first months of 2017. The table below shows the parameters of the 25 MLRs produced according to the kind of facility where the examinations took place (asylum detention, open reception centre or the capital), the diagnose(s) given to the applicant, their nationality, the kind of torture suffered, the aim of the MLR (challenge detention, aid the asylum process, judicial review or other) and the entity requesting the MLR.

						TOTAL
Country of origin	Afghanistan (8); Iran (2); Iraq (2); Somalia (2); Cameroon (1); Congo (1); Algeria (1); Pakistan (2); Egypt (1); Gambia (1); Bangladesh (1); Nepal (1); Morocco (1); Cuba (1)					**25**
Location	Asylum detention center (16)	Open reception) center (7	Other location (2)			**25**
Goal of MLR	Asylum procedure (11)	Challenge detention (12)	Strasbourg case (prevent transit zone detention) (2)			**25**
Diagnosis	PTSD (23)	Major depressive disorder (5)	Schizo-phrenia (1)	Generalized anxiety disorder (1)	Paranoid disorder (1)	**31**
Requested by	Office of Immigration (1)	Hungarian Helsinki Committee legal counsellor (24)				**25**

As the table shows, a vast majority of the examinations related to the MLRs took place in detention. According to the information that the UNHCR provided to the Hungarian Helsinki Committee on 18 April 2017, the Immigration and Asylum Office hosted 191 asylum seekers: 17 were accommodated at open reception centres and 174 were detained in asylum detention centres.

Examinations in detention facilities have many shortcomings compared with those carried out in safe and open locations, where multiple examinations can take place and the asylum seekers' freedom is not limited during the often stressful and lengthy process of such an examination. In Hungary, examinations in detention facilities took around 2 hours, with an additional 2 hours added to this if required. However, in such prolongations, the second half of the examinations was carried out on another occasion. The reason for this is the limited access of Cordelia's professionals to the given facilities. In such circumstances, 2 hours was the maximum of time that could be dedicated to a single client at once. Cordelia's staff were not granted a permanent room to work in, but often had to share common areas with social and legal service providers, or work with two colleagues and interpreters parallel in the same room.

Examinations were conducted by psychiatrists and psychologists of Cordelia. Either of the two professionals could issue an MLR alone, supervised and countersigned in all cases by the medical director. However, if any physical sequelae were to be documented, or if the patient's current therapy was to include psychiatric medication, a medical staff member was included in the MLR's examination at all times. In some instances, as described above, other medical experts were involved in assessing symptoms or signs shown by the patient. Whenever this was possible, private examinations were financed in such cases. The involvement of public healthcare providers was possible only when the patient was in detention. In such cases, the results obtained should be used with restricted reliability. Examinations that took place in such circumstances were carried out by medical staff who were not aware of the reason for the examination. They were also not familiar with the documentation of torture sequelae and they often had no interpreter available during the time of the examination.

For the examinations carried out by Cordelia's staff, a native-speaker interpreter was present at all times during the full length of the examination. Cordelia works with a pool of native-speaker interpreters who have been trained to work in medical and therapeutic circumstances and who have worked with the organization for several years. It usually took between 3 and 5 hours to write an MLR, after all the examinations were concluded. This length of time was due not only to the difficulty in collecting, matching and interpreting all evidence, but also to the cooperation between legal and mental health professionals, necessary all along this procedure. For instance, in cases when the reason for asking for an MLR were inconsistencies in the client's statements and it was suspected that that was caused by traumatization. In those cases, the history of traumatization described in the MLR had to

be examined and understood carefully, as well as compared with the statements given by the client in the asylum interview. The length of MLRs varied greatly in Hungary: a longer MLR was usually issued if the reason for its use was solely the asylum procedure, or if the examination could take place in open and well-accessible facilities. In these cases, the length of the MLR was between four and seven pages. In detention circumstances however, MLRs as short as three pages were sometimes issued due to severe place and time constraints.

MLR RESULTS

As for the follow up of the MLRs produced, no exact information is provided to Cordelia. In those cases where clients were released from detention on the basis of their mental health status however, Cordelia's MLRs played a decisive role and led to an average success rate of 60%. In asylum cases, the evidence and information considered to make a decision is manifold, and the role of the MLR within it is difficult to single out. It is estimated that, in approximately 70% of the cases, MLRs documenting torture or other severe trauma played an important role in the decision-making process leading to a client's protection status.

3 > PROJECT IN THE NETHERLANDS

THE CURRENT ASYLUM PROCEDURE [1]

Any person arriving in the Netherlands and wishing to apply for asylum must report to the Immigration and Naturalisation Service (Immigratie- en Naturalisatiedienst; IND). Asylum seekers from a non-Schengen country, arriving in the Netherlands by plane or boat, are refused entry to the Netherlands and are detained. In this case, the asylum seeker needs to apply for asylum immediately before crossing the Dutch (Schengen) external border, at the Application Centre at Schiphol Amsterdam airport.

When an asylum seeker enters the Netherlands by land, or is already present on the territory, they have to report immediately to the Central Reception Centre (Centrale Ontvangst Locatie; COL) in Ter Apel (nearby Groningen, in the north-east of the Netherlands), where registration takes place (for identification fingerprints are taken; travel and identity documents are examined). After registration activities in the COL have been concluded, the asylum seeker is transferred to a Process Reception Centre (Proces Opvanglocatie; POL). Third-country nationals who are detained in an aliens' detention centre can apply for asylum at the detention centre.

The application/registration procedure in the COL takes 3 days. During this procedure, the asylum seeker has to complete a form, their fingerprints are taken and they are interviewed regarding their identity, family members, travel route and profession. Depending on the procedure ('track') in which the asylum application is assessed, the asylum seeker is granted a rest and preparation period, starting from the moment the asylum application is formally lodged by signing an application form. The rest and preparation period grants first-time asylum applicants some days to cope with the stress of fleeing their country of origin and the journey to the Netherlands.

The rest and preparation period takes at least 6 days. The main activities during this period are investigation of documents conducted by the Royal Military Police (Koninklijke Marechaussee), a medical examination by FMMU (Forensische Medische Maatschappij Utrecht [Utrecht Forensic Medical Company];

[1] *AIDA the Netherlands country report up-to-date as of 31 December 2016. http://www.asylumineurope.org/reports/country/netherlands*

this is an independent agency, hired by the IND to provide medical advice on whether an asylum seeker is physically and psychologically capable of being interviewed by the IND), counselling by the Dutch Council for Refugees (VluchtelingenWerk Nederland) and substantive preparation for the asylum procedure by a lawyer. During the rest and preparation period, the IND continues its investigation into whether, according to the Dublin Regulation, another member state may be responsible for examining the asylum request. In case a 'match' is found in Eurodac, the IND can already submit a request, during the rest and preparation period, to another member state to assume responsibility for the asylum application under the Dublin Regulation (Dublin claim).

After the rest and preparation period, the actual asylum procedure starts. In the first instance, all asylum seekers are channelled into the so-called standard/general asylum procedure (algemene asielprocedure), which is, as a rule, designed to last 8 working days (hereinafter called 'short asylum procedure'). The short asylum procedure may be extended by 6, 8 or 14 working days if more time is needed.

If it becomes clear on the fourth day of the short asylum procedure that the IND will not be able to take a well-founded decision on the asylum application within these 8 days, the application is further investigated in the extended asylum procedure (verlengde asielprocedure). In this extended asylum procedure, the IND has to take a decision on the application within 6 months. This time limit can be extended to 9 months, with a further 3-month extension being possible.

The short asylum procedure can be described as fast, but technically speaking it is not an accelerated procedure. Every asylum application is examined initially under the short asylum procedure. Positive as well as negative decisions can be taken in the short asylum procedure. The examination of more complex cases takes place in the extended asylum procedure (the period for making a decision is then 6 months to a year).

Asylum seekers whose application is rejected may appeal this decision at a regional court (rechtbank). In the 'short' regular procedure, this appeal should be submitted within 1 week after the negative decision. Depending on the ground(s) for rejecting the asylum claim, this appeal either has a suspensive effect or does not. This means that the asylum seeker can be expelled from the country before the court's decision. To prevent expulsion, the legal representative (or, in theory, the asylum seeker) should request a provisional measure to suspend removal pending the appeal. This must be done immediately after the rejection in order to prevent possible expulsion from the Netherlands. After a rejection of the asylum request in the short regular procedure, the asylum seeker is entitled, as a rule, due to a granted provisional measure, to accommodation for a period of 4 weeks regardless of whether they lodge an appeal and of whether this appeal has a suspensive effect.

An appeal against a negative decision in the extended procedure has a suspensive effect and must be submitted within 4 weeks. The asylum seeker is entitled to accommodation during this appeal. Both the asylum seeker and the IND may lodge an appeal against the decision of the

regional court to the Administrative Law Division of the Council of State (Afdeling Bestuursrechtspraak Raad van State). This procedure does not have a suspensive effect, unless the Council of State issues a provisional measure. If this provisional measure is denied by the Council of State, the asylum seeker is no longer entitled to accommodation.

The Council of State ruled in 2016 that a request for a provisional measure preventing expulsion during the appeal has to be granted if the asylum request is considered to be a tenable claim (as in Article 13 of the European Convention on Human Rights).

LEGAL PLACE AND IMPLEMENTATION OF THE MEDICAL EXAMINATION IN THE DUTCH ASYLUM PROCEDURE

Due to the modification of the Asylum Procedures Directive, the Dutch Secretary of State implemented, on 20 July 2015, national legislation in which a medical examination (to be used as supportive evidence) is guaranteed.

In the Netherlands, the IND prepared for the introduction of a medical examination by calling several meetings in 2014 to discuss the questions of when a medical examination arranged for by the state is indicated and by whom it should be performed. iMMO participated at these meetings.

In the spring of 2015, a public tender was issued by the immigration services (IND) in order to decide upon a medical service to perform these 'state examinations'. Because of the extensive demands and because the IND desired an institution working exclusively on their behalf, no organization could meet the requirements. Thereafter, the IND decided to seek cooperation with the two national forensic services of the Ministry of Justice: the Dutch Institute for Forensic Psychiatry and Psychology (Nederlands Instituut voor Forensische Psychiatrie en Psychologie, NIFP) and the Dutch Forensic Institute (Nederlands Forensisch Instituut, NFI). In 2016, these organizations started carrying out medical examinations at the request of the state (IND).

The IND published a manual in which it informed the public when it was deemed relevant to call for a medical examination according to Article 18.1 (Werkinstructie 2016/4).[2]
A medical examination can be requested by an IND decision maker if it is thought helpful in cases where the IND has doubts concerning the credibility of (some parts of) the asylum application. An MLR will be adjusted to all other elements upon which the decision maker decides to grant asylum. It is important to consider whether an MLR might result in valuable information establishing the credibility of the asylum request. In those cases, the IND will order for an MLR and pay for the costs.

According to the IND Aliens Act Implementation Guidelines, the following criteria are taken into consideration by the IND while assessing whether to request a medical examination.[3]

- Could a 'positive' MLR in any way lead to an asylum permit?
- The explanations of the asylum seeker about the presence of significant physical and/or psychological traces.
- Submitted medical documents in which reference is made to significant physical and/or psychological traces of distress .
- The presence of other evidence in support of the proposition that return to the country of origin would lead to persecution or serious harm.
- The explanations of the asylum seeker about the cause of physical and/or psychological traces of distress in relation to publicly available information about the country of origin.
- Indications about the presence of scars, physical complaints and/or psychological symptoms may come from:
  - The 'Hear and Decide medical advice'.
  - The reports of the IND asylum interviews.
  - Other possible medical documents.

[2] *IND Werkinstructie (Work instructions) 2016/4, Forensisch medisch onderzoek naar steunbewijs (Forensic medical investigation into supporting evidence).*

[3] *C1/4.4.4 Aliens Circular (Vreemdelingcirculaire).*

It is also stated in the mentioned act that, if the IND does not deem a medical examination necessary but the asylum seeker wants to have an MLR conducted, the asylum seeker can, according to Article 18.2, proceed on his own initiative and costs. According to Article 18.3, the results of the examination (Articles 18.1 or 18.2) should be used in the decision-making process.

In this regard, the main question is whether the IND deems it relevant to arrange for an examination.

Recently, the Secretary of State informed parliament that the NIFP and NFI together performed 14 medical examinations during more than a year.[4] As far as iMMO is informed 6 of these 14 examinations were a request as a second medical examination in an asylum application procedure where iMMO already had delivered an MLR. Since 2012, iMMO has conducted around 100 MLRs per year at the request of asylum seekers and other parties. The authority of IMMO is 'codified' in the Dutch aliens policy, and its authority has been accepted by the Council of State.[5]

So, during 2016, an interesting situation existed. On the one hand, on a national level, the two national forensic institutes developed their own format and standards to perform MLRs at the request of the IND. On the other hand, the IND had an agreement with iMMO to cooperate in this EU project. At the very beginning of this project, iMMO came to an agreement with the IND that the latter would attend meetings of experts, participate at a training session and evaluate the piloted MLRs in order to get response from the decision makers themselves. The IND wanted to involve input from the national forensic institutes whenever possible. Naturally, it was decided that no discussion on the content of any individual MLR during the pilot phase could take place as long as that particular asylum procedure was not yet completely finished.

It was not foreseen that, during the pilot phase of this project, it turned out to be impossible to discuss fully the format and results in individual procedures because none of them was completely finished. The two forensic institutes considered as well that they first needed more experience with this new type of MLR, and the

[4] *Letter, Secretary of Security and Justice to Parliament 9 May 2017.*

[5] *§ C1/4.4.4 Aliens Circular (Vreemdeling-circulaire).*

IND supported that idea. Thus, instead, iMMO, IND decision makers and medical professionals from the two forensic institutes met on different occasions during the project to discuss the position of MLRs within asylum procedures in general.

The IND attended the two international meetings in February and May 2016 (see above), and medical professionals from the NIFP attended the latter.

On 18 October 2016, a further meeting was conducted between iMMO and representatives from the NIFP/NFI. The different formats were discussed, and iMMO stressed the importance of the Istanbul Protocol and the standard of proof that should be applied towards possible victims of torture and violence. The outcome was that the NIFP (forensic psychiatrists and psychologists) would examine asylum seekers and conclude its findings guided by the Istanbul Protocol. However, the NFI (forensic physicians) expressed that they would examine asylum seekers according to their own working method: by making use of the Bayes Theorem. This means that NFI examiners will answer the following central question after the physical examination: what is the probability of the medical findings related to the following hypotheses?

- The statement of the asylum seeker is true.
- The statement of the asylum seeker is not true.

This is quite different to using the five-point scale of the Istanbul Protocol with which every medical finding has to be graded and at the end an overall evaluation is obligatory.

Of course, iMMO wants to discuss the outcome and consequences of the above-mentioned hypothesis of the state forensic institutes for the MLRs within asylum procedures. Hopefully, this can be done soon between iMMO and NIFP/NFI professionals. In the meantime, iMMO turned to internal meetings to discuss the differences in format and guideline development. Since the forensic institutes conducted several MLRs in asylum procedures where iMMO had already delivered an MLR, it was possible for iMMO to compare the different MLRs concerning the same person. On three different occasions (3 November 2016, 23 February 2017 and 11 May 2017), the permanent and temporary staff of iMMO discussed fully the first reports from the national forensic institutes.

TRAINING OF HEALTH PROFESSIONALS IN THE NETHERLANDS

iMMO organized two training sessions for health professionals (doctors and psychologists). These professionals are all fully qualified and registered by the government as health workers. On 3 October 2016, three physicians, one psychiatrist and three psychologists were trained. On 30 January 2017, another four physicians, two psychiatrists and one psychologist were trained. The training session consists of 1 day of theory followed by three examinations under close surveillance of a clinical psychologist and a physician, both staff members of iMMO. The training session is based on the Istanbul Protocol and the format and guideline of this project. In the training session, participants get information about the legal procedures in the asylum procedure. They are trained to recognize the medical and psychological signs of persecution and serious harm and how to describe these

signs in order to write a proper MLR. All newly trained health professionals judged the training session as being very positive but some wanted more theory included. They approved the system of peer review after each examination and the extra coaching they get in the first year. At iMMO, intervisions twice a year are organized and a compulsory additional training every nine months.

TRAINING OF DECISION MAKERS IN THE NETHERLANDS

In the project, a training programme for IND decision makers was planned. iMMO organized a training session on 13 June 2016 for medical coordinators of the Dutch IND. Six coordinators attended the training session, which was given by a physician and a psychologist, both staff members of iMMO and working on this project. The training subject was: establishing a dialogue about medical aspects of the asylum procedure. Which medical signs and symptoms could lead to the decision to request an MLR were discussed, as well as the impact of torture and serious harm on the cognitive functions of an asylum seeker.

On 20 April 2017, iMMO and the Dutch IND had a meeting in which the most frequent misunderstandings between legal and medical professionals were addressed on the basis of MLRs. It was an interesting meeting that emphasized the importance of coming together as legal and medical professionals in order to discuss the implications of medical findings deriving from MLRs.

EVALUATION OF THE 25 MLRS IN THE NETHERLANDS

The 25 medical examinations in the pilot of this project took place in the Netherlands between August 2016 and May 2017. All these examinations were carried out by experienced and trained iMMO staff members: two physicians and two psychologists. They were sometimes assisted by other external medical professionals.

Sixteen men and nine women were examined. The average age was 26 years; the youngest person was 17 and the oldest was 46 years. A youth worker or family member was present at three examinations. In those situations, a heteroanamnesis was conducted.

The countries of origin of those examined were: Afghanistan (8), Armenia (1), Ethiopia (2) , Iraq (3), Ivory Coast (1), Libya (1), Mongolia (1), Senegal (1), Sri Lanka (1), Sudan (4) and Ukraine (1); one person was stateless.

Most of the asylum seekers (17) were examined by both a physician and a psychologist because of the amount of physical and psychological signs and symptoms. In eight examinations, only a physician (five) or a psychologist (three) carried out the examination, since beforehand the applicant's dossier showed only severe physical or psychological signs and symptoms.

Nearly all examinations took place at a specially equipped room at the office of iMMO (24 out of 25). Only one examination had to take place in a detention centre, at Rotterdam Airport.

From the beginning, all working hours were registered. On average, it took the physician

and psychologist three and a half hours to prepare one medical examination. This means reading: the legal documents of the IND asylum application interviews; the later corrections and additions of the lawyer; medical documents, if any; the medical advice given by FMMU (an independent agency providing medical advice to the IND whether or not an asylum seeker is physically and psychologically capable of being interviewed); and possible medical files. The shortest preparation took 2 hours and the longest 8 hours.

On average, the medical examination took 5 hours. The shortest examination conducted took three and a half hours, the longest one 7 hours. In three examinations, a second appointment had to be made, since it was not possible to gather all necessary information during the first one.

On average, the health professionals took 12 hours to write an MLR. The shortest writing period was 6 hours, the longest 20 hours.

iMMO made use of official authorized interpreters. At all examinations, an interpreter was present. If the first language of preference was not possible, then the medical examination had to be conducted in the second-best language.

For half of the examinations, the person examined became highly emotional during the examination for a shorter or longer period of time. On five occasions, the asylum seeker decompensated. In one examination, the person involved got very irritated.

From the external medical information, in 12 cases, there was no indication that any psychological healthcare had been given before the examination took place. In 10 cases, the person examined had already received general psychological treatment, while another three persons had received specialized psychological healthcare.

THE CONTENT OF THE EXAMINATION

The kind of torture experienced and described by the victim

In 11 out of 25 cases, the victim suffered from torture as defined in the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

In all of the 25 cases, alleged psychological violence (e.g. threatening, kidnapping etc.) was reported.

In 22 out of 25 cases, alleged physical violence (e.g. suspension, beating, slapping, kicking, burning, cutting etc.) was reported.

In 19 out of 25 cases, alleged sexual violence was reported.

Some persons mentioned, in general, that they were tortured 'in all possible ways' and that the torture left many scars (e.g. at least 40).

Physical effects
Wounds/scars described by the physicians include lacerations, cutting wounds, burning marks, bruises/contusions, fractures and haemorrhoids.

Physical complaints described by persons include severe headaches (in more than half of the cases), dizziness, obstipation, stomach ache, back pain and pain in legs, abdomen, feet and arms.

Perpetrators mentioned were security services (5), authorities (6), Taliban (4), rebels (2), soldiers/prison guards (3) and family or other unidentified citizens (5)

Psychological effects
In all of the 25 cases, the person examined suffered from symptoms of PTSD.

In 23 out of 25 cases, the person examined suffered from symptoms of fear/anxiety.

6 *Dissociation is a mental process that causes a lack of connection in a person's thoughts, memory and sense of identity.*

7 *Istanbul Protocol Para. 187:*
(a) Not consistent: the lesion could not have been caused by the trauma described;
(b) Consistent with: the lesion could have been caused by the trauma described, but 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.

In 21 out of 25 cases, the person examined suffered from symptoms of depression.

In 18 out of 25 cases, the person examined suffered from psychosomatic complaints.

In eight cases, the person examined suffered from dissociation.[8]

In four cases, the person examined suffered from self-mutilation.

In, one case there was a serious suicidal risk.

Psychological testing
During an examination, three psychological tests are conducted: a concentration test, a questionnaire on trauma symptoms and a questionnaire on general psychopathological symptoms.
On 21 occasions, all these tests were carried out.

On two occasions, these tests were not carried out completely because the person examined was too tired or too anxious to fulfil this task. In another two cases, testing was not conducted at all, since the medical examiner involved decided that the clinical picture was obvious for the psychologist to interpret.

Istanbul Protocol gradations and medical evidence

Physical
It is important to remark here: it is possible that more than one gradation is used in the overall conclusion to describe different scars and lesions.

In 12 cases, the gradation 'consistent' has been used to describe scars. In 10 cases, the gradation 'highly consistent' has been used, and the gradation 'typical of' was used nine times. In none of the cases was the gradation 'diagnostic of' used, although one physician remarked that, during the evaluation process, there had been a lot of discussion and doubts – with fellow physicians – about whether to use 'diagnostic of' or not.

8 *Dissociation is a mental process that causes a lack of connection in a person's thoughts, memory and sense of identity.*

Psychological
In 22 out of 25 cases, the gradation 'typical of' has been chosen by the psychologist concerned to describe the relation between the psychological problems suffered and the traumatic events. In three cases, the gradation 'highly consistent' was used.

Psychological impairment
An asylum seeker with psychological problems might suffer from a loss of concentration, loss of memory, avoiding talking about any traumatic event and/or feeling ashamed. It is possible, therefore, that they are unable to formulate accurately the reasons for fleeing the country of origin. That is why, within the Dutch asylum procedure, a medical organization (the FMMU) is appointed by the state to investigate whether a person is mentally able to be interviewed by the IND. The results are given in a so-called 'Hear and Decide medical advice '.

This examination takes about 20 minutes and is conducted by specialized nurses backed by a general practitioner. If they decide that mental 'impairments' should be considered, they have to instruct the IND decision makers how these could influence the interview situation itself, as well as the process of decision-making. It also means that the IND decision makers are obliged to make explicit how they took these 'medical impairments' into account within their decision.

In seven out of the 25 pilot cases, the FMMU concluded that the person examined had psychological impairments (e.g. being very emotional, not being able to remember dates or months and other details etc.). On those seven occasions, physical complaints (1) or scars (6) were registered as extra information. The FMMU does not investigate any physical complaint or scar; this is merely noticed in their advice.

In the MLRs produced during the pilot, the cognitive functioning of the applicant is evaluated and the effects of the presented medical problems on the cognitive functioning (.e.g. head trauma and its relationship with storing of memories [amnesia], feelings of avoidance and shame and its relationship with the ability to

9 *Istanbul Protocol Para. 187:*
(a) Not consistent: the lesion could not have been caused by the trauma described;
(b) Consistent with: the lesion could have been caused by the trauma described, but 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.

retrieve memories) are discussed.
In the MLR, two questions are answered about a person's ability to formulate complete, consistent and accurate accounts. The first question addressed concerns *the moment of the medical examination itself*. The second question addresses *the period during which the IND asylum interviews took place:*

- *Are there medical problems that will interfere with and/or hinder the ability to formulate a complete, coherent and consistent account during the medical examination?*

- *Were there medical problems that interfered with and/or hindered the ability to formulate a complete, coherent and consistent account during the asylum application interviews?*

For this evaluation, a special type of gradation is used, as in the Istanbul Protocol: 'not', 'possible', 'probable', highly probable' and 'certainly'. To answer the second question, medical and legal documents are consulted in order to achieve a clear picture about the particular medical condition of the asylum seeker during the immigration service interview situation.

In the pilot, the results on this subject are that, for 22 out of 25 asylum seekers, medical problems 'certainly' caused impairments during the medical examination at iMMO. For three asylum seekers, the concluded gradation was 'highly probable'.

Concerning the question of whether impairments due to medical problems interfered with the interview situation at the IND, the outcome was as follows: for 16 out of 25 asylum seekers, the gradation 'certainly' was chosen. In eight cases, the gradation 'highly consistent' has been concluded. On one occasion, the question could not be answered because there was no medical information from that period present.

TIME PERIOD TO PRODUCE AN MLR

APPLICATION PERIOD

The average period from the first interview at the IND until the lawyer lodges an application with iMMO was 5 months (151 days). The shortest period to apply for an examination was on the same day as the asylum interview was held, and the longest period took more than one and a half years (525 days). It is important to stress here that iMMO always considers carefully whether the requested medical examination will be honoured. iMMO accepts an application for an examination only if all necessary legal and medical documents are present. In most cases, additional legal or medical information has to be collected before the medical examination starts.

FROM EXAMINATION TO AN MLR

After applying to iMMO for an examination, and after iMMO gave consent to start an examination, it took on average 6 months (178 days) before an MLR was finished.

The shortest period being 1,5 months (49 days), and the longest period was almost 11 months (323 days).

It took the examiner on average 27 days to write an MLR. The shortest time to finish a draft report was within a day; the longest time for a draft MLR to be produced was 3 months (91 days).

In eight out of the 25 cases during the process of writing, more medical information was needed, so another hospital/physician was consulted. Therefore, the final report was delayed.

It is standard procedure that peer review takes place by another medical doctor and psychologist for every report. This has everything to do with independent quality control and professionality purposes. The average time spent on this peer-review process was 3 hours.

From first draft MLR to a second draft with corrections from the client/lawyer took on average 14 days. The shortest period in which a second draft was produced was 1 day; the longest period before a second draft was finished was 2 months (60 days). This extremely long period was because it was a difficult case in which a lot of consultation was needed.

From second draft to a final MLR took on average 4 days. The shortest period for the definitive report to be produced was 1 day, and the longest period was 18 days.

The whole process from examination to a final MLR took on average 118 days: the shortest period was 16 days and the longest period was 71 days.

MLR RESULTS
All MLRs were requested during the very first asylum procedure.

All MLRs except one were used in the asylum procedure.

After the initial decision of the immigration services: seven.

During the procedure at court: 10.

During the procedure at the Council of State: one.

In a second asylum request: six (thus the immigration services or the court did not deem it necessary to wait for the report and proceeded with a ruling without it.)

Other kind of procedure: one

Known outcome of the asylum procedures on 1 June 2017:
Residence permit: six.

Rejected: 0.

Unknown: 18.

Other: one

EVALUATION BY ASYLUM SEEKERS AND LAWYERS
Evaluation forms were sent both to applicants and to lawyers. Applicants were asked about the circumstances of the medical examination, whether the most important issues had been considered and whether they felt safe enough to talk about the most important issues concerned. The lawyers were asked about the quality and content of the MLR, whether it was useful and whether they missed some items. Unfortunately, only a few applicants and lawyers returned the forms. Although those responses were all positive, the response rate is too low to be able to make any conclusions in this respect.

CONCLUSIONS

In this AMIF project Common standards for the medical examination in the asylum procedure, iMMO, Cordelia Foundation and Parcours d'Exil developed a guideline and training material for a medical examination in order to support and strengthen the development of an effective European Asylum Procedure. In France and the Netherlands, the new EU directive had been implemented in the national asylum law in 2015, but this is still not the case in Hungary. The national situation of the three participating countries in this project differed a lot.

The purpose of Article 18 Directive 2013/32/EU is that an MLR is used as medical evidence and as such serves as a complementary element during the decision-making process of an immigration officer. The decision maker might arrange for an MLR. It was therefore defined as being of crucial importance to work together with the national immigration services during this project. All three immigration services were officially asked to cooperate at the beginning of this project. In France and Hungary, the services declined. In France, the simple reason was that they were 'not going to participate' although they declared 'to be very interested'.[10] It has not yet been decided how to implement the new medical examination into the system there. The Hungarian service thought this project was 'an extremely important programme' but was not able to participate 'due to their general workload and commitments in international cooperation'.[11] In the Netherlands, the general manager of the immigration service (IND) agreed to cooperate, and iMMO and the IND signed an agreement about the nature of this cooperation. At the same time, however, the IND employed the two national forensic institutes from the Ministry of Justice to carry out the examinations. The authorities and the national forensic institutes first wanted to have some experience with medical examinations for asylum seekers before they engaged further within this EU project.

Because there was not much cooperation possible with the immigration services, the following was observed in all three countries:

- Requests to the participating organizations for MLRs came in all three countries from asylum seekers and their lawyers and not directly from the immigration

10 *Email dated 12 April 2016 from C. Capdebosca, head of the human rights section OFPRA.*

11 *Letter dated 28 April 2016 from Dr Zsuzsanna Végh, director of the Office of Immigration and Nationality, Hungary.*

services themselves.

- Most requests came in cases where the immigration services already had denied asylum.
- The MLRs made by the organizations on the request of the asylum seeker/lawyer led to new decisions by the immigration service (Article 18.2 situation). This leads to the question: if the new decision leads to granting asylum after all because of the MLR presented, will the state then reimburse the costs of these MLRs?
- The guidelines and MLRs produced could be discussed in general only with the immigration services in the Netherlands but not with those in France and Hungary.

In all countries, the immigration services were requested to attend a 1-day training session about the MLR and medical problems that asylum seekers displayed. In Hungary, a successful meeting was organized in November 2016. It was attended by immigration officers and asylum lawyers, and that created a fruitful exchange of experience. In France, the meeting was scheduled to be held after this report was written. In the Netherlands, different meetings were held in which the medical problems and how to evaluate these were discussed with immigration officers. In all countries, these meetings are seen as vital to creating a better understanding between the medical and legal roles within asylum procedures.

The three organizations involved in this project agreed that clinical experience, and especially with psychiatric and physical trauma, is of vital importance for these particular examinations. In nearly all examinations, experienced psychiatrics and psychologists were needed.

Training of the health professionals is of vital importance in order to learn how to write clear, objective and unbiased reports. Training sessions took place in all three countries. For the 76 MLRs included in this project, medical professionals who were more experienced were selected. This facilitated the evaluation of findings and timely adjustments within the organizations.

It is strongly recommended in the forensic practice to have a second health professional's opinion or peer review as a quality-control system. In France, the head of doctors peer reviewed all 25 MLRs. In the Netherlands, every report was peer reviewed by another health professional (medical doctor and psychologist).

The aim of this project was to try to perform examinations and write the report within a 'reasonable' time frame. This turned out to be rather difficult. To come to a well-founded conclusion about the correlation of medical problems with persecution or serious harm, a carefully carried out medical examination as well as a detailed explanation of the reasoning are needed, and this proved to be time consuming. It was concluded, however, that there is a possible advantage in writing the reports. The general principles and methods to do so are described in detail in the Istanbul Protocol. We believe that adding specific guidelines for reporting on behalf of asylum seekers can lead potentially to a less time-consuming process of report writing and peer reviewing. Through combining the existing literature and the information from the process of evaluating

the 76 examinations as part of the pilot in the three countries, as well as with the expertise of the leading experts in the field, the manual for health professionals and legal workers has been developed. This manual includes a detailed guideline and gives options for a more standardized way of reporting.

From the start of this project, there was one common goal in mind: to achieve a format and guidelines for an effective medical examination that would comply to the standards of Article 18 and be applicable in all EU countries. This project has proven a first step in mapping the most important problems and minimum standards for these MLRs. It resulted in a format and guidelines that can be used as a starting point for further discussion and necessary research.

ACRONYMS

BSI	Brief Symptom Inventory Test
CEAS	Common European Asylum System
EASO	European Asylum Support Office
EU	European Union
FMMU	Forensic Medical Company Utrecht, Netherlands
FfT	Freedom from Torture (UK)
GCA	Dutch Asylum Seekers Health Centre
GGZ	Dutch specialized centres for psychological treatment
HTQ	Harvard Trauma Questionnaire
iMMO	Netherlands institute for Human Rights and Medical Assessment
IND	Immigration and Naturalisation Service, Netherlands
IP	Istanbul Protocol
IRCT	International Rehabilitation Council for Torture Victims
MD	Medical Doctor
MLR	Medico-legal report
NFI	Dutch Forensic Institute
NGO	Non-Governmental Organization
NIFP	Dutch Institute for Forensic Psychiatry and Psychology
OFPRA	Office Français Protection Réfugiés
PTSD	Post-traumatic Stress Disorder
UN	United Nations
VWN	Dutch Refugee Council

MEDICO-LEGAL REPORT FRANCE

ARTICLE 18 DIRECTIVE 2013/32/EU / *BASED ON THE ISTANBUL PROTOCOL*[1]

File number: xxx

1. INTRODUCTION

1.1 Personal details of the applicant

Name :	XXX
Gender:	male
Country of origin:	West Africa
Ethnicity:	
Date of birth:	DD-MM-YYYY

1.2 Data related to the medical examination:

Date of examination:	XXX
Place of examination:	Parcours d'Exil healthcare centre
Name examiner, discipline:	Karin Teepe, graduate psychologist and Pierre Duterte, medical doctor
Professional ID number:	ADELI Number: 959300716 and ADELI number 75 160 2525
Institute where the examination is undertaken:	Parcours d'Exil healthcare centre
Name referrer and the designation:	Lawyer, XXX
Name interpreter:	-
Language spoken:	French
Other attendants:	-

[1] *United Nations, Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations 1999*

QUALIFICATIONS OF THE PSYCHOLOGICAL EXAMINER:

Karin Teepe, graduate psychologist: DESS in clinical psychopathology University of Paris VII 1984 (equivalent master 2) and DEA of Psychoanalysis, University of Paris VII 1986. She is recognized as being qualified to practice as a psychotherapist by the Regional Agency of Health (ARS).

Professional training in Systemic Family Therapy. Since 2008, she has been working in the Parcours d'Exil healthcare centre with torture survivors and politically persecuted persons. She is affiliated to a psychologist's association, the FFPP, and is signatory of the code of ethics of psychologists.

Qualifications of the physical examiner:

Dr Pierre Duterte, registered within the Council of the French Order of Physicians and Psychotherapists, (diploma issued by the Regional Health Agency, ARS). He qualified as a medical doctor at the University of Lille in 1981.

In 2004, he obtained a certificate in systemic family therapy for family counselling after training at the Mony Elkaim (Paris). From 1994 to 2002, he was Medical Director of the Avre Healthcare Centre.

From 2002 to the present day, Dr Duterte is doctor-director and founder of Parcours d'Exil, a centre for medico-psychological treatment and social support for victims of human rights violations and refugees. He is also president and founder of several other institutions, including the Ballal Association, which assists Mauritanians living in Senegal (1995), president and founder of the Coalition of the Centre for the Care of Victims of Torture in Latin Europe (CCVT-EL; 1999), co-founder and general secretary of the Namuwao Monrovia Association, a non-profit organization that assists former child soldiers (2008), and president and founder of the Association Enfants d'Afghanistan et d'ailleurs (2012).
From 1998 to 2005, he was Professor of Victimology at the University of Paris V René Descartes.

Since 1999, Dr. Duterte provides training to officers of the French Office for the Protection of Refugees and the Stateless (OFPRA), and the Refugee Appeal Board; he also provides training programmes for the Office of the United Nations High Commissioner for Refugees. Since 2006, he is a member of the European Family Therapy Association and since 2009 a member of the French Family Therapy Society.

Dr. Duterte has examined, supervised and cared for the treatment of more than 7000 torture survivors. He has published on this subject, as well as numerous articles and books on the psychological consequences of torture and mental health of refugees.

He is a member and director of the Steering Committee of the Independent Expert Group (IFEG), an international group of recognized experts specializing in the forensic assessment, under the auspices of the United Nations, of allegations of torture and ill treatment. This involves the effective investigation and documentation of torture and other cruel or inhuman or degrading treatment or punishment (commonly referred to as the 'Istanbul Protocol').

1.3 File
RELEVANT DOCUMENTS, IF AVAILABLE:

Medical
Not applicable

Legal
Receipt of the registration of the asylum application by the Prefecture authorities

1.4 Special remarks concerning the examination:
No comments regarding the conditions of the examination. The examiner introduced herself and explained the purpose of the examination, the way it was going to take place and the topics about which she would ask questions. The applicant had the possibility to not answer questions and to stop the examination whenever he wanted, to have a break or to stop it altogether. In order to make the applicant feel confident, he was encouraged to express himself, and thus the examination began by talking about the current psychological health of the applicant: the 'way he felt'.

2. BACKGROUND

2.1 General information:
It is noticeable that the applicant's family history is really the starting point of the his traumatic history, being in itself an intrinsic part of it and the main reason for later developments.

The applicant relates the following:
The applicant declared that he did not know the identity of his parents nor whether he had brothers and sisters. He declared that he had been brought up from his early childhood (at least as far as he always could remember, he said) by a couple of farmers, who he called his adoptive father. The applicant declared himself incapable of specifying the degree of kinship of these persons with his own parents.

From the very first question about his parents, The applicant started to dissociate, no longer hearing the examiner. He was visibly lost in his thoughts; the examiner had to question him so that he would return again to the topics under discussion; the applicant dissociated many times.

2.2 Allegations of torture/abuse/traumatic event(s)
The applicant relates the following:
The applicant declared that this couple had two children, a boy, who would have been almost his own age, and a daughter, who was younger. The applicant explained that he would not go to school, 'never', and that throughout the days of his childhood, he would work: washing everything, cleaning after the others, sweeping the courtyard. The applicant declared that he would systematically be punished, but that he would be the only one to be punished, never the couple's own children: they would accuse him of mischief for which he was not responsible and that they had committed themselves.

He also explained that, as a child, he would often suffer from hunger and that he would not be given food (this latter point arose only after a specific question from the examiner: some minutes before, speaking of his psychological state, he had mentioned that, when eating, he often would stop, thinking of nothing, and after a while, he would put down the spoon, unable to continue his meal further).

The applicant explained that his adoptive father would 'come, remove every piece of clothing from me, is going to make me like a woman', declaring that this was the reason for his departure from the family as soon as being able to do so. The applicant added that if 'this' would come to be known, and if he would have spoken of 'that', 'they would kill him'.

The applicant was unable to add details of the sexual violence he had alleged to have suffered. He added only that, for a long time, he would have been struggling to retain faecal matter and that he would have considerable anal pain.

The applicant declared that, thus, at the age of 15, he went to XXX and sought work there, initially selling ice creams for several years. Then he was a 'trainee', learning to work in a transport organization, with 25-seater taxi minicars; his job was to carry the customers' bags and to load them in and out of the cars to monitor the customers' payment regarding the transport, etc. He explained that, in exchange, his employer promised to pay for him to get his driver's licence. Once, while he was loading a client's bags, two other youngsters, who were trainees like him, gave him a beating and left him for dead. He was hospitalized for a month and a half at the regional hospital. The applicant explained that no one came to see him during the whole period of hospitalization; the hospital did not issue any certificate, nor did they give him any document mentioning the reasons for his hospitalization, and no investigation was started. When he was discharged, he fought with one of his two attackers when he found him alone, and left him disabled. The other 'trainee' then swore to kill him.

The applicant would try to speak on several occasions about these beatings. At every attempt, the flow of his sentences then changed, accelerated; he became confused, he was unable to specify the circumstances of the aggression and also was incapable of telling how he was beaten; finally, however, he succeeded in telling who were his attackers – 'the other two trainees' – without succeeding in explaining anything about their motivation. The difficulty in explaining this traumatic event contrasted noticeably with the clarity of his other declarations.

Mentioning this beating-up, the applicant wondered what the authorities would say about the fact that he, in return, had beaten a boy. He was very concerned about whether OFPRA would refuse to recognize his application as a refugee because he had beaten this boy badly.

The applicant declared that he then took his savings and fled through XXX and XXX, to XXX where he worked in a house, looking after the garden, in order to earn some money and be able to continue his journey. He came to Italy by boat, a small boat. The applicant related that this was a tiny boat that continuously took on water and that the passengers bailed out the water using a tin can; this journey lasted 2 nights and 3 days, during which he believed that 'he was about to die'.

As soon as he spoke of this journey and of this boat, the applicant began to laugh in an unusual way: 'Oh yeah, a tiny boat, the water was coming in …'. He was not able to give further details about the circumstances of this journey; it appeared to be impossible to describe further.

3. NAMNESIS

The applicant explained that he was given shelter by a female compatriot and that she declared that she was worried about his state of health, saying that he should not remain like that. He explained that his mental state had worsened during the previous months.

3.1. Former physical and mental health status
The applicant relates the following:
Given the childhood described by the applicant, which contains only traumatic narratives and memories, the examiner found it difficult to ask questions about the 'previous state' of the applicant. Nevertheless, the applicant dated the worsening of his psychological state to a few months previously (which corresponds to the relative progress of his safety situation created through being given shelter by the compatriot. A situation of relative security coincides regularly with the flare-up of a range of trauma symptoms for heavily traumatized persons and refugees).

3.2. Physical and mental health status during and shortly after the torture/abuse/traumatic events as described in 2.2.
Same as for 3.1.

3.3 Current physical and mental health status
The applicant relates the following:
The applicant declared that he thought continuously about the traumatic events: 'of what had happened'. He also declared that he suffered from quasi-hallucinatory flashbacks concerning the events that he had undergone; he said 'it's as if the people were in the same room'.

Sleeping was proving to be very difficult. He declared that he would not fall asleep until two o'clock in the morning. He described about suffering regularly from nightmares and waking up startled. Once he had nightmares and woke up, he would be unable to fall to sleep again; he would have 'finished sleeping for the night'. The applicant explained that he also would suffer from nocturnal terrors, that he would cry out in his sleep, which would disturb other people in the same room and who would be frightened by his shouting, and that his sleep would not be restful. He would wake up tired in the morning.

He declared that he suffers from continual headaches; he would have a headache every day. He also explained he would suffer from stomach ailments such as a burning sensation, which would suddenly arise.

The applicant explained he would feel sad. He would not see anything positive to come in his future, and declared he had not felt this way before.

He explained that he would feel a sudden anger, especially when he thought of 'the father who I do not know; he abandoned me …'. He also attributed the violent beating-up of one of the young trainees who had beaten him so badly before to one of these sudden fits of anger. he also explained that his anger was related to the violence suffered from his 'adoptive father', and declared he was terrified while talking about this subject. The applicant said: 'If I talk about all this, they will come and kill me, cut my throat, cut off my head', and he made a sign to indicate having his throat cut, passing his hand under his chin.

The applicant expressed his worries about his nutrition. He explained that he would suffer from having an uneven appetite; regularly, he would be incapable of swallowing anything, that, with a plate in front of him, he would suddenly freeze, no longer eat and break off his meal after a few (or the first) mouthfuls. He explained that he smoked too many cigarettes, but did not drink any alcohol.

He declared that he suffers from intense shame and guilt. His guilt is linked to his anger; the shame is linked essentially to the violence that he had to suffer and also to the resulting post-traumatic phenomena.

4 EXAMINATION OF PHYSICAL PROBLEMS

Physical examination

4.1 Physical examination

The applicant is examined in the framework of the requested expertise, immediately after he was examined by the psychologist in charge of the psychological documentation of his complaints.

The applicant produced a certificate of an asylum application to prove his identity.
After explanations, he signed an informed consent form so that this examination could be carried out.

4.1a General

The applicant explained that he had no medical or surgical history, mentioning initially the beatings in his youth received from his adoptive father. He then added that the latter regularly raped him and that these rapes, lasted for about 5 years.
He added that the only health problems in his childhood were anal pain following these rapes. That anal pain is now much less.
Currently, the only physical complaint he has are headaches. With his consent, therefore, a medical examination was carried out.

*4.1b Skin lesion*s

At the middle dorsal part of the thorax, in the right lateral vertebral area, two scars were found close to one another, of irregular morphology, slightly elevated, both surrounded by a tattooed haematoma, with diameter of 1 cm (photos A1, A2 and A3).

These scars are attributed by this patient to the sequelae of blows received with sticks or chairs thrown at him. The morphology and location of the scars may well corroborate the alleged aetiology.

At the level of the lumbar region, a scar of similar morphology was found in the left lateral vertebral region (photos B1 and B2). This scar was attributed by this patient, also, to the sequelae of blows received with sticks or chairs that were thrown at him. The morphology and location of the scars may well corroborate the alleged aetiology.

On the left forearm, in the middle and posterior part, were two oblique linear scars, the left ends of which were joined. These scars were attributed by this patient, also, to the sequelae of blows received with sticks or chairs that were thrown at him. The morphology and location of the scars may well corroborate the alleged aetiology (photos D1 and D2).

At the level of the right leg was found an oblong lesion, irregular flat, dark brown, 5 cm in its largest dimension, erythematous (red) lesion in its centre, with a lesion caused by scraping (photos E1 and E2). The aetiology here also related to blows, followed by scratching of this scar, resulting in a zone of red and white colour, corresponding to a lesion caused by scratching.

The left pre-tibial region had a large irregular scar in the shape of a geographical map, 17 cm long, 4 cm wide, covering most of this area (photos F1 and F2). This patient attributed this juxtaposition of scars to the multiple blows of which he was a victim. The traumatic aspect of these scars may corroborate the alleged aetiology.

The external surface of the left knee had a scar of 6 cm in its largest dimension, in the form of spindle, with a dehiscent (split) zone at its centre (photo G1), whose morphology was highly evocative of a wound not treated in time and left untreated.

The scalp had, in its central region, an approximately circular scar around 1.5 cm in diameter, where the hair no longer grows. The alleged aetiology was that, again, of blows with sticks or other objects by an aggressor.

On the right frontal region (photo H2) was found a scar whose alleged aetiology was a blow caused by a particularly violent assault with a chair; examination of this lesion caused the applicant a great deal of spontaneous portraying, leading him to show the lesion several times.

On the the anterior surface of the left and right wrists, fine lesions around 5 cm in size are found; their morphology is quite compatible with the aetiology alleged by this patient of being tied up too tightly (photos I1 & I2).

4.1c Specific examination of physical complaints/ symptoms
The blood pressure found, when he was seated for more than 10 minutes, was 160/100 mm Hg.

The otoscopic examination revealed no lesion; during that examination, Mr K. X indicated that he experienced episodic itching of the outer ear canal opening (external auditory meatus).

The ganglionic areas examined were free of problems (cervical, axillary, supraclavicular, inguinal).

The osteo-tendon reflexes in the upper and lower limbs were strictly normal and symmetrical.

Pulmonary auscultation revealed no abnormalities; breathing in the two pulmonary fields occurred in a normal and symmetrical manner.

Cardiac auscultation measurements were normal.

Abdominal palpation was also normal except for slight pain in the epigastric region and during palpation of the pelvic region; The applicant claimed to experience pain in the bladder region, which occurs intermittently, The semiology did not have any peculiarity that can orient towards a particular aetiology.

Examination and palpation of the urinary genital region revealed no abnormality; the testicles are normal and not painful to palpation.

Examination of the anal region showed no anomalies externally; there are no external or prolapsed haemorrhoids. The applicant explained that, at the moment, episodic bleeding no longer occurred.

To my question as to whether this examination was not too painful for him, in view of the alleged antecedents, he explained that, at present, it was difficult but not as impossible as it would have been a few months previously.

4.2 Interpretation of findings, according to the Istanbul Protocol gradation scheme [2]
The clinical findings of the scars presented by the applicant proved to be entirely compatible with the allegations concerning their aetiology and corroborate convincingly with the applicant's statements.

At the end of the examination, the applicant was prescribed medication to try to improve the sleep disorders he presents, as well as to treat epigastric pain.

5. EXAMINATION OF PSYCHIATRIC AND PSYCHOLOGICAL PROBLEMS

5.1 Psychological examination
5.1a Mental Status
General appearance
The applicant is xxx years old and his appearance corresponds to this age; he is tall and slender. He was initially intimidated by the examination and by the examiner but relaxed quickly. He volunteered for the examination and wanted to explain himself about the events that led him to flee from his country and first to XXX where he took refuge before having to depart again. He is dressed properly and neatly in a t-shirt and jeans. Given his determination to come through the examination, he managed to look at the examiner in order to scrutinize his reactions. During

[2] *Istanbul Protocol Para. 187:*
(a) Not consistent: the lesion could not have been caused by the trauma described;
(b) Consistent with: the lesion could have been caused by the trauma described, but 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.

the examination, the applicant expressed various facial expressions. He blinked quickly and uncontrollably when traumatic events are discussed.

Psychomotor behaviour
The applicant behaved in an appropriate manner. Awed at first, he was quickly interested by the questions; he was thought carefully about formulating his responses, was eager to share his impressions and his reasoning and was willing to think about and be precise in his answers to the examiner. When traumatic events were came up (which occurred very quickly, as soon as the first question was asked about the composition of his family), the applicant stopped, became dissociated, sighed and interrupted contact with the examiner. He looked down, passed his hand over his face or rested his head on his forearms and blinked rapidly when traumatic topics causing shame and guilt were discussed. Later, he showed a second moment of significant dissociation: he began to laugh, in complete contradiction with the problems under discussion, when it came to talking about the crossing of the Mediterranean sea from XXX to Italy, a journey of 3 days and 2 nights while the boat took in water and he strongly feared for his life.

The applicant was not limited in his movements because of any disability.

Emotions and Affects
The applicant showed emotions and affects appropriate to the situation of the examination. Several times he expressed emotions that were not related to the actual interview situation but showed the need to protect himself against the influx of uncontrollable emotions linked to traumatic events. This was the case when the sexual abuse perpetrated by the 'adoptive father', the beatings by the 'trainee' in XXX and the boat trip between XXX and Italy were discussed. Outside of these distressing moments, he was in a good mood, maintaining a good relationship with the examiner; he was capable of smiling and being interested and attentive.

Speech
The applicant first apologised for not being able to speak French well but did express himself correctly. The examiner repeatedly asked whether she had understood his responses correctly, and Mr K. X was able to clarify his remarks without difficulty. He stopped talking when the traumatic events were discussed, and the examiner had to help him out of a sudden silence that was not due to a refusal to communicate but to involuntary dissociation.

Every time the traumatic events in XXX were discussed (being beaten-up by the two trainees, followed by a month and a half hospitalization, the lack of a hospital certificate or any investigation concerning the violence and the continuation of the beatings when he returned, followed by his flight in panic across Africa and to Europe because of the death threats), the applicant expressed himself in a very confused manner. Consequently, the examiner had to go through these topics several times in order to obtain a comprehensible narrative. It was even necessary to draw a rough sketch in order to understand how the cars were parked, what the applicant was doing before being beaten up and what the other two trainees were doing. It was not possible to know either where the beating occurred or how he was transported to the hospital. Apart from this event, his rate of speech was uniform, and his sentences were

comprehensible. The sexual assaults and the migratory journeys by boat were events that could not be detailed more than what he said spontaneously (see formulations in section 2).

Attention and memory
The applicant remained concentrated throughout the examination (about one and a half hours). He showed dissociation on several occasions but succeeded in resuming the thread of the narrative. He succeeded in producing a narrative of his life, but the intensity of the sufferings as well as the associated shame and guilt prevented him from developing more differentiated narratives (and therefore a memory). The applicant did not produce an analysis of his experiences; he simply told the events without reflecting on them. He was very conscious of being in a bad mental state and he felt guilty about this. Mr K. X is well oriented in time and space. He has a moral judgement about the attitude of others and his own actions.

Thought
The applicant demonstrated logical and coherent thinking and firmly established moral values. He was very disturbed by the presence of flashbacks and obsessive thoughts about traumatic events.

He does not present a risk to his surroundings and has not reported suicidal thoughts.

5.1b Special examination of psychological issues
The applicant is extremely affected by shame and guilt directly related to the traumatic events he claims to have experienced. This guilt, in connection with the horror of events, makes them unutterable. The need for psychological tests was not indicated by the narrative, which was clear and constructed, apart from the traumatic areas where the inconsistency of the discourse was directly related to psychological and physical shocks.

5.2 Interpretation of findings, according to the Istanbul Protocol gradation scheme [3]
The applicant suffers from severe post-traumatic stress disorder

[3] *Istanbul Protocol Para. 187:*
(a) Not consistent: the lesion could not have been caused by the trauma described;
(b) Consistent with: the lesion could have been caused by the trauma described, but 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.

[4] *Para. 105 Istanbul Protocol*

(PTSD). The latter is **very consistent** with his statements about the traumatic events that he suffered and that made him decide to flee his country. It appears clear to the examiner that the applicant can identify the traumatic events: the violence suffered as a child in XXXX that led him to flee the country, having no one to support him, the violence suffered in XXX, which was the reason why he would continue his flight, and the boat trip between XXX and Italy. These successive events increase the traumatic effects. It is noticeable that non-verbal and bodily reactions, gestures, rates of speech are each specific for each traumatic situation (dissociation to the sexual violence suffered as a child, confused discourse in reaction to beatings in XXX and unmotivated laughter in reaction to the recollection of the boat trip). In conclusion, the applicant distinguishes between these different moments, and this shows increased compatibility with the criteria of the Istanbul Protocol.

6 ADDITIONAL INFORMATION

No additional information.

7. REFLECTIONS ON THE RELIABILITY OF THE EXAMINATION [4]

(a) Are the psychological results of the review consistent with the allegations of abuse?
The applicant's statements and reactions are highly compatible with the descriptions of the suffered ill treatment. He showed a logical thought process and willingness to contribute to the reflections that arise through the exchange with the examiner. The applicant showed involuntary avoidance reactions that occur through dissociation reactions characteristic of post-traumatic stress syndromes (see section 5.b.).
(c) IAre the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
The psychological state of the applicant is also highly compatible with his statements. He suffers from overwhelming and repetitive memories, flashbacks, about past events during the day and night. Because of this, he suffers from massive sleep disorders. He is affected by repetitive and continual headaches. He is affected by a depressive state of mind that does not allow him to think about the future and that can results in sudden bursts of anger. The applicant defends himself against the return of invasive memory, and the psychological mechanisms of dissociation appear every time the discussion turns to traumatic problems. He is affected by sudden and panic-ridden fears about his life. Heis affected by shame and guilt related to the trauma sustained.

(d) What is the current state of the applicant's mental state?
Is it possible to detect an improvement?
The applicant is affected by a massive and severe PTSD. Given the relative security that he has experienced in recent months, this range of symptoms has developed particularly since then.

(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?
The applicant has recently lodged an asylum application. It is not certain that he can stay in France; he cannot work and he has no family or acquaintances except the compatriot who

welcomed him. This situation contributes to the increase in the effect of the range of psychological symptoms.

(f) Does the clinical picture suggest a false allegations of torture?
All the elements indicated show a very low probability of false declarations and, on the contrary, indicate the authenticity and veracity of those declarations.

8. SUMMARY OF APPLICANT'S STATEMENTS AND THE MEDICAL FINDINGS

8.1 Recapitulation of applicant's statement
The applicant declared that he did not know the identity of his parents, whether he had brothers and sisters and that he was raised by a couple of farmers, xxx and xxx who he called his adoptive father.

This couple had two children, a boy and a girl. He declares that he did not go to school and worked as a child, washing everything, sweeping the courtyard and suffering from hunger
The applicant declares having been the victim of domestic exploitation and rape by his adoptive father and does not know anyone in XXX outside this family.

By the age of 15, he had gone to XXX and looked for work there.

He alleged that two other trainees had beaten him up and left him for dead. He was then hospitalized for a month and a half at the regional hospital. When he could finally leave hospital, seeing that nobody cared about his situation and that no investigation would be made, he beat up one of his attackers and was threatened with death in retaliation. He took his savings and fled, through xxx and xxx to xxx and came to Italy by boat. The conditions of the crossing were such that the applicant feared for his life at every moment.

8.2 Opinion on psychiatric and psychological examination
The whole range of psychological symptoms corresponds to a massive and severe post-traumatic stress state and corroborates completely the statements of the applicant concerning the abuses suffered and the conditions of life and migration endured.

The life story and psychological symptoms typical of PTSD are **very consistent** with the statements of the applicant about the reasons that led him to flee his country.

The psychological state of the applicant requires specialized medical treatment.

9 OVERALL CONCLUSION

On the basis of this expert opinion, it is possible to conclude that the overall symptomatology (physical and psychological) observed corroborates convincingly with the allegations of the applicant.

10 SIGNATURE

Date: DD-MM-20YY
Place:
Name: Mr. P. DUTERTE and Mrs. K. TEEPE
Signature:

APPENDIX 1:
Four contact sheets of photographs taken during the examination, accompanied by the colorimetric rule used during this examination.
APPENDIX 2:
Consent to the examination signed by the applicant.
APPENDIX 3:
The asylum certificate presented by the applicant to attest to his identity.

MEDICO-LEGAL REPORT HUNGARY

ARTICLE 18 DIRECTIVE 2013/32/EU / *BASED ON THE ISTANBUL PROTOCOL* [1]

1 INTRODUCTION

1.1 Personal details of the applicant:

Name:	Xxx
Gender:	male
Country of origin:	West Africa
Ethnicity:	xxx
Date of birth:	DD-MM-YYYY

1.2 Data related to the medical examination:

Date of examination:	11-10-2016
Place of examination:	Budapest Trauma Center, Cordelia Foundation
Name examiner, discipline:	Dr Lilla Hárdi, psychiatrist
Professional ID number:	138900AE
Institute where the examination is undertaken:	Cordelia Foundation
Name referrer and the designation:	lawyer
Name interpreter:	-
Language spoken:	English
Other attendants:	-

[1] *United Nations, Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations 1999*

QUALIFICATIONS OF THE EXAMINER:
Dr Lilla Hárdi is a medical doctor licensed at the Semmelwes Medical University, Hungary, Budapest since 1981. She is a psychiatrist certified by the Imre Haynal University, Hungary, Budapest since 1985. She was admitted as a full member of the International Psychoanalytic Association in 1992. Dr Hárdi has been a psychotherapist since 2003, licensed by the Hungarian Ministry of Health, and a rehabilitation psychiatrist since 2005, licensed by the Hungarian Ministry of Health. She was active as the chair of the section of the World Psychiatric Association Section on Psychological Consequences of Torture and Persecution from 2008 until 2012 and later as the vice-chair and board member of the section. She was the European Council member and the Executive member of the International Rehabilitation Council of Torture Victims (IRCT) between 2010 and 2013. She has been a member of the IFEG (International Forensic Expert Group) of IRCT since 2010, publishing scientific statements against torture.

In 2014, Dr Hárdi was awarded the Inge Genefke prize (for the rehabilitation of torture victims) in Copenhagen, Denmark. She has been working in the field of refugee mental health and clinical treatment of victims of torture since 1993. Having been the medical director of Cordelia Foundation for the Rehabilitation of Torture Victims (Budapest, Hungary) since 1996, she has personally examined several hundred survivors of torture and human rights abuses, written multiple reports and treated and/or supervised the treatment of hundreds of torture survivors. She has lectured and trained nationally and internationally on this topic and has published multiple articles, monographs and book chapters relating to the psychological consequences of torture and refugee mental health. She was the Chief Guest Editor of the journal Torture from 2015 until 2016.

1.3 File

Relevant documents, if available:
Medical
Not applicable

Legal
Not applicable

1.4 Special remarks about examination
Not applicable

2 BACKGROUND

2.1 General information:
The applicant relates the following:
He is from a Christian family with two children, with a good financial and social background. His father worked as a high-ranked police officer. He had one older sister, who worked as a nurse but had more than one qualification (she also was a qualified laboratory assistant and midwife). The sister occasionally organized and held religious encounters and talks, as the family was very religious. However, his father's older brother was of Muslim belief.

The applicant graduated from university with a degree in geology (at XXX), where he obtained a bachelor's degree. His father later retired and got a house in XXX, where he moved. The applicant's sister moved into the vacant family house and asked the applicant to move there as well. The

house was situated in an area with a majority of Muslim inhabitants.

2.2 Allegations of torture/abuse/traumatic event(s)
The applicant relates the following:
One day, the applicant and his sister went with his sister's car to the market to buy some supplies. They were already on the way home when his sister sent him back for some vegetables that they had forgotten to buy. They agreed that she would wait for him in the car. As he made his way back to the car, it turned out that a bomb had detonated in it. He was confronted with the sight of human carcasses covered with blood, as well as limbs and blood all around the destroyed car. His sister was dead as well. He went to the police station, then to the hospital, where he was issued a death certificate for his sister. Together, the applicant and his father buried the sister in their village of origin.

The applicant subsequently moved to the village and started working on a farm.

One day, he was cutting the grass there when, by mistake, he killed a snake while carrying out the work. He told the landlord that he committed a 'haram', a sinful act. His Muslim uncle as well as the other Muslims in the village told him to bury the snake. His father, however, did not let him do so. Thus, the inhabitants of the village – including his uncle – attacked him and took him to a place of worship.

He was detained here for six days and beaten continuously. They beat him with fists, as well as hitting and cutting him with machete. During the six days, he was given some yam root to eat, and water once. He knew they would kill him if he didn't flee. On the night of the sixth day, he managed to break down the door and set himself free. He went to his father, who told him to flee as his life was in danger.

In the morning, his capturers discovered that he had escaped and started to chase him. The applicant went to XXX and took shelter with friends; however, the villagers came after him, so he fled to XXX. The village people followed him to the capital. He knew that they were being financed by his uncle, because if he died, then upon his father's death, the uncle would inherit the wealth his father had accumulated.

2.3 Current social situation
The applicant relates the following:
The person has a partner who he plans to marry. They live together in an apartment, but, until the end of the application process, he cannot look for an employment.

3 ANAMNESIS [2]

3.1 Former physical and mental health status
The applicant relates the following:
Prior to the attack, he had no somatic or psychiatric disorder or disease. He did not consume drugs or alcohol.

3.2 Physical and mental health status during and shortly after the torture/abuse/traumatic events as described in section 2.2
The applicant relates the following:
A strong anxiety and fear emerged at the time when the attacks started and they remained with him at the time when he started to flee to XXX as well as upon coming to Europe. He could hardly sleep and even then he had nightmares. He was restless, nervous and trusted only his closest friends.

3.3 Current physical and mental health status
The applicant relates as the following:
Currently he does not complain of any physical symptoms.
When talking about the abuse and torture he suffered, he cries. He feels emotionally unstable; he cannot overcome the loss of all that he left behind. He gives an account of past sleeping disorders, nightmares, tension and restlessness, but these symptoms show a decreasing tendency lately.

4 EXAMINATION OF PHYSICAL PROBLEMS

4.1 Physical examination
4.1a General
Satisfactory overall physical conditions; the applicant considers himself healthy.

4.1b Skin lesions
- On the left side of the face below the zygomaticum, a parallel lesion of 3–4 cm deriving from a cut with a sharp object, above which an increasingly pigmented area of a color consistent with the skin color.

[2] The complete physical and mental health history recalled and recounted by client.

[3] Istanbul Protocol Para. 187:
(a) Not consistent: the lesion could not have been caused by the trauma described;
(b) Consistent with: the lesion could have been caused by the trauma described, but 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.

[4] See note 3

[5] Para. 105(f) of the Istanbul Protocol

- On the left side of the upper lip, a 0.5 cm cut injury.
- On the palm of the left hand, on the phalanges of the second, third, fourth and fifth fingers, pigmented signs of cut injuries.
- Decreased ability to grasp with the left hand; limited curve of the second finger on this hand.
- On the back of the left hand, a mark of a 1 cm x 3 cm pigmented lesion (this, according to the applicant's account, derives from repairing a car and not from the abuse suffered).

4.1c Specific examination of physical complaints/ symptoms
Not applicable.

4.2 Interpretation of findings, according to the Istanbul Protocol gradation scheme [3]
The above-listed symptoms and complaints are **very consistent** with the allegations: they may have been caused by the event described by the person concerned, with the exception of the last lesion.

5 EXAMINATION OF PSYCHIATRIC AND PSYCHOLOGICAL PROBLEMS

5.1 Psychological examination
5.1a Mental Status
Clear and well-oriented consciousness. The applicant recognizes the situation and behaves adequately. Normal vigilance and tenacity. No signs of memory or perception disorders. His thinking is of normal form and content; however, his traumatic past appears to be stored in a fragmented, non-linear way. The six days of detention and torture/abuse are mentioned only after the examination, showing a typical pattern of trauma recollection and sharing. His emotional balance is quickly disrupted when recalling traumatic events, but he tries continuously to gain control at such moments. His mood is affected negatively by the current inability to cope with past trauma, showing signs if dysthymia and dysphoria.

5.1b Specific examination of psychological issues
Not applicable.

5.2 Interpretation of findings, according to the Istanbul Protocol graduation scheme [4]
The above-listed symptoms and complaints are **very consistent** with the alleged circumstances: they may have been caused by the event described by the person concerned.

6 ADDITIONAL INFORMATION

The applicant met his current partner, who he would like to marry, in Hungary. He views the stable relationship as important. It has brought relief from his symptoms as well: his nightmares, anxieties and sleep disorders have decreased significantly. In the meantime, his father died at home: this was very painful for him. However, his own apparent death was also announced publicly in his village, and this makes him hopeful that no one will search for him anymore.

7 REFLECTIONS ON THE RELIABLITY OF THE EXAMINATION [5]

The applicant's partner also attended the medical examination at the specific request of the applicant. The legal representative did not raise any complaints about this or about

anything else in the content of the present report – this means that the content shared by the applicant on the occasion of the examination interview is consistent with what he told his lawyer.

8 SUMMARY OF APPLICANT'S STATEMENTS AND THE MEDICAL FINDINGS

8.1 Recapitulation of applicant's statement:
The sudden death of the applicant's sister marked a sudden change in the overall satisfactory physical and psychological well-being of the applicant. Moreover, the subsequent attack by members of his own ethnic group (even if different in their religious beliefs) was unexpected and highly destabilizing for him. In these acts, he experienced a clash between his 'educated, modern' world views and those of a traditional world. He had to flee in a mentally and physically deteriorated state. After his flight, he learned about the death of his father, which constituted a further loss for him.

8.2 Opinion on physical examination:
The lesions and his general physical condition do not impede him in his everyday life.

8.3 Opinion on psychiatric and psychological examination:
After the comprehensive physical and psychological examination of the applicant, I conclude that the above-listed complaints and symptoms of the applicant are **highly consistent with** the presented alleged circumstances.

9 OVERALL CONCLUSION

The recounted traumas are also characteristic of the country in question and of some traditional practices existing there. I confirm that, on the basis of the complaints and symptoms, the patient was victim of severe inhuman and degrading treatment whose consequences still show an impact on his current state.

Treatment for his symptoms in case of deterioration could become necessary.

10 SIGNATURE

Date: DD-MM-20YY
Place: Budapest Trauma Center, Cordelia Foundation
Name: Dr. Lilla Hárdi
Signature:

MEDICO-LEGAL REPORT THE NETHERLANDS

ARTICLE 18 DIRECTIVE 2013/32/EU / *BASED ON THE ISTANBUL PROTOCOL* [1]

File number : *XXXXXX*

1 INTRODUCTION

1.1 Personal details of the applicant:

Name:	NNNNNNNN
Gender	: Man
Country of origin:	East Africa
Ethnicity:	Unknown
Date of birth:	DD-MM-YY

1.2 Data related to the medical examination:

Date of examination:	2016
Place of examination:	Diemen
Name examiner, discipline:	Psychologist B and physician H
Professional ID number:	BBBBBB and HHHHHH
Institute where the examination is undertaken:	iMMO
Name referrer and the designation:	A lawyer
Name interpreter:	Interpreter
Language spoken:	Arabic
Other attendants:	
Peer review medical professionals:	Psychologist F and Physician K
	-

[1] *United Nations, Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations 1999*

1.3 File

Relevant documents, if available:
Medical
1. Medifirst 'Hear and Decide' medical advice (DD-MM-20YY)
2. Query sheet relating to the Medifirst 'Hear and Decide' medical advice (DD-MM-20YY)
3. GCA (Gezondheidscentrum Asielzoekers; Asylum Seekers' Health Centre) patient file dated DD-MM-20YY (20YY–20YY)

Legal
4. First IND (Immigratie en Naturalisatie Dienst; Immigration and Naturalization Service) interview (DD-MM-20YY)
5. Corrections and additions to the first interview (DD-MM-20YY)
6. Second IND interview (DD-MM-20YY)
7. Corrections and additions to the further interview (DD-MM-20YY)
8. IND intention on the decision (DD-MM-20YY)
9. Lawyer's corrections (DD-MM-20YY)

1.4 Special remarks about examination
Throughout the examination, it can be seen clearly that the subject has trouble talking about the traumatic events. The person concerned regularly has tears in his eyes and cries whenever the drastic events or his deceased/absent family members are spoken about. The physical examination was carried out by a female doctor, as no male doctor was available. Although the person preferred that a male doctor examined the genital region, he reluctantly gave his agreement for examination by a female doctor. However, the collaboration was limited, because he did not want to remove his underwear.

2 BACKGROUND

2.1 General information:
The applicant relates the following:
The person is unmarried. He comes from a small town, in East Africa. He had a few years of elementary education, up to his 15th year. He experienced school as fun, was a good student and there were no further noteworthy details. He worked together with his father, helping him with the work on the land and as a corn trader. He obeyed his father. If his father told him to do something or to collect something, he did so without question, as is common in his culture. He tells that his brother, called NNNN, was killed during a bombardment during fighting between the government and the opposition; he found his brother and saw his injured body.

Observation: he becomes emotional and cries.

In 20XX, his father was arrested by the security services on a false suspicion that the father had ties with members of the opposition. It was a bad year with a poor harvest; thus, their cornmeal storage sheds were empty. The sheds were visited by the authorities, who unjustly accused his father that he had sold corn to opposition members, which father denied. The person concerned was not present; he heard about it through their neighbour, who was present at his father's arrest. The person concerned went to the police station to try to get his father free, to no avail. The police told him 'these are the security services; there is nothing we can do'. His mother was afraid that, if he would go through with these attempts, like his father, he would be arrested. The person concerned indicates that it was a troubled time and everyone ran the risk of being

accused of colluding with the opposition, rightly or wrongly. He explains that his father and he himself were not politically active. He indicates that his own problems (arrest, detainment and torture; see section 2.2) here also have a connection with this, because it was usual that, if someone is accused, it is then assumed that the family members are involved also. After some time, he heard through a neighbour, who they knew well for several years and trusted that this neighbour had been detained along with his father, but had been released. The neighbour had seen how the father was tortured while being detained and had died of his injuries. The neighbour saw this because the abuse suffered by the father served as an example for the other inmates, to ensure that they would obey the authority of the guards. They accused his father of having collaborated with the opposition. The subject went to the police and the prison to retrieve his father's body, but to no avail.

Observation: the subject cries. He says 'he was innocent, me too, you here don't know what happens in East Africa.'

He hasn't seen his father since his arrest; also, as a family, they have not seen or been able to bury the body. Since his own detainment, he has also lost contact with his mother, despite an attempt through the Red Cross.

Observation: the subject is emotional as he speaks about his late father and brother.

He tells that, when he fled, he heard from a family member that his sisters had been r aped and murdered while he was detained (see section 2.2.).

Observation: the subject is emotional when he speaks of his deceased sisters and he says he misses his mother.

After the detainment and the death of his father, he found work through an acquaintance, named NNNNN, as a seller of phones and call credit, first in ZZZZ, later independently in a small kiosk in ZZZZZ. There, in MMMM 20XX, he was apprehended by government forces. He was accused of working with the opposition.

2.2 Allegations of torture/abuse/traumatic event(s)
The applicant relates the following:
He worked in his kiosk in ZZZZZ when two men came in. He was beaten and had to walk to a car in which two more men sat. Thus, he was arrested and taken away by four people. In the car, he was blindfolded with a black hood and was shackled with metal handcuffs. Some time later, he had to get out of the car, at a place that was unknown to him at the time; he had to sit on a chair and was questioned regarding his ties with the opposition. He was accused of having collaborated with the opposition because he had sold them chargers and telephone cards/ credit. The subject denied this, because he had not done that. He told them that he couldn't see from the appearance of his customers whether or not they belonged to the opposition and that he sees every customer as a regular customer and sells them products and services. The men who interviewed him did not believe him and continued their interrogation and questions and beat him with their hands on his head, for example on his right temple. Because he was blindfolded, he could not see the perpetrators and he did not know where the blows came from.

Observation: the subject shows how he was struck; he shows how he was handcuffed with his hands behind his back and how he was beaten on the head. He becomes emotional.

Then they took him away and later removed his blindfold. They brought him to a hole in the ground, where he had to go down into using a ladder. Then they took away the ladder, so that he could not go anywhere. The hole could be closed off at the top, making it very dark at the bottom and he couldn't see very well. Sometimes they opened the hatch, whereby sometimes he could see daylight or moonlight and thereby have a vague idea of what time it was, but often the hatch was shut. It was a space in which he could stand and lie down. The space was of earth; there were no stones or tiles. There was some straw, a kind of wicker mat, where he could lie down and sleep. There was a hole in the ground where he could go to the toilet, making the area very smelly and dirty. He got food once a day, via a bucket on a rope. Sometimes daily, sometimes every few days, he was taken out of this hole to the interrogation room to be tortured and interrogated.

They asked him the same questions about his ties with members of the opposition and asked about specific people and names. He denied and continued to deny any connection, because he knew nothing and had nothing to confess. In total, he was detained like this for about 4 months, during which he was regularly interrogated and tortured. This happened so often that he can no longer remember exactly when, how often and what methods were used on which day. This happened often during the day. They tortured him using different methods:

- During the interrogations and torture, he was often undressed, sometimes wearing only underwear, sometimes completely naked (see below for further descriptions). During the interrogations, he was sometimes blindfolded, with his hands handcuffed at the back to a chair; his legs were free.
- He was made to sit on an iron chair; then electricity was connected to the chair. This resulted in a great deal of pain; he shook all over and suffered a lot of pain for some days.
- The interrogators used iron pincers, with ridges on the ends, to squeeze hard and pull at his scrotum. He begged them to stop, but they did not. He moved backwards to avoid the torture, but that did not work.

Observation: he shows with his hands how his genitals were grabbed and how he was sat shackled on the chair. He says that he would rather not talk about these events and stares out in front of himself.

- The pincers turned the skin white. Hit by the intense pain, he was sometimes unconscious. When asked how it is that he had not spoken earlier about this at the IND, he points out that, during the hearing, he indicated that he was also tortured 'there' [he points to his pubic area], but did not go into detail about this because the hearing at the IND took place with both a female IND official and a female interpreter. He was ashamed to discuss it too much, because it is not common within his faith and culture to discuss matters regarding sexuality with people of the opposite sex.
- He was beaten with fists and flat hands,

everywhere on his body, on his head, neck, back, shoulders, stomach and legs. They kicked him with heavy military boots. He was beaten with a heavy object, 'a kind of hammer'.
- He was forced to crawl on his hands and feet, in the hallway, next to the interrogation room, with all kinds of grit and pebbles on the ground. He was also held down and kicked on the underside of his bare feet, which also greatly hurt his knees.

Observation: he's goes on his hands and feet and shows how he had to crawl on the ground and was tortured by having to crawl and how he was beaten on his feet. When he speaks, he blinks his eyes and stares out in front of himself.

- The skin of his knees was damaged, making them bleed. These wounds were not taken care of, which meant that they got bigger. Often he was tortured intentionally on spots where he was wounded, so that these wounds could not heal well. This caused a lot of pain in his knees, and this made it difficult for him to walk.
- The guards lit up, in a kind of basket, charcoal with dried herbs and chilli peppers, called 'shatal', making a very strong-smelling, stinging thick smoke. As a result, he could barely breathe and nearly suffocated. It irritated his eyes and airway.
- He tells several times of being threatened to be murdered, while he had to watch how other prisoners were tortured or murdered. He witnessed the execution of others. He describes an event in which he had to sit with some men in a row, with security guards behind him, and some men in front of them were executed. The guards also threatened to kill the person concerned if he wouldn't confess to having cooperated with the opposition.
- He was forced to witness how other people were tortured in a gruesome way and ultimately killed, in order to put pressure on him to confess. So he had to watch as two men, almost entirely undressed, were beaten with a hammer and tortured. He heard their cries of pain and fear.
- He was also once handcuffed and blindfolded and brought by armed guards to a place in the desert, where he then had to watch as two other people were tortured. They told him that he would undergo the same fate if he continued to deny his guilt. He had to watch how a man was tied up by his legs to two different cars; then the cars drove in different directions, whereby the man was torn into pieces.

After about 1,5 months in detainment, the person concerned was so unwell from the pain, weakening and injuries that he was brought unconscious to a hospital. According to him, this was a military hospital in ZZZZ, which was known to everyone in the area because it was the only military hospital in the area. Here, both citizens and government soldiers were treated. He recalls that a female doctor or nurse told him that he should cooperate with the security service and tell them what they want to hear, because he otherwise would not survive. He stayed here a few days and, among other things, was placed on a drip. He does not know what sort of liquid was administered. He describes that he had injuries and bruises everywhere and that the medical care he received was bad and inadequate. He

was patched up so that he could be interrogated again. After a few days, he was again handcuffed and blindfolded by armed men and brought back to the hole under the ground. The interrogations and torture then resumed in a similar way to before; however, as far as he could tell, this occurred a little less frequently than before. He gave in, wanted some peace and quiet and said 'make this come to an end'.

Observation: the subject gets emotional.

A few weeks later, there was a resurgence of fighting in the area. From his hole in the ground, the subject heard heavy shelling and bombing. This went on for a whole night until the following afternoon. He was taken handcuffed and blindfolded again and thought he was going to be killed. He was physically weakened, despondent and hopeless, and, because of the pain in his knees and body, found it difficult to walk. He was then taken back to the same military hospital, where he had been brought earlier. Under the watchful eye of armed guards, he had to help with the transport of victims and bodies – resulting from the fighting and shelling – to the place where they were buried. There were also a number of wounded people in the hospital. Some doctors checked whether people had actually died, but did so hastily and sometimes barely or not looking at the bodies, said the subject. With another man, named NNNNNN, he had to lift bodies into an open back of a truck. They would hoist about five bodies into the truck and then drive the bodies to a place in the desert where the bodies were buried. The bodies were sometimes covered with sheets, sometimes not, and he could see blood and mutilated bodies everywhere. They drove several times back and forth to, each time, transport many corpses and bodies from the hospital to the desert; this was over dirt roads with potholes and gaps in the road. At one point, a body moved, because they drove through a pothole. He, NNNNNN and the guards got a huge fright. This person turned out not to be dead. He sat upright and grabbed a guard, who was so startled that he then fainted. The other guard put aside his rifle and told the driver to stop. The driver got scared and ran away, along with the guard. This created chaos and bustle in and around the truck. NNNNNN said to him, 'this is our chance'. Initially, he didn't want to run away because he was afraid, but then thought better of it, that this might be the only chance that would arise. He jumped out of the truck and ran away, to the north. NNNNNN ran in a different direction. The subject kept running. He explains that the anxiety and tension were stronger than the pain. He had so much fear of being caught, tortured and murdered again that these thoughts prevailed over the physical pain. As a result, he was able to get away. When he was out of sight and kept running, the complaints and the pain got worse, especially in his knees and lower abdomen, but he forced himself to keep walking. He went to an uncle's place. A cousin told him about the fate of his sisters. He then fled, through a long and complicated journey, from XXXX to XXXXX. In XXXXX, he was arrested because he did have the right papers and was interrogated in detainment for about 4 months. These were difficult conditions, although he was not tortured or mistreated.

They thought at the prison that he came from XXXXXX, but later a senior soldier, who apparently had some power, heard that he spoke Arabic and asked him if he was Muslim, which

he confirmed. He told that he came from XXXX. This officer said that he had worked in XXXX and would help him. This officer freed the person and took him to his home, where he was able to stay for some time. In return, the subject had to work as a shepherd of the officer's sheep and cows. He spent a total of about a year in XXXXX. Afterwards, he crossed over to Italy in a crowded boat. The crossing took a few days; on the way, many became sick, including women and children. He did not quite know where he was when he arrived in Italy. He then traveled through France to Netherlands and asked for asylum here.

Observation: the subject speaks in detail about the undergone violence and detainment and wants his story told. Despite some questions from the investigator, the subject speaks about these events from his own perspective. Sometimes, he seems not to hear or note some of the investigator's insightful questions; he simply wants to complete his sentences and further tell his story in detail. If an investigator interrupts and pursues questions in a more direct manner, the subject answers those questions. As a result, he seems stuck in his memories of the torture undergone in the past.

3 ANAMNESIS [2]

3.1 Former physical and mental health status

The applicant relates the following:
Psychological:
As a child and as an adult until his arrest in MMMM 20YY, the subject had no significant psychological complaints. He experienced his upbringing as positive and normal. However, the death of his brother and later that of his father were very difficult and sad. Life in XXXX was tough for him, but normal, consistent with the circumstances of poverty and political unrest.

Physical:
As a child, the person was physically healthy. He was rarely sick. He never had accidents as a child that led to injury.

[2] *The complete physical and mental health history recalled and recounted by the applicant.*

3.2 Physical and mental health status during and shortly after the torture/abuse/traumatic events as described in 2.2
The applicant relates the following:
Psychological:
During the arrest, detainment and torture, he felt very frightened. He felt dejected and saw no future perspective any more; he told his guards 'kill me, then I am done with all this'. He slept badly, felt tired and weakened by inadequate facilities and torture. Since the detainment and torture, he feels anxious and is burdened by nasty, oppressive memories of the torture undergone in detainment in XXXX.

Physical:
He had various physical symptoms. He had pain everywhere, on the places where he was beaten, kicked and tortured. Especially on his head, back, legs, knees and genitals. The electric chair was very painful, leading to experiencing tingling all over, as well as having a few days of bad vision and stiff muscles. He had bruises and injuries everywhere, whereby regularly he was covered in blood.

The person concerned also had blows to the head on the right side against his ear. He has no problems with his hearing. He has no scars on his head.

Both knees were swollen and very painful. The knees were so swollen that he could no longer put on his pants. There was grit from the floor in the wounds. The wounds were red, and the wound on the inside of his left leg became thicker and more painful. Later, he broke open painful swelling himself. Pus came out of the wound. He doesn't know if he also had antibiotics in the hospital. He can still remember that he had a drip, but was so sick and weakened that he does not know which treatment he has had. After fleeing, someone applied 'blue tea' and later also cobwebs to the wound on the knees; this is a local remedy, to allow the wounds to heal. He has various scars resulting from these wounds.

Because of the hammer blows to his knees and lower legs, the subject also had many wounds on his lower legs. These wounds became larger during detainment but then healed spontaneously. His legs were also full of dark spots from bruising.

During his imprisonment, someone had pulled, with a pair of pliers, his scrotum where it meets the penis. This yanking occurred for so long that, according to the subject, one could see white flesh. This created such a painful wound that he could not put on his underpants. The wound produced a lot of fluid, but later healed spontaneously. The subject also saw blood in his urine and he could produce urine only little by little. Later he could urinate normally.

3.3 Current physical and mental health status

The applicant relates the following:
Psychological:
Currently he has sleep problems. He has hefty nightmares every night, about the torture undergone, and having seen and heared others being tortured. Also the corpses and bodies that he had to transport come back in his dreams. He dreams also that he was tortured again in the same way as in the past (as described in section 2.2). He wakens screaming and frightened. An inmate in the Asylum Centre sometimes locked

the door so that he could not flee from the room as a result of his nightmares. He experiences these feelings and memories sometimes during the day as well, but less frequently than at night. Then it feels as if he is suddenly back in XXXX and experiences the torture again. He tries in vain not to think about the events in the past and would also prefer not to speak about them again in the investigation, because this is too painful. He feels wary, on edge, anxious and has trouble concentrating. He eats moderately, drinks sometimes nothing for a long time and has problems with his knees. He has contact with other people from XXXX in the Asylum Centre, but avoids talking about the painful events of the past.

He feels very sad and gloomy about what has happened to him. He thinks sometimes about death, but indicates forcefully to that his faith prohibits suicide and that only Allah gives and takes life. 'What to expect after suicide in the hereafter is worse than what you have experienced in life.' He mentions repeatedly that he would rather die here in the Netherlands than return to XXXX. XXXX terrifies him enormously, because of the torture he has undergone. He is afraid of being arrested and again tortured and eventually killed. He feels very lonely and alone and misses his mother: 'I just want to see my mother'. Reading in the koran, reading certain surahs and meeting up with some friends from XXXX gives him some support.

Physical:
He says he lost weight because he eats less. He eats less because he is too tense and because he's not with his family; he sees food (also) as a social matter.

He has sometimes had problems with headache, but these are recently somewhat reduced. These complaints arise especially if he frets about his situation. The headache is mainly in his left forehead and temple. His vision is good. Sometimes he also feels sick, but doesn't have to vomit.

Since fleeing, the subject has suffered from having to urinate frequently. He has no pain when urinating. These complaints increased since his arrival in the Netherlands. Also, the person tells that he sometimes feels pain that radiates from his scrotum in the direction his belly. These complaints also occur since his imprisonment. If he relives what he has gone through, sometimes he feels the pain in the same places as where he was in pain during the torture.

In cold weather, the person concerned has pain in his right knee. In warmer weather, he has no complaints. He can then walk without too much difficulty.

Current medications:
The person concerned gets medication prescribed by the GCA. He formerly received Mirtazapine, 15 mg, 1 b.i.d. (relating to mood complaints), now another drug the name of which he does not know.

4 EXAMINATION OF PHYSICAL PROBLEMS

4.1 Physical examination

4.1a General
The person concerned is a lean young man with a dark-tinted skin colour.

4.1b Skin lesions
The person concerned has various scars, spread all over his lower body, that he attributes to the torture he has undergone in prison. These scars are examined and described below.

SCAR 1: Various small and large scars can be seen on both knees (photos 1, 2, 3, 4, 5).
A: On the right knee, three round-oval, well defined somewhat recessed scars with a diameter of 0.5 cm to 1.3 cm. The skin is thin and smooth, with an atrophic appearance (red arrows, photos 2, 3). In addition to these scars, there are, on various places, small scars (a small disturbance in the normal skin structure) visible, all of which are not described separately and are not marked on the photos.

B: On the inside of the right knee is an oval erratic scar of about 4 cm by 3.5 cm. It is moderately edged, the edges have normal skin colour, but in the centre, the scar is lighter in colour. The appearance is smooth and shiny and there are no unusual skin structures visible. There is talk of an atrophic scar (blue circle, photos 2, 4).

C: On the left knee at the height of the top of the kneecap is an oval elongated scar visible of 3 cm by 1.5 cm, well edged. Also this scar has a smooth shiny appearance and lies sunk into the skin (yellow arrow, photos 2, 5). In addition to this, there are also small scars on the left knee at various places (a small disturbance in the normal skin structure) visible, all of which are not described separately and are not marked on the photos.

SCAR 2: On the outside of his right lower leg, a scar that is round in shape of 3 cm by 3 cm and darker in colour at the edges. The edge is blurred. In the centre, the scar is lighter in colour and has the form of a 'plus' sign with, at the top and bottom, cross-shaped hypopigmented discolourations approximately 0.5 cm wide (photos 6, 7).

SCAR 3: In the front of the right lower leg above the ankle are three scars with a consistent appearance. The scars are round-oval in shape, about 1 cm to 3 cm in diameter and have a dark blurred edge, with a central lighter colouration (photos 6, 8).

SCAR 4: The scar on the right tibia is an elliptical-shaped scar of 4 cm by 2 cm. The scar is darker in colour at the edges, having a lighter colour in the centre with a number of (hypopigmented) white round dot-shaped abnormalities (photos 9, 10).

SCAR 5: On the left shin, there are six white (hypopigmented) scars, including a stripe-shaped scar on the edge of the shin about 0.5 cm wide and 13 cm long; this scar is partly hypopigmented, partly normal skin colour or darker in colour, sharply edged and normal skin structures are missing. The other scars are erratic in shape with a diameter of about 1 cm sharply edged and with an absence of normal skin structures (photo 11).

SCAR 6: On the scrotum, at the transition from the penis to the scrotum, is an erratic blurred edged hypopigmented scar of approximately 2 cm by 3 cm not having normal skin texture and hair growth. The skin there is normally thin

(photo 12 – due to privacy reasons, this is not attached. This photo is available upon request from the office of iMMO).

4.1c Specific examination of physical complaints/symptoms
Examination of the left and right knee: both knees have normal stretch and bending function that is not painful. The kneecap moves smoothly but both knees creak below the kneecap when bending. The meniscus tests show no irregularities. The thin atrophied thigh muscles stand out.

Examination of the scrotum: the person concerned finds it difficult and shameful to have to undergo this examination, but in the end he nevertheless agrees. However, he keeps his underwear on and shows the scar from the leg of his pants. The scrotum shows no further abnormalities and both testicles feel normal. The penis was not examined.

4.2 Interpretation of findings, according to the Istanbul Protocol gradation schemes [3]

4.2a. Assessment of Scars
The above described scars (under 4.1.b) are interpreted below according to the same numbering.

SCAR 1: Various small and large scars can be seen on both knees. The applicant states that these were formed after being forced to crawl on his bare knees through the corridor of the prison complex. The floor was covered with tiles and grit. While crawling he was kicked with heavy solders boots against the back of his feet causing the grit to penetrate deep into the skin of his knees (photo 1,2,3,4,5). The atrophic appearance of the scars indicates deep wounds healed inside out. The scar on the inside of the right knee fits, because of its irregular aspect, into the recovery of a large infected wound that healed secondarily. The location and the size of the scar on the left knee are remarkable: however, because of the explanation (maximum bending of the knee and kicking against the feet) and demonstration by the applicant, it is very well possible that on this particular location such a scar occurred. Other possible causes are few for such a large scar on

[3] *Istanbul Protocol Para. 187:*
(a) Not consistent: the lesion could not have been caused by the trauma described;
(b) Consistent with: the lesion could have been caused by the trauma described, but 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.

this location. Given the number of (large and small) scars and the unambiguous atrophic aspect, the total of scars on both knees is assessed as **highly consistent with** the alleged circumstances (which are explained and depicted in much detail).

SCAR 2: The scar on the outside of the right lower leg is, according to the applicant, caused as the guard pinched the skin with force, using tongs, some kind of pincers with a ribbed head, creating a wound (photo 6, 7). The aspect of the scar with the smooth margins, the hyperpigmentation on the margins and the lighter coloring in the center fits a bruise. A significant hemorrhage emerges in the subcutaneous tissues, due to the pressure from a severe bruise wound, which later stays visible as hyperpigmentation. At the point of maximum pressure, a wound might emerge which leaves a white coloring after healing. The shape of the scar as well as the diagonal lines can fit with bruising caused by an object, such as the pinchers the applicant describes. As such, the scar is assessed as **highly consistent with** the alleged circumstances.

SCAR 3: the applicant recalls that he contracted these scars during abuse, but cannot remember how exactly. The upper scar shows similarities with the above described scar (scar 2). However, because of the absence of an exact explanation, no assessment is possible according to the Istanbul Protocol regarding the causal relationship between the scar and the alleged abuse (photo 6, 8).

SCAR 4: the applicant recalls that he contracted these scars during abuse, but cannot remember how exactly. Because of the absence of an exact explanation, no assessment is possible according to the Istanbul Protocol regarding a causal relationship between the scar and the alleged abuse (photo 9, 10).

SCAR 5: (photo 11) the applicant states that a guard hit him with a hammer on the knees and lower legs. This caused various wounds. The aspect of the scars, namely the white coloring and the irregular shape, fit the injury after deep impact through multiple layers of tissue. Also the distribution of the wounds indicates impact from the outside. There is no skin abnormality which causes this type of tissue damage. These scars are assessed as **consistent with** the alleged circumstances.

SCAR 6 + complaints scrotum: according to the applicant this scar is caused by a wound inflicted by the guards who grabbed the applicant's scrotum with tongs. This was extremely painful, the applicant moved backwards creating a wound by which 'white tissue' came out of the scrotum. The fact the applicant saw 'white tissue', means the wound went through several layers of skin on to the lowest tissue. Given the fact that the skin of a scrotum is very thin, this is very well possible. Additionally, the applicant states that he suffers from pain in his scrotum ever since. He also experiences this pain during intrusive memories. It is possible that a nerve was damaged which causes the pain to remain. Persistent pains on the location of torture are documented regularly.2 Additionally, the applicant suffers from frequent urination, which is seen more often after sexual abuse 3. The scar and the remaining pain in the scrotum are also described in the GCA-file on 24-12-15 (file 3). The location of the scar is not known for

spontaneous injuries nor does it have the aspect of any surgical procedure (photo 12). This scar as well as the pain- and urination complaints are all together assessed as **highly consistent with** the account of the applicant regarding the torture of his scrotum.

4.2b Assessment of physical complaints/ symptoms
Examination of the knees shows creaking under the kneecap. This arises, when the knee is bent, because the kneecap does not move well over the thighbone. This may be the result of direct violence to the knee, as stated by the person concerned, but such complaints are frequently due to other causes. Therefore, the pain of both knees is rated as being **consistent with** his account.

Examination of the scrotum:
see under scar 6 above.

The causal relationship between the scars and the physical symptoms and the attributions by the person concerned are indicated, in this investigation, as ranging from consistent to **very consistent.** The total range of scars spread all over his legs and scrotum, as well as his physical symptoms, is, judging by the distribution over the body, by the details given by the person concerned about the causes and by his narrative, **highly consistent with** the account of the person concerned regarding the described torture.
This assessment of the total of findings is in accordance with § 188 of the Istanbul Protocol.

5 EXAMINATION OF PSYCHIATRIC AND PSYCHOLOGICAL PROBLEMS

5.1 Psychological examination

5.1a Mental status

5.1a.1 First impression
He is a XX-year-old man from East Africa, tidy appearance and in accordance with calendar age. In contact with others, he is initially reticent and polite. He shows little emotion, until there is talk of the traumatic events in the past; then he becomes emotional several times. He gives a depressed, fearful and sombre impression. A high degree of distress is clearly observable and tangible.

5.1a.2 Cognitive functions
Consciousness is at first sight clear; at the start of the examination, his attention span and concentration are reasonable. He seems preoccupied with the torture, detainment and flight that he experienced. He tells, when asked, in detail about various traumatic events and torture that he underwent. As a result, he seems stuck in his memories of the torture undergone in the past. He indicates to be having trouble with remembering some events and details.
In addition, there are also strong feelings of avoidance from certain aspects and details of the torture. He gives the impression of having average intelligence. Currently, he shows good orientation in space, person and time. His sense of reality seems intact. How he presents himself and how he perceives things are undisturbed. How he thinks is, in terms of tempo normal; the content is coloured by fear, sadness and traumatization. His current frequent nightmares,

flashbacks and intrusive recollections relate in detail to the undergone torture methods, the bodies/corpses that he has seen and has had to transport, as well as sounds and images of other people who were tortured and murdered. Following on from this, he also experiences strong physical sensations and stress complaints, such as severe pains related to the undergone violence, trembling, sweating, increased heart rate and hot shivers. This fits in with the flashbacks and intrusive recollections as a result of undergone traumatic events.

5.1a.3 Affective functions
The mood is depressed; the person concerned is sombre, sad and anxious; during the recollection of the history, at one point, he indicates that it would have been better if he had died. What is striking is that he person often starts to cry when it comes to a painful subject. The affect is mostly flat and modulating. His fear is accompanied by increased wariness. There is growth in making contact with others.

5.1a.4 Conative functions
Psycho-motor skills are largely undisturbed; the person concerned makes an sober impression. He is mostly silent, with arms folded. His facial expression is lively when he depicts the undergone torture. He has thoughts about death, resulting from the loss of future prospects and gloom; however, currently he has no acute suicidal thoughts or plans. He is motivated to take part in the examination, although he also finds it difficult to talk about the past again.

5.1a.5 Alcohol and drug use
The person concerned reports no substance abuse such as of alcohol, nicotine or drugs.

5.1a.6 Diagnostic considerations according to history (section 3.3) and examination (section 5.1)
It is a XX-year-old man who appears very anxious and sombre. He describes various experiences of loss (father, brother, sisters) due to political turmoil in East Africa. After those events, he was, in 20YY, himself arrested on suspicion of collaborating with the opposition and, during that detainment, underwent various traumatic events for about four months. Several times he was tortured severely by electrocution, physical torture such as hitting, kicking and choking, being kept in solitary confinement in deplorable conditions, being forced to witness severe torture and the murder of other people, as well as undergoing threats and mock executions, sensory deprivation, psychological weakening and bestial/inhumane treatment.

As a result, since then, he has various mental and physical problems. He currently suffers daily from intrusive recollections, in the form of nightmares and flashbacks, of the undergone torture (thus, he experiences again how it was tortured, sees images and hears sounds of detainment, his own torture and that of others, sees corpses and bodies); this also leads to experiencing physical symptoms such as increased heart rate, trembling and sweating. He is anxious, wary and suspicious. He tries in vain to avoid these memories and stays clear of topics that remind him of what he has gone through. He meets all the criteria that match having a post-traumatic stress disorder (PTSD), in accordance with DSM-IV-TR, with complaints relating to all three clusters: intrusive recollections, avoidance irritability and hyperarousal. Given the frequency, intensity and distress, these complaints are serious in nature.

There is also talk of a depressive mood, loss of perspective about the future, mourning for deceased relatives and loss of his mother. He feels gloomy about what he has endured and about his current situation. He is afraid to be sent back to East Africa and to be tortured and murdered there. He experiences lack of future prospects and support.

The above complaints correspond to what is described in the medical record of the GCA (file item 3).

The person concerned makes contact in a restrained, socially adequate way. The post-traumatic stress complaints and the high degree of distress are clearly visible. .
Given the seriousness of the current psychological complaints, the examiner, according to the BIG-professional code of the examiner, referred the person concerned to the mental healthcare consultant at the GCA for treatment and counselling.

5.1b Specific examination of psychological issues

Psychological examination
Some cross-cultural validated psychological tests were carried out, like the Bourdon–Wiersma test for identifying concentration problems, the Harvard Trauma Questionnaire (HTQ) for the determination of complaints associated with a possible PTSD and the Brief Symptom Inventory (BSI) for measuring symptoms of psychopathology.

THE BOURDON–WIERSMA TEST
The Bourdon–Wiersma test measures the ability to concentrate. It is a non-language test, where the test subject has to differentiate, as quickly as possible, a certain number of dots.

RESULTS OF THE BOURDON–WIERSMA TEST
The person concerned understands the explanation of the instructions and is motivated to take part. During the try-out, he makes some mistakes. During the actual test, he stops after about 10 lines. With some encouragement, he continues, although it is apparent that his attention waned: he makes various errors, has several omissions and stares out in front of himself. Halfway through the test, he is already well over the standard time (4 min and 10 sec). Therefore, the test is stopped before completion. This is a clear indication of problems in concentration.

THE HARVARD TRAUMA QUESTIONNAIRE (HTQ)
The HTQ measures if there are symptoms associated with PTSD. Per item, the client indicates, on a four-point scale, to what extent he or she suffers from a particular complaint, ranging from 'no burden' to 'a lot of burden'. The questionnaire gives a score for PTSD as described in the DSM-IV-TR.

RESULTS OF THE HTQ
The subject has trouble with some questions, which need extra explanation. He scores very high on all three clusters: intrusive recollections, avoidance and increased irritability. The contents of the thoughts, memories and nightmares relate to the recollection of violence in East Africa. Consequently, he conforms, on the basis of this questionnaire, to the three criteria that are associated with a PTSD, according to the DSM-IV-TR.

THE BRIEF SYMPTOM INVENTORY (BSI)

4 See note 3

The BSI is a questionnaire for measuring symptoms of psychopathology in adults. The list is used to get a first impression of the nature and severity of complaints. Many common complaints are measured such as depression, anxiety and somatic complaints but also less common symptoms such as hostility, paranoid ideas and complaints that indicate psychotic symptoms. For each item, the person indicates the degree to which they suffer, on a five-point scale, from a certain problem, ranging from 'no difficulty', to 'extreme difficulty'.

COLLECTION AND OUTCOME BSI

Due to time constraints, this questionnaire was not carried out.

The results of the psychological assessment tests confirm the clinical findings of the history and the examination of the psychiatric problems. From the results of the two examination tools (HTQ and Bourdon-Wiersma), a clear picture emerges: the person concerned has serious mental complaints that fit with a PTSD according to the criteria of the DSM-IV-TR. He also has serious concentration problems.

5.2 Interpretation of findings, according to the Istanbul Protocol gradation scheme [4]

The history and the psychiatric examination suggests that this involves a seriously traumatized XX-year-old man, originally from East Africa, who gives a fearful and sombre impression. The subject is currently experiencing a serious PTSD with intrusive recollections, as well as symptoms of avoidance symptoms and hyperarousal.

The psychological symptoms, such as mourning and grief, originated initially as a result of the death of his brother and father because of the unsafe political situation in his country of origin. The complaints were emphatically aggravated by the arbitrary arrest, detainment without any hope of getting released and frequent and severe torture including sexual violence for several months in 20YY in XXXX.

Since then, the subject suffers from PTSD complaints, mainly in the form of intrusive recollections, flashbacks and nightmares about the memories of the way in which he was tortured, both physically and sexually, as well as specific images and memories of the detainment, interrogation and forced clearing away of bodies/ corpses. There is also talk of avoidance and increased irritability. The fear of deportation to his country of origin is felt by him as very threatening, because of the violence that he underwent there.

Because of the nature, content and timeline of the complaints and symptoms, the findings are typical of the essence of the asylum account of the person concerned. There are other stressful experiences as well (such as the death of his brother, father and sisters), in accordance with § 105(e) of the Istanbul Protocol. The current psychological complaints form very strong supporting evidence for the person's asylum account regarding the undergone detainment and torture.

Specific complaints, such as his nightmares, intrusive recollections and flashbacks about detainment under the ground and being (sexually) tortured in his country of origin, fit very emphatically the type and content of the alleged violence in detainment, as described in sections 2.2 and 3.3.

Some other symptoms, such as sadness, grief, loneliness and loss of future perspective, relate both to the undergone violence as well as to the other stressful experiences including the current life situation.

5.3 Difficulties recounting the history

5.3a Assessment of current difficulties
In the current examination, the subject showed signs of psychiatric problems, both in the past as well as during the investigation; this was confirmed by the additional psychological investigation. There are clear indications of mental problems in the form of a PTSD and a depressive disorder according to DSM-IV-TR.

From scientific research, it is known that, in cases of post-traumatic stress and depression, often there exist concentration and memory problems. It is also known that, in cases of sexual violence, there are very strong feelings of shame and avoidance strategies especially were it concerns sexual violence. This seems also to be demonstrably the case with the person concerned here. Talking about the sexual violence calls up unpleasant thoughts and memories, accompanied by feelings of shame and avoidance. Thus, he has trouble talking about the various emotionally loaded events in his past. The complaints are aggravated because of his uncertain and insecure existence, which is currently characterized by the uncertainty about the outcome of the asylum procedure and risk of forced return to his country of origin; this is experienced by him as very threatening.

In conclusion, it can be stated that the subject's serious mental complaints at the moment certainly interfere with him being able to make a complete, coherent and consistent account.

5.3b Assessment difficulties at the time of the asylum interviews
When looking at the available sources, it is

striking that, according to the FMMU (Forensisch Medische Maatschappij Utrecht; Utrecht Forensic Medical Company) advice document (file item M1), no restrictions and no exceptional details had been mentioned. When we look at the evidence for this in the corresponding 'Hear and Decide' file (query sheet), it is striking that this underlying form, concerning complaints and psychiatric examination is not filled in. This is even more remarkable because it is also not mentioned that there are no problems or exceptional details, which is commonly the case. Thus, what is not sufficiently clear is whether these complaints were indeed queried but not noted, or the extent to which these were queried/examined. Also, it can be noted that the initial interview took only 4 minutes. As a result, based on the underlying, more detailed FMMA 'Hear and Decide' query sheet, it remains unclear to what extent any psychological symptoms or limitations were present during/before the interviews of DD and DD MMMM 20YY.

During the initial interview at the GCA (General Practioner) on DD-MM-20YY, so before the FMMU interview took place, it was reported that the subject indicated to have undergone horrid things but didn't go into any further details. He was described as a very skinny young man who wouldn't look directly at the doctor/nurse. Also, the possible consequences and complaints that he can get as a result of the experiences, such as fears or anger, were explained to him, and that he then can report for help. This suggests that the GCA suspected such complaints and problems.
Because of the observed feelings of avoidance, and also given the duration of the FMMU investigation, it is understandable that the person concerned did not mention his complains to the FMMU, but these were told to the GCA.

The first and further hearings at the IND took place on DD and DD MMMM 20YY, respectively.

From MMMM 20YY, the GCA file repeatedly makes mention of a man who has undergone physical violence during captivity. He has been beaten and mishandled with sharp objects in, among other parts of his body, the scrotum. He has pain in his knees and in his scrotum. Also, scars are noted on his knee, lower leg and scrotum. He also mentions nightmares, anxiety and flashbacks. Because of these problems as a result of violence, he was referred to the mental healthcare consultant, who described the referral as 'very correct'. Referral to a specialized Mental Health Care institute was immediately considered and put into effect. Since then, there have been various contacts with the mental healthcare consultant who has diagnosed PTSD, including fears, nervousness, tension and nightmares as a result of torture in detainment in the country of origin. The mental healthcare consultant considered the lawyer's request for a forensic medical examination at iMMO as being 'correct'.

During the asylum interviews, the person concerned avoids speaking about any of the undergone violence. From the current examination, it becomes evident that the he did not want to speak about the undergone sexual violence, because of the prescence of a female interpreter and IND officer (which also appears from the 'Further Hearing' report; see file item 6). He indicates that it is not appropriate for him, personally and culturally, to talk about such

matters with someone of the opposite sex; this corresponds to what is known in the scientific literature about feelings of shame and avoidance to speak about undergone sexual violence.

Given the amount, severity and enormity of the torture that he has undergone (physical torture, sexual torture, electrocution, suffocation, solitary confinement), including witnessing the torture inflicted on other people (witnessing [mock] executions, the quartering of a prisoner) and other undergone traumatic events (seeing his brother's mutilated body and seeing other corpses and mutilated bodies and wounded war victims), the chance that this person has developed a PTSD is very large. This corresponds to what is known from the scientific literature about the 'building block' effect, where the amount and intensity of various traumatic events considerably increase the chance that an individual develops a PTSD, as well as experiences substantial collateral psychological complaints. This is the case for the person concerned. In addition, the strong avoidant power of shame as well as the emotional pain involved in speaking about sexual abuse, especially in the presence of women, as is currently evidently found, is expressly taken into account.

In short, with regard to the start and development of the documented mental problems as well as the accumulation and severity of the undergone traumatic events, these complaints **certainly** hindered, at the time of the hearing, the formulation of a complete, coherent and consistent narrative.

6 ADDITIONAL INFORMATION

Does not apply.

7 REFLECTIONS ON THE RELIABLITY OF THE EXAMINATION [5]

With regard to the psychological symptoms that the subject describes, there seems to be no question of aggravation or pretence. The situations described by the subject are backed up by concrete personal examples. Thus, he portrays how he was

[5] *Para. 105[f] of the Istanbul Protocol.*

tortured on his hands and knees. Also, questions concerning the events of the past call up physical and psychological responses in the subject (tachycardia, sweating, avoidance, shame) that are visible and understandable. The person concerned is unambiguous in this examination with regard to the complaints and emotions that he shows at different times. The clinical picture is highly similar to how it is described in medical records. There is no reason to doubt the reliability of the examination or any falsification of the clinical picture.

8 SUMMARY OF APPLICANT'S STATEMENTS AND THE MEDICAL FINDINGS

8.1 Recapitulation of applicant's statement:
The person concerned is a XX-year-old man from East Africa. He worked for years with his father as a farmer and corn merchant. He describes various experiences of loss that he has gone through because of political turmoil in East Africa, whereby his brother was killed in a bombardment. In 20YY, his father was falsely accused by the security forces of working with the opposition, which led to his arrest and torture, resulting in death. The subject sought help in vain from the local authorities (police).

After the death of his father, he worked in a small telephone/phone credit kiosk in ZZZZZ. In 20YY, he was visited there by the security services and, like his father, arbitrarily arrested, mishandled and held in detainment, without hope of release, in a hole in the ground. He was falsely accused of collaboration with opposition members, and for about 4 months was, several times, tortured through electrocution, physical torture such as being beaten, kicked, choked, placed in solitary confinement in deplorable conditions, forced to witness the serious torture and murder of other people, undergoing psychological threats and mock executions, as well as weakening and bestial/inhumane treatment. At one stage, he succumbed to the effects of this torture and was for a short time moved to a hospital, where the medical care was inadequate. He was then brought back to the same captivity, where the interrogations and torture continued. One day he was taken away; he expected to be killed, but had to clear away victims resulting from increased fighting and shelling. He had to transport bodies and corpses to be buried. During this work, an unexpected situation occurred: a body suddenly moved and turned out not to be dead, whereby his fellow prisoner, NNNNNN, and the armed guards got a huge fright. One guard passed out, the other guard and driver ran away in panic, and so he had the opportunity to flee. His fear and tension were more powerful than his physical complaints, which got worse in the course of his flight. He found shelter and help from his cousin and uncle and fled to XXXXX (where he spent a year, among other things in detainment and then took the boat to make the crossing to Italy. From Italy, he travelled to France and then to the Netherlands, where he asked for asylum. Since the torture and detainment, he has intense memories of the undergone torture, and suffers from various physical and psychological problems.

8.2 Opinion on physical examination:
The causal relationship between the scars and the physical symptoms and the subject's own attributions are indicated in this examination as ranging from **consistent** (the scars on the left shin and the pain in the knees) to **highly**

consistent (the scars on both knees, on his right lower leg and on his scrotum). The totality of scars all over his legs and scrotum and his physical symptoms, given the distribution over the body, the details given by the person concerned of how they occurred and the consistency of the account, are **highly consistent** with the subject's account relating to torture. This assessment of the overall findings is in accordance with §188 of the Istanbul Protocol.

8.3 Opinion on psychiatric and psychological examination:
This opinion comes about because of the way in which the person concerned describes, explains and illustrates his psychological complaints, the visible and perceptible distress, the detailed representation of various methods of torture that he underwent, the findings, both physical and psychological/psychiatric, noted in the current examination, which, because of the nature, content and timeline of the complaints and symptoms, can be judged to be **typical of** the essence of the asylum account of the person concerned.

9 OVERALL CONCLUSION

To summarize, all findings of the investigation taken together form very strong medical-evidence of the subject's asylum account of the alleged torture that he underwent.

10 SIGNATURE

Date:
Place:
Name:
Signature:

ABOUT THE PARTNERS

IMMO (THE NETHERLANDS INSTITUTE FOR HUMAN RIGHTS AND MEDICAL ASSESSMENT) is an independent organization founded on 14 July 2011.
iMMO contributes to the protection of human rights, especially by making forensic medical assessments of suspected victims of torture and inhumane treatment and the transfer of expertise thereof. This is done especially in the context of a procedure for asylum seekers. iMMO works with freelance professionals – especially physicians and psychologists – who have the required knowledge and expertise, who commit themselves on a voluntary basis and who are not bound to iMMO by an employment contract. Every year iMMO receives around 150 applications for a medico-legal report. Besides forensic medical assessments iMMO offers advice and consultation to professionals having questions regarding medical aspects of the asylum procedure. iMMO also provides training and education, e.g. with regard to the early recognition of victims of torture or inhumane treatment. iMMO works not for profit and depends on funding. For more information: *http://www.stichtingimmo.nl*

THE CORDELIA FOUNDATION FOR THE REHABILITATION OF TORTURE VICTIMS is a non-profit medical organization operating in Hungary since 1996, with the aim to provide complex rehabilitation to those asylum seekers and beneficiaries of international protection who survived torture or other forms of inhuman or degrading treatment. Cordelia's team of psychiatrists, psychologists, other therapists and specially trained mothertongue interpreters, works country-wide, providing medical treatment, psychotherapy, counselling, crisis intervention and psycho-social care to more than 1000 patients per year. Cordelia was founded and is still today led by dr. Lilla Hárdi, psychiatrist, psychotherapist and member of the International Forensic Expert Group. The Foundation is the only Hungarian member of the International Rehabilitation Council for Torture Victims and besides the above activities, the only entity in Hungary that issues medico-legal reports based on the Istanbul Protocol for its clients.

Founded in 2001 by Pierre Duterte and accredited as a charitable organization, **PARCOURS D'EXIL** ("a journey of exile") runs a healing center in Paris that provides free medical and psychological services to victims of torture, government-sponsored violence, human rights violations and unaccompanied minors. Each year the center welcomes nearly 750 men, women and children. Parcours d'Exil is one of Europe's leading centers for specialized rehabilitation cares for torture survivors.
The majority of the patients are either asylum seekers or refugees who have no other choice but to flee their home country in order to save their own life.
The efforts of the multidisciplinary team focus on achieving three primary goals:

- Treating victims of various human rights violations, most notably torture.
- Training the professionals who interact with torture victims;
- Informing professionals, institutions and the public in general.

NOTES


iMMO


PARCOURS
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