

2012

## Session Two: Concurrent Panels

Mariam Jishkariani

Maria Natividad P. Hernandez

Pierre Duterte

Daniel Carey

Irit Ballas

*See next page for additional authors*

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### Recommended Citation

Jishkariani, Mariam, Maria Natividad P. Hernandez, Pierre Duterte, Daniel Carey, Irit Ballas, Ala'a Shehabi, Felicitas Treue, Frances Lovemore, Rafael Garrido Álvarez, Silvia Serrano Guzmán, Mechthild Wenk-Ansohn, Rodger Haines, and Christy Fujio. "Session Two: Concurrent Panels." Human Rights Brief 19, no. 4 (2012): 21-52.

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## Session Two: Concurrent Panels

### Authors

Mariam Jishkariani, Maria Natividad P. Hernandez, Pierre Duterte, Daniel Carey, Irit Ballas, Ala'a Shehabi, Felicitas Treue, Frances Lovemore, Rafael Garrido Álvarez, Silvia Serrano Guzmán, Mechthild Wenk-Ansohn, Rodger Haines, and Christy Fujio

## SESSION TWO: CONCURRENT PANELS

## CASES INVOLVING MARGINALIZED GROUPS

## Opening Remarks from Dr. Mariam Jishkariani\*

## INTRODUCTION

Georgia is a post-Soviet country that restored independence in 1991. The whole population living in Georgia is around 4.5 million. Georgia is a low/middle income country with a developing economy and democratic reforms. Georgia acceded to the United Nations Convention against Torture on 22 September 1994 but, unfortunately, the relevant changes have not fully been made in the national legislation, bearing heavily on the efforts to fight torture. In 1999, Georgia became a Member State of the Council of Europe, and accepted all relevant documents and Conventions, among them European Convention on Human Rights and Fundamental Freedoms and the European Convention on Prevention of Torture and Inhumane, Degrading Treatment or Punishment. In 2005, Georgia ratified the Optional Protocol to the UN Convention against Torture, which entered into force in June 22, 2006. In December 2005, special articles regarding torture and inhuman treatment, including the definition of torture, were incorporated in the Criminal Code of Georgia. The prohibition of torture is likewise included in the Article 17 of the Constitution of Georgia. In 2011, the new Anti-Torture Plan of Action of

Georgia was elaborated and ordered. Since December 2009, the National Preventative Mechanism (NPM) has been formed in the framework of the Public Defender's Office and the Optional Protocol is implemented in Georgia.

## RCT/EMPATHY, GEORGIA

RCT/EMPATHY is the first torture victims' rehabilitation centre in the Caucasian region. It was established in 1996 to provide a wide range of services to victims of torture and members of their families, including medical and psycho-social rehabilitation with art therapy and legal assistance. The Centre also conducts forensic evaluation according to the Istanbul Protocol. The program is designed to select torture cases from the vulnerable categories of RCT/EMPATHY clients and to observe the application of forensic evidence in legal proceedings.

A case study method is used, pursuant to the Istanbul Protocol guidelines, for complex forensic medical and mental/psychological examination, in particular Protocol annexes III and IV.<sup>1</sup> Diagnostics are provided according to the International Classification of Diseases.<sup>2</sup> According to the requests of lawyers, examinations may be provided by RCT/EMPATHY and IRCT Experts, involving the participation of psychiatrists, neurologists, orthopedists, psychologists, and forensic experts, and employing several clinical psychological tests. At the first stage of intervention, informed consent is received from the juvenile, and from any parents or guardians for all medical and legal procedures and advocacy campaigns.

## THE CASE OF M.M.

M.M. is a juvenile of 17 years old, 16 at the time of his arrest. He is currently imprisoned in the Juvenile Colony of the Ministry of Correction and Legal Assistance of Georgia. At the age of 7, he was diagnosed with scoliosis. At 11, he was the victim of electric burn and numerous fractures, which led to his being assigned the status of a child with disability. At 12, he was diagnosed mental retardation and a range of physical defects. By 14, the patient had his first episode of lost consciousness.

M.M. was first arrested in 2009 and given a 5-year conditional sentence. On 6 April 2010, he was arrested again and accused of breaking into a grocery store to steal cigarettes, alcohol, and cash. His criminal case also included two instances of petty theft. His

\* Dr. Mariam Jishkariani has been a Certified Doctor Psychiatrist since 1990. She has been founder, president, and director of RCT/EMPATHY since 1996. She is an Expert Psychiatrist of the National Preventive Mechanism at the Georgian Public Defender's office, an invited teacher of the Tbilisi State Medical University an invited expert psychiatrist for quality control expertise of the Georgian Medical Association, and a UNHCHR/Tbilisi invited trainer/expert. She is also Board Member of the WPA Scientific Section: Psychological Consequences of Torture and Persecution, a Member of the Board of Directors of the Georgian Medical Association and Head of Section on Torture at the Society of Georgian Psychiatrists, and a member of the Penal Reform International. She has experience of Trainer/Expert in several IRCT, PRI and RCT/EMPATHY's training programmes on Documentation and Prevention of Torture, health in prison etc. She is the author of about 10 projects of RCT/EMPATHY. Over 24 years, she has participated as expert/trainer in more than 20 international, regional or national training/seminars related to torture, health in prison and stress related disorders, organized for doctors "at risk" and legal experts. She participated and made presentations in more than 26 national and international meetings and conferences, and published about 35 articles, papers, books, reports on Georgian, Russian and English languages.

mental disability was not investigated at this stage in violation of Articles 641 of Criminal Procedural Code of Georgia (which was the criminal code in place during this period). M.M. reports that, during his time in detention in Telavi Regional Police Station, he was beaten by policemen with fists, rubber clubs and kicked; insulted verbally, threatened with physical elimination, and intimidated with guns; and deprived of food and water. Neither his lawyer nor his parents were called. The aim was to obtain confessions.

In conditions of physical and psychological pressure M.M. was feeling very poor. Over the course of the beatings, he fell and hit his head on an iron safe. He had a headache, pain in his whole body, and problems with movement. He was intimidated, restless, and had a desire for self-mutilation grounded anger and feelings of insult. In preliminary detention, he had a sleeping disorder and started having nightmares. He was not taken for medical examination and did not undergo check-up to document his injuries. M.M. did not make any statement on the beatings and inhuman treatment, later reporting feeling too afraid and intimidated by the policemen.

M.M. was subsequently sentenced to imprisonment for a term of ten years and eight months, despite his status as a disabled person. Neither an investigation nor a forensic psychiatric examination was conducted.

#### INTERVENTION BY RCT/EMPATHY

The Juvenile was found in juvenile detention by the psychologist of the Centre in April 2010. A first medical investigation was immediately provided by the neurologist, traumatologist

and by medical expert of the Public Defender. Several body injuries, among them on the head area, were found. On April 23, 2010, the Alternative Forensic Medical Expertise was provided by RCT/EMPATHY and the independent forensic centre *Vektori*. Taking into consideration the location of injuries and the morphological picture, the experts considered it possible that these injuries were caused in circumstances as described by M.M., namely due to beating with fists, kicking, and the use of blunt objects. The treatment, combined with stress factors associated with his detention and other emotional stresses, has triggered in the frequency of fits, which provided the need for additional diagnostics and treatment. There is a high probability that the treatment caused a manifestation of epileptic disease.

Taking into consideration international standards concerning the particular diagnosis of the patient, M.M. needs intensive treatment and rehabilitation with the involvement of psychiatrists, neurologists, endocrinologists, psychologists, social workers and teachers, in a rehabilitation facility and in psychosocial correction and development program. Detention and staying in a social group is source of additional stress for the patient and may have negative impact on his psychosocial state. The patient requires safe and protected environment and individual program, which shall reduce his sense of inferiority and disadaptation, and promote maximum development of his capacities and correction of behavior. The patient also needs continuation of pharmacy-therapy, including lengthy treatment with anticonvulsants.



As a result of interventions on his behalf, M.M.'s sentence was reduced from ten years to eight years; he will be released from prison in April 6, 2012. A separate investigation was opened according to the Article 332 of the Criminal Code—overuse of force. Lawyers of RCT/EMPATHY were seeking to qualify the investigation as a violation of Article 144—torture. After 2 years of investigation, the Chief Prosecutor's Office did not find sufficient evidence to support such allegations.

In February 2012, RCT/EMPATHY applied to the European Court of Human Rights. The application alleged violations of Articles 3 and 13 of the European Convention of Human Rights,<sup>3</sup> and a violation of the right to rehabilitation enshrined in Article 14 of the UN Convention Against Torture.<sup>4</sup>

## DISCUSSION AND CONCLUSION

The following issues were identified during the course of observation: (1) forensic evaluation is not provided in time and is not considered obligatory in cases of torture; (2) medical examination in penal system is not in line with International Standards; (3) the lack of photo and audio evidence before,

during, and after interrogations; (4) state forensic reports are not provided; and (5) the limited rights of victims enshrined in the new criminal code of Georgia.

The case of M.M. represents an example of cooperation between experts from different countries and different specialties, which is most important for countries where the independency of forensic evaluation system is not sufficient and where the rights of experts are at risk. This partnership is highly important for development of independent forensic evaluation services that will play important role in the fight against impunity. The case of M.M. also represents good practice of medico-legal cooperation that significantly reflected in the medical and legal outcomes of the case. It presents an innovative model of intervention provided by the torture victims' rehabilitation centre that shows importance of integrated multifaceted intervention for eradication of impunity and fulfill rehabilitation of victims. Finally, the case demonstrates the importance of comprehensive intervention inside the penal system, especially for most vulnerable categories, such as in cases involving juveniles with disabilities and mental problems.

## Remarks of Maria Natividad P. Hernandez\*

### INTRODUCTION

These remarks are concerned with linking poverty and torture, and we have evidence from the ground that proves a direct link. Since 1987, the Philippines has prohibited the use of torture. We ratified the United Nations Convention Against Torture in 1986, and codified the Anti-Torture Act into law in

2009. Despite that, there are newly documented cases of torture. There are three organizations that are known to document cases of torture, while the Medical Action Group documents the medical side of it. Specifically, involved in the documentation process are the Task Force Detainees of the Philippines, the Philippine Alliance of Human Rights Advocates (PAHRA), the Alliance of People's Rights, and the Commission on Human Rights.

The number of poor Filipinos is increasing at an alarming rate, particularly in the rural countryside. From 2006 to 2009, there has been an increase in the poverty rate of 4.4% and, consistently, three regions in Mindanao have been declared the three most impoverished provinces. There is a direct link between being poor and being a torture victim. This is our position, together with the Task Force Detainees of the Philippines. To this end, we completed a comparative study wherein we identified Muslim brothers and sisters allegedly tortured in 2005 and 2006, and the rate is increasing despite reforms in our country.

### CASE STUDIES

There are a few particular cases involving alleged torture in the Philippines that I want to discuss this afternoon. The first case: Lenin Salas. Mr. Salas is considered the first torture victim under this administration. At the time of his arrest, he was a 29-year-old college graduate and performing artist. He was arrested with four others and labeled as a Marxist-Leninist group member together with the others. He was blindfolded, detained in the police office for interrogation, and tortured, receiving

\* Maria Natividad P. Hernandez is a registered nurse and Executive Director of the Medical Action Group, based in the Philippines. She has worked with different NGOs that deal with human rights issues and was currently a member of the board of directors of the Philippine Coalition for the International Criminal Court (PCICC) and the Philippine Alliance of Human Rights Advocates (PAHRA). She has attended and is often invited as a resource person to local and international conferences that deal with victims of torture and desaparecidos (disappeared). Her office initiates training for medical practitioners, law enforcers, and human rights defenders regarding medical documentation, monitoring, and investigation of human rights violations in coordination with the Commission on Human Rights of the Philippines, the United Nations Development Program (UNDP), the European Commission, and other leading human rights organization of the world regarding torture and human rights cases. She recently participated as presenter and debater on the Philippine experience during the FIDH Strategy Workshop on Terrorism in Yerevan, Armenia. She also served as an educator on labor issues and concerns before she got fully involved in human rights.



sustained injuries. He was examined a day after his arrest once he was transferred to the provincial jail.

Immediately, amidst harassment from the police, the families filed a *writ of amparo*, which, after two or three meetings, the Court granted. Medical documentation was done by our doctors together with the higher city experts, which is part of the process. Cases are documented by the doctor and the expert from the higher city, and are then filed with the Commission on Human Rights. Unfortunately, this case was dismissed twice due to insufficient evidence. According to the decision of the public prosecutor, the victim could point out the perpetrator, which is of course very interesting considering he was blindfolded. All torture victims are blindfolded! We were, and continue to be, very angry.

The Salas case violates the Anti-Torture Law. While the law states that there should be a decision within sixty days, the Prosecutor issued his own decision roughly 300 days after the incident. The case is now under the Secretary of the Department of Justice, and we wait for the Secretary to review it and issue his decision to the Prosecutor.

The second case: Ronel Cabais. At the time of his arrest, Mr. Cabais was 21 years old, a high school graduate and a welder. He stood accused of being a part of the New People's Army [the armed wing of the Communist Party of the Philippines]. Soldiers took him into an army detachment, where he was tortured. Mr. Cabais was able to identify his perpetrator at one point, when they removed his blindfold. He was then brought to a police station, but he did not receive immediate medical treatment and was documented by government doctors. We documented his case as well. Once again, the Commission on Human Rights

filed a case of torture against the soldiers who arrested him, and the case is pending. He is now under the supervision of NGOs, and just recently finished his testimony in the case.

Alimanan and Samal were both farmers when they were arrested and accused of bombing a rural transport in October 2010. Interestingly, this case was considered under 2009 Anti-Torture Law, the first among many. Though most cases must be filed in court, the Department of Justice panel is charged under the law with deciding whether this is a case of torture. As such, this case was immediately handled by the Department of Justice, the military court, and the Department of National Defense, particularly because it involved a senior police inspector being videoed during the alleged commission of torture. There was significant pressure from the people for a positive result in this case. Unfortunately, the police inspector is now teaching in a police academy. He did not get his time in court.

One final case: Abdul Khan Ajid Balanting is a 30-year-old Muslim and baker in Basilan. This case is interesting because his torture lasted for four days, continuously until the end of the night. There are burns that can prove that he was tortured.

## CONCLUSION

All of these individuals come from a poor family, and all were accused of being members of armed groups. Poverty and torture are interdependent. A majority of those who are victims of torture are amongst the poorest strata of society. And, today we struggle to resist large-scale violence. Torture in the Philippines is widespread because of impunity, and definitely it is very, very hard to address, but we have to address it to have a better life.

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## Remarks of Dr. Pierre Duterte\*

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### INTRODUCTION

Before I start, I want to dedicate this to all of the indigenous people from the Andes who have not been heard. I do feel bad because while we were in Huanta, they heard we were there. They came from down the mountain, women, babies, for the first time to tell someone about their suffering. They came to testify, to use what was for the first time

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\* Pierre Duterte—medical doctor, psychotherapist and family therapist, trainer and supervisor—was born in Tourcoing in 1953. In 1994, he made a commitment as voluntary doctor in a health care center for torture victims and, in 1995, became the director of this center. In 2001, he co-founded the association *Parcours of Young People*, then opened in 2002 the health care center, *Parcours of Exile*, which is dedicated to the treatment of victims of torture and foreign isolated minors. In 1994, he was honored as “Gold MD” for his professional activity and his commitments.



for twenty or thirty years the opportunity to talk with someone about their suffering. And lacking of money, lacking of time, we had to send them back. Today, here, I want to talk for them, I would like to be their voice, and that's why this intervention is for them.

### THE CONTEXT

I've been working for 18 years in full-time practice with the theme of torture and I really believe that this disappearance of relatives is a long-term, full time, never ending torture. I recently wrote an article about disappeared children. If we have a few people speaking French, they can obtain copy of it. For me disappearances are very important because it's something that has been used very much in Latin America. In Argentina, with the military junta, in Paraguay, in Chile by Augusto Pinochet. Paraguay is not as well known as Chile or Argentina, but disappearances have been widely used. Mass graves are still found. Last week they found again another mass grave. Remains of corpses are still discovered. When I went there, they found remains of dead bodies.

In Europe, when I talk about what happened in Peru, I just meet people who think I am a maniac. Most of them know Peru through the gold of the Incas and Machu-Pichu. From 1980-2000, under a so-called democratic regime, the army of Peru did not hesitate to turn to terror, to fight the bloodthirsty guerrilla warfare of the Shining Path. Under three successive elected governments in the so-called democracy, in the silence of most of the Peruvian population and the international community, estimates suggest that the number of Peruvians who have undergone any sort of violence is 75,000 victims. For me, the true number will never be known and will remain always underestimated because of the lack of a Registry Office. The Indians of the Altiplano, caught in the crossfire, were the main victims of this mass murder, mass torture, mass terror. So many Indians in the Andeans have no legal identity. After the condemnation of Alberto Fujimoro for the violations of human rights, it's obvious that the fate of the fragile Peruvian democracy is connected today to the recognition of the rights and the memory of the families of the victims.

### WORK WITH IRCT

Now I would like to thank the IRCT for what I have learned with them. 2011 was a very special year for me. After I started with the *Parcours d'Exil* association, a mission to Rwanda to work with victims, and to start an art therapy workshop, IRCT asked me to go to Cambodia to put my expertise on the Khmer Rouge trial. I'm used to writing reports for the French Courts, but in Cambodia it was for an international purpose. I learned a lot from the manual that IRCT issued, I learned a lot with the team, and I learned a lot from the victims. Then IRCT asked me provide expertise concerning Uzbek victim in Paris. Subsequently, IRCT offered to help us in the mission that I had built up all alone with Rafael Gillén-Barnett a franco-peruvian ethnologist, president of Cuenta Conmigo Perú association and Takiy, a trans cultural institute. The experiences in Cambodia

and in Paris were quite helpful for me in the work I had to do in Peru. This mission in Peru was conducted by *Parcours d'Exil* (Paris-France), together with IRCT (Copenhagen-Denmark), ADEHR (Lima-Peru), Cuenta Conmigo Perú (Nantes-France) and the trans-cultural institute Takiy (Nantes- France) took place from November 15 to December 3, 2011.

### LEGAL ASPECTS OF THE CASE

A penal instruction of the case, Huanta 84, has just been opened by the judge of the first penal court of Lima. This means that this judge will have to take a lot of action and make several travels to complete information missed by the the prosecutor of Ayacucho. The prosecutor will also interview the witnesses. This step might last about six months before the upper prosecutor of Lima handles this case (this transfer can last from 4 to 5 months).

The prosecutor has to proceed to lodge a penal complaint before the national penal court officially opens the trial. It is at this level that it is possible to present psychological expertise. Once the trial begins, the lawyer of the private party associated in the court with the public prosecutor will express the importance of the expertise to determine the damage caused to the victims. Then, the judges fix a date when the expert has to appear at the trial to explain his expertise. The trial will probably begin at the latest in January 2013 and the testimony of the experts will occur in July or August 2013.

### MISSION

The mission took place in Huanta, martyred, unknown city, taken in pliers between the fighters of the Shining Path and the armed forces of the Peruvian state. It was a 12-hour journey by bus to arrive in Huanta. To save money I prefer to ride in a bus rather than plane but now I know never again will I be a miser. It was an oppressive ride up to more than 5,400 meters, which is three miles high in the mountains. After twelve hours of bus driving, then it was a 1.5 hour race in a mad taxi on the verge of deep valleys. Travel sickness plus altitude sickness make this trip unpleasant both ways. Eventually, we arrived to Huanta, where a number of deaths and massacres occurred. There was a balcony where a girl was shot down; there were street corners where a lot of people were killed. I also went to the stadium. It was disturbing to me, and I've been told there are a lot of bodies under the ground. It's very strange.

I met the victims with the translators in a premises lent by an elderly persons home in connection with the association Cuenta Conmigo Perú: In this place we met with old people, alone, victims of the disappearance of their family. It was a place of poor appearance, but had the impression of brotherly wealth, sharing, mutual aid, and generosity. A storekeeper, a policeman, a farmer, and other people told us how they were taken hostage. They never received any healthcare or treatment for their traumas. The interviews were conducted in a hypersensitive atmosphere. It was difficult to conduct expertise in the very place where the totalitarian horror occurred. Thirty years later,

the trauma was still there. Huanta is a seemingly calm city, but the violence is still perceptible.

The interview was conducted in Spanish with a translator for the Spanish-speaking victims. For the Quechua language-speaking victims, it was a bit more difficult because it was not possible to find a Quechua-French translator. So for the first time in my life I had to use two translators, which made it a bit difficult because sometimes I had to rephrase my question to be sure that I understood or I had to ask that they explain some expressions. One thing that seemed to be difficult in the beginning was to have this interview in a *topico*, a small hut, warm, and with a small window. I didn't think it was good enough for these victims; I felt bad receiving them in such a small uncomfortable place. Very quickly I realized that these people were not intimidated by the place. Compared to the room where I interviewed victims in Phnom Penh that was inside a big clean building, in a clean room with naked walls, three chairs and one table, this was not as intimidating. It seemed to me that the victims in Huanta felt they were in a safe place in the *topico*. This was a real lesson for me. It is so difficult to overcome our own standards.

The victims were very eager to talk to someone. For most of them, it was the first time they received therapy. The people I interviewed expressed very clearly: "I feel much better, I was able to talk. You were asking questions no one ever asked and I do feel better. I realized I am not mad, I am not alone. I can express my feelings." One woman even asked the local association manager if she could see me again before I left, which I was not able to do.

The reports have been transmitted to the lawyer of the ADEHR in charge of the files for the trial. As I told you a few minutes ago, probably the trial will begin at the latest in January 2013, and the testimony of the expert will occur in July or August 2013.

### COMPARISON OF WORK IN CAMBODIA AND PERU

I would like to make a quick comparison to my work in Cambodia with victims from the Khmer Rouge period from 1975-1979 because in June and November I had the opportunity to interview survivors. It was amazing to notice that there was no healing of post-traumatic stress disorder. The trauma was so present, so much alive, and no justice had come to allow for healing. I think it's very important to document these cases

because each victim is not able to have his own trial. One lawyer came up to me and said that after talking to me, he realized in a very systemic way, that it's not normal, the experiences of the victims. All the stories are important and telling them has a positive impact.

While they were translating an old woman who was eighty years old, she kept punctuating her story with "it was terrible, it was terrible," and she showed huge distress in her eyes. I had a question about memory and concentration problems since the events happened, but the woman explained that this was not a problem. She said it was quite important to her to benefit from such expertise.

Another woman, a younger one, in response to my questions if it was possible to speak to other people about what happened, explained that she tried in the past, but that people always told her that she should not remember, that her uncle was now her father, and that she should forget about her real father. She added with a lot of emotion that she felt very much alone. She often looked at the picture of her father who had disappeared. I asked whether she can trust justice or have any faith in it, and she said that she has faith in justice because strangers, foreigners, were participating in it. I think that's also very important in a country where a dictatorship is very difficult for people to trust.

### CONCLUSION

I will just try to finish with the role of life and justice. Once again let's talk of these victims. A woman answered that she wants truth—she wants to know if her father is dead, she is not sure. She is always imagining that she could meet him in the street—that she could recognize him. She hopes to see him again. For her, this expertise was a way to begin justice, and she was really expecting that the justice would find the dead body of her father. What surprised me: I've been told that was the first time that she went for expertise. It's true that therapy is not easy to access. But no one has ever been to these people. No one has been taking care of these people. They are not rich. They live very deep in the mountains. But for me, it's really fascinating that no one ever went there. And they really ask if we will go again. I don't know when I will go again, but if I do I'm not sure what will happen. Thank you very much.

### ENDNOTES: Session Two: Concurrent Panels – Cases Involving Marginalized Groups

<sup>1</sup> U.N. Office of the High Comm'r for Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)*, 2004, HR/P/PT/8/Rev.1, available at: <http://www.unhcr.org/refworld/docid/4638aca62.html>.

<sup>2</sup> World Health Organization, *International Classification of Diseases* (1994), available at <http://www.who.int/classifications/icd/en/>.

<sup>3</sup> *Convention for the Protection of Human Rights and Fundamental Freedoms*, Apr. 11, 1950, C.E.T.S. No. 005 (1950).

<sup>4</sup> *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, Dec. 10, 1984, 1465 U.N.T.S. 85 (1984).



## CASES IN THE SO-CALLED WAR ON TERROR

### Remarks of Daniel Carey\*

#### INTRODUCTION

I am a lawyer at Public Interest Lawyers in the UK. I work with Phil Shiner. I'm here to talk about UK forces in Afghanistan. I'll talk about a case that we ran in the UK, but the principles are equally applicable to any of the states that currently have troops on the ground in Afghanistan, whether it's the US or any of the other ISAF (International Security Assistance Force) states. The issue of torture in Afghanistan is a very important one because it is an ongoing conflict and it was one of the first reactions of the international community after 9/11. It's also important because it involves the participation of supposedly advanced western states that have all the means to prevent torture, but their interaction with a country like Afghanistan, which is at the very other end of the scale, and has a problematic history with the use of torture. There are various perpetrators involved in torture in Afghanistan, whether it's the US forces at Baghram Air Base, whether its other ISAF countries like the UK, or whether it's the Afghan security forces themselves. The case that I'm going to talk about is called *Queen In Re: Maya Evans v. Secretary of State for Defence*,<sup>1</sup> which involved the issue of handover of prisoners from UK forces to the Afghan security forces. In particular, I'm going to look at the use that we made of forensic evidence in that case and how useful it was.

#### OVERVIEW OF CASE AND NON-REFOULEMENT IN AFGHANISTAN

Just briefly then, an outline of the case: It is a judicial review case, which is a form of constitutional challenge that we have in the UK by which acts of government can be impugned as

unlawful. It was brought by a public interest claimant called Maya Evans. She's a well-known human rights and peace campaigner in the UK. Because of the fact that the prisoners being handed over couldn't access the UK court, she had standing to bring this challenge effectively on their behalf, and we acted for her in the case. The principal allegation in the case was that UK practice of handing over prisoners to the Afghan Intelligence Services – the Afghan National Directorate of Security (“NDS”) – breached the UK's non-refoulement duties. For those of you that aren't familiar with that, that's the duty first found in the refugee convention and now in all of the major human rights treaties that prevents the handover of detainees to a state where they face a real risk of torture. In the ECtHR context, the test is principally found in the case of *Soering*<sup>2</sup>. The remedy that we were seeking in the case was to stop all prisoner handovers from taking place. The judgment was given in June 2010.

I think it's particularly important to look at non-refoulement in the Afghanistan context because the coalition countries learned the errors that they made in Iraq and they changed their detention policies. In Iraq, the UK and the other coalition partners had their own detention facilities. But that was such a public relations disaster that when it came to Afghanistan, they decided to do things a little differently and let the problem of detention and torture lie primarily with the Afghan authorities. The issue of non-refoulement in Afghanistan is therefore one of the key issues if accountability for the carrying out of torture in the Afghan conflict is to be achieved. There was an extra issue in the case that I should also point out, which is that there was a suspicion that this was not just non-refoulement, but this was in essence UK rendition. Prisoners were being handed over to the Afghan authorities not only so they could be dealt with within the Afghan system, but so that as a result of the torture to which Afghan authorities were subjecting prisoners, intelligence would be gained that would then be fed back to the UK and other coalition partners. So it was a very important case to try to establish—whether these handovers were in fact lawful.

#### FACTS OF CASE

There were 500 prisoners that were transferred by UK forces between 2006 and 2012, and that figure I think has now gone up to 900, so these transfers are continuing even up to today. The way that the UK ran its transfer policy, and indeed how all the other ISAF countries ran their detention policies is to hold prisoners temporarily, perhaps interrogate them during that time, and then transfer them to the Afghan intelligence service (the NDS). They would then monitor how these prisoners were being treated by the NDS, having handed them over. In reality

\* Daniel is a solicitor at Public Interest Lawyers (PIL) in the UK, a practice specialising in public law and human rights cases. In recent years PIL has been at the forefront of efforts to eradicate torture from British military and intelligence services practice. Daniel has worked on a number of notable PIL cases including *Al-Skeini* (ECHR jurisdiction in Iraq); *Al-Saadoon* (the non-refoulement duty in relation to the death penalty in Iraq); and the *Baha Mousa Public Inquiry*. He lead the team on *Evans*, concerning the handing over of prisoners by UK forces in Afghanistan to face torture at the hands of the Afghan intelligence service. He is currently working on the *Al-Sweady Public Inquiry*, an investigation into an incident involving alleged torture and unlawful killing of a large number of Iraqi civilians in Iraq in 2004. In 2009, Daniel received the Peter Duffy Award at the Liberty and Justice Human Rights Awards in the UK for his work on a number of these cases. In 2007 he received the Law Society's New Solicitor of the Year for his work in Guatemala with the NGO Peace Brigades International (PBI). Prior to his work at PIL, Daniel worked at the Louisiana Capital Assistance Center in New Orleans, USA and as a commercial lawyer.

this system was clearly broken. There were massive problems with torture once prisoners had been handed over.

A recent 2011 report from the UN Assistance Mission in Afghanistan (“UNAMA”) confirms that they interviewed a vast number of prisoners in NDS facilities throughout Afghanistan and found that forty-six percent of them complained of torture. So basically one in two people were being tortured. The actual figure is probably much higher when you account for the reluctance of some victims to actually talk about their experiences. The kinds of torture to which prisoners are commonly subjected by the Afghan NDS are hanging from the ceiling, beating with sticks whilst being hung, electrocution, pulling out of fingernails, really terrible stuff.

Disclosure in the case also revealed serious problems with the UK’s monitoring system once the prisoners had been handed over. There was a failure to track those prisoners within the Afghan detention system; prisoners had simply disappeared. The NDS was shown to be hiding prisoners on the roofs of detention facilities when inspectors from the Red Cross actually came to the facilities to see the prisoners. When inspectors from the UK visited, they couldn’t find the prisoners and there was the possibility they were being hidden. There was a complete lack of privacy in the interviews that the UK monitors were carrying out with the prisoners. Habitually, the NDS guards were actually in the room at the time the UK inspectors were asking

the prisoners whether they had been tortured. It was unsurprising under those circumstances that victims of torture were not happy to talk about what was being done to them. That was if a private interview had actually been achieved. In many cases the UK monitors would go to the prisons and interview the prisoners through the cell doors, where all the prisoners could hear the conversation. Clearly again, the prisoners would not be happy to talk in those circumstances. Monitors were being denied access to facilities, visits were extremely irregular, and visits were forewarned so the Afghan authorities knew that the UK inspectors were coming.

Disclosure in the case also revealed a series of serious allegations, known to the UK Government but not disclosed to the public. See for example the following excerpt from the High Court judgment:

Allegations by prisoner G of ill-treatment at Lashkar Gah emerged at a late stage, during a UK visit to Pol-i-Charki [Afghan Prison] on 24 November 2009. He had not been seen on previous visits to the prison. His allegations were that while in detention at NDS Lashkar Gah in July 2007 he had been beaten with steel rods on his back and legs for six consecutive nights, and that this was the only reason why he had made a confession. He claimed to be able to identify the perpetrators.<sup>3</sup>



These kinds of allegations bear a remarkable similarity to those which later appeared in the UNAMA report that I referred to earlier. These kinds of allegations were also clearly echoed by other sources. At the same time that the *Evans* case was proceeding, there was a Canadian case in which for example one prisoner spoke to journalists about his torture and when he said that he'd been whipped with electric cables, he pointed to the chair on which the journalist was sat, and asked him to lift it up, and under the chair were the cables that had been used to torture the prisoner. Despite all of this evidence, the prisoner transfers were continuing. The system was clearly broken. Where allegations such as these were made to UK investigators, the UK would try to discredit them and claim that the allegations were simply not credible.

### USE OF EXPERT EVIDENCE

So the problem we had was, we needed an expert to critique the UK's clearly inadequate monitoring regime, and that's why we turned to the International Rehabilitation Council for Torture Victims ("IRCT") for some expert evidence. Onder Ozkalipci (of the IRCT, now International Committee of the Red Cross) gave a very helpful witness statement in the case, which pointed out all of the flaws in the UK's monitoring process. This was very important context for the court because they really hadn't heard of the Istanbul Protocol, and they needed to know what the minimum standards were. It shifted the emphasis of the case onto a more victim-centered approach, and brought to the front and center of the case the professional standards that the UK should have been following. The statement highlighted several breaches—that investigators should be trained specialists, the overriding importance of private visits, having visits without notice, visits of sufficient duration. He also sounded a note of caution about the UK's attempts to discredit people who had come forward to make allegations, making clear that silence or inconsistencies in account aren't sufficient to undermine a victim's account. It may well stem from their own fear, psychological damage, their lack of trust in who they are talking to, from avoidance behavior, or PTSD. Clearly the UK needed to go much further before they deemed all of these allegations to be false.

The statement also criticized the two medical examinations that the UK had carried out. In those examinations the UK concluded that because a prisoner had no visible scarring, he couldn't have been electrocuted. The expert statement made very clear that electrocution is often used precisely because it leaves no marks.

### CONCLUSION

By the time we finished the case, we'd shown clearly that there was a risk of torture; we'd shown that the allegations were credible; and we'd also shown that the UK's monitoring regime was clearly not up to the task. The inevitable conclusion was therefore that the UK was clearly not complying with its non-refoulement obligations and should cease transferring prisoners to the Afghan authorities. The court did agree with us on all of those questions, save for what the remedy should be. It concluded, firstly, that in the absence of specific safeguards, the scale of torture by the NDS did mean that there was a real risk of torture post-transfer. Secondly, it concluded that the system of UK safeguards was not sufficient to adequately diminish this risk. However, all through the case, the "elephant in the room" had been the consequences of forcing the UK Government to cease prisoner transfers in Afghanistan altogether. Whilst not relevant to the legal issue at the heart of the case, the court nevertheless tried to find a way that it could both conclude that the UK hadn't been living up to its non-refoulement obligations, but also that it could carry on transferring prisoners. The Court's third and final conclusion was therefore to prohibit transfers to the NDS facilities in Kabul, but to allow them to continue in Helmand and Kandahar, but only on the basis of very strict further conditions with which the UK now had to comply: it had to carry out regular private interviews, and it had to impose a moratorium on transfers if any further allegations came to light.

The court referred to the IRCT's witness statement in its judgment, and it's clear that measuring the UK's practice against international standards and showing how short the UK had fallen significantly helped us get over the line in what was ultimately a very helpful judgment. I think the kinds of conditions that the court imposed should be replicated by other ISAF states, including the US, as a matter of urgency. The case is a good example of better practice for other conflict contexts. It is an important application of the Istanbul Protocol in the non-refoulement area, and it's a good example of medico-legal cooperation in litigation to improve policy. Experts can in fact assist in these kinds of cases even when you don't have a victim for a forensic examiner to examine.

However, the job isn't quite finished because as I've said, the UK was still permitted to continue transferring prisoners, and we're likely to head back to court in the near future to try and finish the job in light of a new series of allegations.



## Remarks of Irit Ballas\*

### INTRODUCTION

The Public Committee Against Torture in Israel and other human rights organizations have been dealing with victims of torture and ill-treatment for over twenty years. The subject of forensic documentation has always been part of our strategy. However, many difficulties make it hard for lawyers representing detainees to achieve cooperation with doctors and to obtain medical records that substantiate victims' complaints. I am here to tell you about these difficulties and about the ways we are trying to deal with them.

I will start by giving some background about the peculiar legal status of torture in Israel. Then I will explain the mechanisms created to grant full impunity for interrogators, and I will describe the important role doctors play in this mechanism. Finally, I will discuss the possible solutions we are trying to pursue.

### LEGAL STATUS OF TORTURE IN ISRAEL

In Israel, torture and ill-treatment enjoy a peculiar semi-legal status. This semi-legality is a construct created by a landmark ruling of the High Court of Justice in 1999. After about two decades of public and legal struggles starting in the mid-1980s, the question of the legality of the investigation methods used by the Shin Bet, Israel's secret service, was brought before the High Court of Justice.<sup>4</sup> The court's decision is an important milestone in the efforts to end torture. It affirms the absolute prohibition against torture and explicitly bans the methods of torture which were commonly used at the time. Yet alongside this absolute prohibition, the court ruled that if Shin Bet interrogators employed these means of interrogation in order to save human life, they could, if brought to criminal trial, claim the necessity defense. The court went even further. It authorized the attorney general to publish guidelines as to when interrogators who supposedly acted out of necessity would be exempt from criminal prosecution. This ruling has had far-reaching



consequences. The Attorney General has interpreted this authority very broadly, and his guidelines grant *a priori* permission to use certain interrogation methods. These guidelines became one of the central tools used for proving torture in Israel. The court's ruling is a landmark and indeed affects the way interrogations are held. However, more than a decade later, not only do torture and ill-treatment continue in interrogation rooms, they also continue to receive the full institutional backing of the state.

### IMPUNITY FOR INTERROGATORS

This is not the only obstacle to stopping torture in Israel. Even if we look at the bright side, the achievement of having such a ruling remains incomplete, because there exist several layers of protection that guarantee complete impunity to Shin Bet interrogators. To name but a few, the identity of Shin Bet interrogators is classified, which denies torture victims the chance to cite their interrogators' names in their complaints. Also, the Shin Bet is exempt from created the audio and video documentation required in police interrogations. Furthermore, the handling of complaints of torture and ill-treatment is appalling. Not one of the hundreds of complaints of torture or ill-treatment filed by victims in recent years has led to a criminal investigation. The interrogators can rest safely, assured that even if they do violate the prohibition, no harm will come to them.

### IMPORTANT ROLE OF MEDICAL PROFESSIONALS

Medical professionals who interact with detainees, whether employed by the Israel prison service or part of the civilian hospital staff, comprise one of the most important layers in the system of Shin Bet protection. They are often the only people

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\* Irit Ballas, is head of research at the Public Committee against Torture in Israel (PCATI), and a graduate student at the Hebrew University of Jerusalem's Department of Sociology, the. After completing her studies at the Hebrew University's Faculty of Law, Ms. Ballas did her legal apprenticeship at the Association for Civil Rights in Israel (ACRI). In the course of her work at PCATI, she wrote several of the organization's key reports, i.a. "Accountability Denied: The Absence of Investigation and Punishment of Torture in Israel" (2009) and "Doctoring the Evidence, Abandoning the Victim: The Involvement of Medical Professionals in Torture and Ill-treatment in Israel" (2011). Ms. Ballas was also actively involved in various petitions to the High Court of Justice relating to state violations of human rights in Israel and in the Occupied Territories.

the detainees meet other than their interrogators and prison guards. Their documentation the only real-time evidence available to a detainee about injuries resulting from the interrogation. Unfortunately, our research clearly shows that doctors neglect to do their duty by failing to document and report torture.

Let me give you two examples. M.A. was 22 years old at the time of his arrest. He testified that during his arrest, soldiers cuffed his hands behind his back with plastic handcuffs so firmly that the marks lasted for a week. He was forced to sit in a kneeling position and to rest on his fingertips for hours. A soldier slapped him across the face some ten times, and slammed his head into the bench twenty more. The resulting pain in his eyes was so severe that one month later, while giving his affidavit to our lawyer, he was still unable to read at all. M.A. was subjected to a preliminary medical examination the day after the injuries were inflicted on him. In the column reserved for doctor's commands, it says, "overall, conditions satisfactory; heartbeat regular," followed by a completely illegible sentence. Then, it says, "not in need of treatment at this point." Though there is a note attesting to additional visits to the clinic in the next two weeks, there is no record of the injury until two weeks after the arrest, when the following line appears: "complaints of pain in teeth and eyes." While we do not know for sure if M.A. told the doctors about what happened to him, according to the affidavit, the injury was clearly visible for all to see. The doctors ought certainly to have noticed it, and should have documented, photographed, and reported, even without an explicit request from the detainee. Moreover, three weeks after the arrest, M.A. was referred to an eye doctor by a judge at the hearing on his matter. That was three weeks after he sustained the injuries, yet the judge was convinced of the necessity of treatment. So the same certainly should have been expected of a doctor who saw him closer to the time of the injury, and whose job it is.

Doctors' duties extend far beyond simply recording, describing, and treating injuries. They are also obliged to report any sign of violence. Their obligation is all the more pronounced when it comes to detainees and prisoners. According to the Israeli penal code, they are defined as helpless because their ability to independently complain of any injuries is very limited. Moreover, the patients are in custody and are subjected to the same prison system that employs the doctors, which clearly places an obligation on the system to create effective channels of reporting. However, with the exception of one case, we have not encountered a single case where torture and ill-treatment were reported. This is true even in cases which were documented, even if only partially, removing any doubt that the doctor was aware of any injury having been inflicted.

J.M. was twenty years old at the time of the arrest. His affidavit testifies to a great deal of violence at the time of his arrest. Soldiers broke into his bedroom and began to beat him up, using their guns. One of the soldiers seized his arm so violently that his shoulder was dislocated. J.M. lost consciousness and woke up to find himself in a clinic, at a location unknown. He told the doctors there what had happened to him. In his medical file

under the title "Intake," the detention center doctor noted that J.M. suffered from pain in the right shoulder. Yet there is no documentation of either his having been unconscious, or of his claim of violence by the soldiers.

These two cases are just two examples of the many cases in which doctors do not offer any refuge for interrogees, and do not provide the kind of documentation that can help a detainee if he wishes to take his interrogators to court. What makes matters worse, and makes the doctors' failure even more deplorable, is that Palestinian detainees are usually held incommunicado. Although they are prevented from meeting anyone outside of the interrogation or prison system, including family members, lawyers, Red Cross representatives, or other prisoners. They do, however, get to meet doctors on a regular basis. This makes the role of prison doctors as providers of evidence of an injury a crucial one, as their medical records constitute the sole source of real-time evidence to support any allegations of torture.

## POSSIBLE SOLUTIONS

At the Public Committee Against Torture (PCAT – Israel), we decided on two different courses of action. The first avenue is making prison doctors more aware of their professional and ethical obligations. We want them to remember that the well being of their patients has to be their first priority. One way of doing this is raising public awareness. This was one of the objectives of the report we issued not long ago, in collaboration with Physicians for Human Rights – Israel. The report, called "Doctoring the Evidence: Abandoning the Victim," which describes in detail the issue of doctors' involvement in torture and maps the different ways in which this involvement perpetuates the impunity system. Also, getting media coverage of specific cases helps make the subject the topic of public debate.

A second way of raising awareness is getting the health system in charge of prison doctors more involved in the doctors' conduct. This includes the Israel Prison Service, the Ministry of Health, and the Israeli Medical Association. Many of the issues discussed here are caused by the reluctance of these bodies to get involved and formulate clear guidelines as to when and to whom doctors should report, as well as the obligations regarding torture and ill-treatment. We have extensive correspondence with these bodies and one of our major achievements is that the Ministry of Health has decided to set up a joint committee of the relevant bodies. Doctors will be able to turn to the committee when they discern signs of torture. But even though we received the announcement of the established of the committee over six months ago, we have not seen any signs that it is actually being set up.

A third way is holding doctors personally accountable. We are trying to achieve that by submitting complaint regarding doctors' conduct to various professional authorities. So far, even though these bodies are quick to declare that they do everything they can to prevent torture; we have very little success in convincing them to take action against doctors who take part



in it. Recently, we went so far as to lodge a complaint against a certain doctor to the police. This cause of action is possible because the doctor's omission to document and report are not only unethical, but also illegal. Doctors are obliged to report and document injuries of helpless people, as defined by the penal code. People under custody fall within this category. No official answer from the police has yet been received.

Those are the three different ways in which we act to make doctors more aware of their obligations. A different avenue of action is not aimed at improving the conduct of prison doctors, but rather at replacing it. That is using independent external doctors to give medical opinions that can be used in court. In Israel, this is a very difficult endeavor, though not impossible. First, as mentioned, most Palestinian detainees are held incommunicado during the time of the interrogation. When they are finally permitted to meet a lawyer, we visit them and hear their story ex post facto. At this point in time, an independent outside doctor is allowed to see them, but after so much time has passed, it is difficult to observe any trace of injury. This doesn't mean that there is no point visiting them when the interrogation is over, it means that we really can't do without the evidence provided by the prison doctors. Second, there is a lack of doctors—let alone doctors with forensic training—who are willing to visit detainees, an act which is considered extremely controversial in the Israeli-Palestinian political climate. In order to change the situation, we are trying to train those who are willing to take this

role on themselves, from a large pool of professionals we can recruit for these purposes. In collaboration with IRCT, we are in the process of setting up a workshop for training physicians. An additional benefit for such training is the potential effect not only of the possibility of visiting Palestinian detainees and collecting evidence, but also raising awareness within the medical community.

## CONCLUSION

What follows from everything described here leads to the conclusion that we still have a long way to go to ensure proper medical documentation that can serve as evidence in litigation. It is impossible to exaggerate the importance of such evidence. In the Israeli context, prison doctors are the only people who have access to detainees at the time of interrogation, and could play an important role in ending impunity. Unfortunately, doctors who come across detainees show time and time again that they are part of the interrogation mechanism, rather than taking a clear stand against any violence inflicted upon their patient. I wish I could have presented a success story, but that is a story yet to be written. We at PCAT-I are constantly trying to find new opportunities for action, but this is not unusual in our line of work. Change has been slow and difficult to achieve. However, there are some recent improvements that make me optimistic that, in the not too distant future, doctors will be better partners for this cause.

## ENDNOTES: Session Two: Concurrent Panels – Cases in the So-Called War on Terror

<sup>1</sup> [2010] EWHC 1445 (Admin).

<sup>2</sup> *Soering v United Kingdom* (1989) 11 EHRR 439

<sup>3</sup> *Id.* at para. 219.

<sup>4</sup> Supreme Court of Israel, *Judgment Concerning the Legality of the General Security Service's Interrogation*, 38 I.L.M. 1471 (Israel, 1999).

## CASES RELATED TO POLITICAL ENGAGEMENT

### Remarks of Dr. Ala'a Shehabi\*

#### BACKGROUND

The use of torture has been systematically practised in Bahrain for decades. This was noted in 1997 by several reports by the UN Special Rapporteur on Torture, and in 2010 by Human Rights Watch.<sup>1</sup> In 2002, Royal Decree 56 was passed by the King of Bahrain granting amnesty to all state security officers who may have committed human rights abuses prior to 2001. On this basis, the Bahrain Public prosecutor refused to accept any complaints of torture lodged against security officials and no individuals had been charged or tried by the state, despite pleas by international human rights groups. Most of the officers concerned have remained in post and some promoted to senior government positions.

More recently, the use of torture returned on an unprecedented scale in the state's campaign to suppress the political uprising that began on February 14, 2011 as part of the regional upheavals in the so-called "Arab Spring." The Government of Bahrain (GoB) responded brutally with a crackdown that led to the arrest of thousands of people. Around 500 prisoners of conscience remain, and the death toll that has reached 76 according to the Bahrain Centre for Human Rights. The Bahrain Independent Commission of Inquiry (BICI) established in 2011 to investigate human rights violations found that approximately 3000 people were arrested within a three-month period alone. It also established that the police used excessive force against protesters and a systematic practice of torture:

*There was a systematic pattern of torture [...] The security services of the GoB resorted to the use of unnecessary and excessive force, terror-inspiring behaviour and unnecessary damage to property. The fact that a systematic pattern of behaviour existed indicates that this is how these security forces were trained and were expected to behave.<sup>2</sup>*

The report goes on to say that, "the extent of this physical and psychological mistreatment is evidence of a deliberate practice, which in some cases was aimed at extracting confessions and statements by duress, while in other cases was intended for the purpose of retribution and punishment."<sup>3</sup>

As part of the retribution and punishment, approximately 4500 people were sacked from their jobs as well. The BICI relied on forensic evidence. It brought a forensic medical team that examined 59 out



of 559 complaints of torture that it received. Local NGOs however, have documented approximately 1800 complaints of torture.

The most common techniques of torture documented were enforced standing for prolonged periods; beating; punching; hitting the detainee with rubber hoses (including on the soles of the feet), cables, whips, metal, wooden planks or other objects; electrocution; sleep-deprivation; exposure to extreme temperatures; verbal abuse; threats of rape; and insulting the detainee's religious sect. BICI blamed a culture of impunity: "the lack of accountability of officials within the security system in Bahrain has led to a culture of impunity, whereby security officials have few incentives to avoid mistreatment of prisoners or to take action to prevent mistreatment by other officials." BICI urged the government to conduct investigations and to prosecute implicated individuals both direct and at all levels of responsibility. The Ministry of Interior claimed that it opened investigations into cases of alleged torture; however, less than a handful of officers have been prosecuted, and none have been convicted. These low-level officers are viewed as scapegoats despite evidence of superior responsibility reaching the ministerial level if not higher. These officers are mostly being prosecuted on misdemeanor charges (such as accidental death, or grievous bodily harm) that amount to less than the crime of torture as outlined in the penal code only & face minimal punishment even if convicted.

#### CURRENT SITUATION

The situation at the time of writing continues to worsen, as torture is yet to be eradicated and security forces continue to act with impunity. To avert accountability, torture is now taking place mostly

\* Dr. Ala'a Shehabi is a lecturer, writer, and a civil rights activist in Bahrain with a Ph.D. in economics from Imperial College London. She has authored several human rights reports for local NGOs, and policy reports for international think tanks. Shehabi co-founded the Bahrain Rehabilitation and Anti-Violence Organisation (BRAVO), and Bahrain Watch, a transparency and anti-corruption NGO. Her husband was a victim of torture in Bahrain.

upon arrest, in the street, in police cars, or in secret detention centers to avoid monitored police centers and prisons. However, torture at the National Security Agency continues during interrogation in cases to do with political crimes. This is one of the detention centers to which BICI was not given access. In addition, there has been no initiative to offer rehabilitation and redress for the hundreds of torture victims. The justice system is also complicit in condoning torture and sustaining the system of torture. Judges refuse to listen to defendant's direct testimony of torture in court, let alone order investigations into alleged torture. In the rare cases where a judge approves a medical examination of the defendant, a forensic doctor employed by the Ministry of Interior is used, and who rarely corroborates any evidence of torture. Judges still rely on forced confessions as evidence against defendants. Accountability therefore remains an aspiration.

### ROLE OF THE IRCT

The IRCT recently supported the autopsy of a young man, Yousif Muwali, who went missing for several days. The police claimed that the missing man was found dead in the sea. The family was adamant that he was arrested based on witness accounts. The GoB rejected the family's request for an independent medical examination. The doctor found physical evidence of electrocution most likely obtained through torture. Yousif Muwali was particularly vulnerable due to the mental illness he suffered from. The doctor also documented two other cases of torture using the Istanbul Protocol. The GoB claims that all torture in Bahrain ended in 2011; however, this strong evidence suggests otherwise, as human rights activists have been claiming all along, with three deaths in January 2012 alone.

### CHALLENGES IN ERADICATING TORTURE

The biggest challenges to solving problem of torture thus far have been primarily the State's denial of the practice of torture, impunity for torturers, and an environment of fear and persecution. Additionally, State control of forensic medicine makes it impossible to practice independent forensic medicine. There is restricted access to health care for political activists in detention and wounded protestors. There is a lack of legislative and institutional structures to prevent torture. There has been targeting of doctors who treat protestors.<sup>4</sup> A lack of resources results in a limited number of dedicated specialists, particularly doctors and lawyers. There is strong community but weak civil society institutions.

### BAHRAIN'S FIRST REHABILITATION CENTER

The Bahrain Rehabilitation and Anti-Violence Organisation (BRAVO) was established in January 2012 by lawyers, doctors, and activists. It aims to offer physical and psychological rehabilitation services to torture survivors, counter impunity for perpetrators and promote justice for survivors, raise awareness of torture among policy-makers and citizens. The biggest hurdles facing BRAVO are as follows: Obtaining authorization to operate as an NGO amidst restrictive association laws and state control of civil society; knowledge, training, and capacity-building; obtaining a license to operate a clinic that allow doctors to practice forensic medicine and deliver rehabilitation services; resources and funding; and long-term sustainability.

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## Remarks of Felicitas Treue\*

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### INTRODUCTION

Torture continues to be practiced systematically in Mexico, in spite of the fact that the state has signed and ratified all relevant conventions. In our work we can distinguish two main scenarios of torture: (1) Torture related to political



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\* Felicitas Treue is a Psychologist, Psychotherapist, and General Coordinator of the *Colectivo Contra la Tortura y la Impunidad – CCTI* (Collective Against Torture and Impunity), Mexico. She has a masters degree in Psychology from the University Johann Wolfgang Goethe in Frankfurt, Germany with a specialization in cognitive behavioral therapy. Since 1998, she has worked in the rehabilitation of torture survivors (psychotherapy, counselling, psychosocial support), training for health and legal professionals, and documentation of torture. She participated in the implementation process of the Istanbul Protocol (IP) in Mexico since 2000, co-authored the national adaptation for Mexico, and was a trainer in the first international seminar about the IP in Mexico. She has also been a trainer for the Istanbul Protocol in national/international seminars in Mexico, Chile, Ecuador, Peru, and for the Inter-American Commission on Human Rights.

activism; and (2) Torture related to criminal investigations and the so-called war against organized crime.

In order to understand the phenomena of torture related to political activism in Mexico, it is necessary to give some general information about the political and human rights context in the country. I am going to mention some elements that seem important to me.

### GENERALIZED VIOLENCE AND FIGHT AGAINST ORGANIZED CRIME IN MEXICO

Since 2006, when President Calderon declared the “war against drug trafficking,” there has been a dramatic increase of violence in Mexico, with over 50,000 killings in the past five years, that include members of organized crime but also an unknown number of persons that have nothing to do with this.

Within his strategy of national security, the president has increased the military budget 44% since 2006, and has been using the armed forces to take over duties of public security, with more than 50,000 soldiers taking part in big operations against the cartels all over the country. Within their mandate, they can realize detentions, search houses, investigate, and interrogate, functions that should be carried out by the police forces. After all these years it has become more than clear that these policies have not reduced but increased the violence and the authorities are far from having disarticulated the cartels.

The security forces have incurred a growing number of gross human rights violations, including arbitrary detentions, torture, forced disappearances, extrajudicial executions, committed by state and federal police, the military and the Marines. During the first three years of the Calderon administration, the National Human Rights Commission registered an increase of 1000% in the number of complaints against members of the armed forces (up to June 2011 it had received more than 4772 complaints), including torture, arbitrary detention, sexual abuse, and forced disappearances. Yet we know that this is only the tip of the iceberg because many victims are afraid to denounce. This militarization of the whole country has been used, especially in the regions with strong presence of social movements and community organizations that defend their territories, to control and intimidate the population and repress the movements. Still, more and more critical voices can be heard that demand an end to this failed strategy and investigations of the crimes committed by the security forces against the population.

### POVERTY AND MARGINALIZED GROUPS

Mexico is a very unequal country. Recently for the third time the country was classified by the Organization for Cooperation and Economic Development (OECD) between the nations with major inequality in salaries and distribution of wealth. In this oil-producing country rich in natural resources, biodiversity, water, number 14 of the world economies, 46.2% of the population live under the poverty line, 10.4% in extreme poverty, 21.7% with difficulties in access to alimentation. (At the same

time, the richest man in the world, Carlos Slim, owner of telecommunication systems comes from Mexico, his fortune is estimated at \$69 billion USD.)

Poverty is extreme in the southern states (Chiapas, Guerrero, Oaxaca, Veracruz) with a high percentage of indigenous and rural populations. Although these states are rich in natural resources, the population is highly marginalized, without access to basic services of health and education.

### CONFLICTS RELATED TO NATURAL RESOURCES

In many regions, we can see conflicts about the exploitation of natural resources, like water, wood, biodiversity, mining. The government has been more than willing to give concessions to international firms without consulting the population or against their will. For example: since 2000, the Mexican government has given concessions to mining companies that cover more than 25% of Mexican territory. There are several big hydro-electrical projects in Guerrero, Oaxaca, Jalisco. These projects destroy the livelihoods for people, forcing them to migrate, leave their lands and join the big group of cheap labor. There has been strong opposition against many of the projects, nevertheless government has not shown willingness to resolve the conflicts and has chosen to use repression as a means of resolving the conflicts. In this political-economical-social context, torture is used by the Mexican State as one instrument in a strategy of repression and criminalization of social protest. Torture is used selectively against leaders of union, student, peasant organizations in order to break their will, their convictions and their capacity to organize, to motivate others and continue defending fundamental rights of the population.

### CASE EXAMPLE: MARCELINO COACHE

Marcelino Coache is a social activist and union leader from Oaxaca since the 1980s. In 2006, he participated in the union movement that demanded the destitution of the governor and became the spokesperson of the Popular Assembly of the Oaxaca People and member of the negotiation committee with the Oaxaca government.

In November 2006, there was a violent repression against the teachers' union movement that had installed a permanent protest camp in the Main Plaza: 502 arrests, 141 persons were illegally transferred to federal prisons in the north of Mexico, many were tortured after detention and during transport to prison. Marcelino was arrested a few days later in Mexico City, accused of rebellion, sedition, criminal association) and tortured for the first time. In May 2007, he had to be released free of all charges. During all this time, his family received threats and harassment.

From 2008 onwards, the aggressions against Marcelino increased again. He was attacked and injured, documents were stolen from his car; he and his son received direct threats. In March 2009, he was arrested by unidentified police officers (Oaxaca State Police), blindfolded, taken to a car and brought to a secret detention place (casa de seguridad). There, he was



stripped naked, beaten, suffocated with a bag over his head, threats were made against his family, he was put into a forced position with a rope tying together his mouth and his arms, burnt with cigarettes (breast, testicles, pubis). After some hours, he was taken to an unknown place where the aggressors performed a mock execution and then left him there. Finally, he managed to get to a hospital where he was examined; they took X-rays and then sent him home.

Despite the medical reports from the hospital and several private practitioners that attended to Marcelino during the following weeks, and despite his very obvious altered emotional state, the official expert reports found no evidence of torture. In 2011, our organization practiced an independent exam and still found physical evidence as well as psychological effects (post-traumatic stress syndrome, depression, and a high level of anxiety). Now his defense has asked for a third expert opinion and suggested two internationally recognized experts. Nevertheless, the Prosecutor did not accept them, ironically using the argument that they were not impartial as they belonged to the IRCT expert group and our center belonged to the IRCT network.

Torture is also used indiscriminately against groups of populations in regions with strong rooted community movements. Its aim is to intimidate people, paralyze them, to create mistrust and fear in the community. Torture is also used as a punishment and intimidation against persons who participate in demonstrations and other actions of inconformity. In this context, torture is used in a very demonstrative way. Its intention is to let everybody see what can happen if people get involved and show their opposition, creating fear and paralysis in society as a whole.

#### CASE EXAMPLE: BARBARA ITALIA MENDEZ

Barbara Italia Mendez was arrested May 4, 2006 in the village of San Salvador Atenco, in a massive police operation after clashes between demonstrators and police the day before. In the early morning, police forces stormed the village, arresting very violently and indiscriminately more than 200 people.

Italia was severely beaten on the head and body during detention, her eyes were covered, and she was brought to a bus with other 50 or 60 detainees. Many persons, including those severely injured were piled up in the aisle between the seats, there were up to four on top of the others with the police officers beating everybody who would complain or ask for help. Italia was taken to one of the seats. During the five to six hours transport to jail, she was repeatedly beaten and received death threats against herself and her family. She was violated by several police officers who inserted their fingers and objects into her vagina, touched, punched and bit her breasts and kissed her by force, introducing their tongue in her mouth. Italia also witnessed the sexual aggressions against other women. In jail there were no proper medical exams, and she was refused adequate medical assistance. She was released from prison two weeks later, but had to go through a legal process during the next two years until she was finally declared innocent. Together with

ten other women who were sexually tortured, she decided to file a claim against the perpetrators, in her case we have two positive Istanbul Protocol exams but the process is not advancing. Just recently the case was admitted by the Inter-American Commission on Human Rights.

The aim of torture is not only to break the individual, it seeks to damage or destroy the social network, the family, the organization, and to manipulate the society as a whole. Combined with impunity for the perpetrators it is a strategy used by the states to protect themselves from the so-called threats to stability and national security and control social unrest—in Mexico but also in many other states.

#### ISTANBUL PROTOCOL IN MEXICO

In Mexico, the application of the Istanbul Protocol has become obligatory in all cases where a person alleges having been tortured. The General Prosecutor emitted an agreement in 2003 that obliges all State Prosecutors to include this medical psychological exam in their investigations. This regulation was first established on the federal level with the plan to promote it also on the state level and up to now half of the Mexican states fourteen have followed. On the other hand, medical exams are obligatory for every detainee before and after interrogation and at arrival at a state or federal prison.

The problem here is that the forensic doctors, psychiatrists, and psychologists who are in charge of carrying out the Istanbul Protocol exam are employed and belong to the Attorney General's office, just like the police agents who allegedly tortured them. So the perpetrators, the investigative body and the medical personnel in charge of documenting torture all belong to the same institution. This complete lack of independence is a structural problem that is one of the major obstacles for torture investigation. Mexico was the first country to institutionalize the Istanbul Protocol, but after 8 years we consider that this way of implementing it has contributed to consolidate impunity in Mexico.

In all the torture cases we have documented, there is only one case, the case of Barbara Italia, where the official expert report based on the Istanbul Protocol concluded there was evidence of torture. This context brings about a very difficult situation for the victim and a high risk of retraumatization as he/she will be examined by an official expert (or maybe two—a doctor and a psychologist), then by an independent expert and finally—as there will be contradictions in most cases—the Judge will name a third expert who will have the final verdict. So in general, the victim will go through at least three Istanbul Protocol examinations, and apart from all the other difficulties of maintaining a legal process against the perpetrators, this is an unbearable situation for many survivors.

Nevertheless, being convinced that the adequate and professional documentation of torture and the use of the Istanbul Protocol is an indispensable factor in the fight against impunity,



there is a need to rethink the implementation of the Protocol in Mexico, and to press the State to recognize and respect the principle of independence. The international bodies and mechanisms play a crucial role in this process, and we hope that our

experiences as well as the experience accumulated in other countries can help to find the best proposals of how to implement the Istanbul Protocol and how to sharpen international recommendations in that sense.

## Remarks of Dr. Frances Lovemore\*

### BACKGROUND

Zimbabwe's independent years have been turbulent and fraught with power retention struggles by the ruling party, Zimbabwe African National Union – Patriotic Front (ZANU PF), who have used intimidation and terror systematically against all forms of opposition.

Zimbabwe inherited an Eastern European and communist type government structure where power was and is protected by fear, rule by law, detention and disappearances, torture and extra-judicial executions, and where investigation and durable evidence of these activities carries inherent risk to health and legal professionals and relatives.

During the 31 years ZANU PF has been in power, there has also been remarkable development in issues of prohibition of torture and in the role of human rights in the development and promotion of democracy and economic empowerment.

The rapid development of information technology and the ability to disseminate information has had an overall positive impact on accelerating the reform processes of government in Zimbabwe, but with high humanitarian and human rights costs, often difficult to document and quantify. The control of information by the ruling party, as seen in the eighties and nineties was no longer possible with the introduction of satellite media and the internet, allowing alternate perspectives on news and easier access to rapid information flow. However, access to information, broadcast of the truth and holding information about abuse of power remains dangerous in Zimbabwe and many people have encountered the wrath of both the law and the state terror mechanisms as a consequence of their legitimate activities.

*\* Dr. Frances Lovemore is the Medical Director of Counselling Services Unit, an organization providing medical, psychological, and rehabilitative services to victims of organised violence and torture throughout Zimbabwe through a network of medical services providers. CSU also prepares medical and legal affidavits for all victims, and submits narratives and affidavits to relevant domestic, regional and international mechanisms as requested by the victims. CSU has collaborative activities with local and regional legal organisations around both individual cases and matters of systematic torture, and appropriate litigation and investigative mechanisms to eliminate impunity. Dr. Lovemore has worked with victims of organised violence and torture for 12 years.*



With the development of more visible resistance to the ruling party and opposition political parties with substantial support, the state security mechanisms have been used extensively to retain power.

The past 11 years in Zimbabwe have required the development of robust systems of capture, protection and analysis of forensic evidence of human rights abuses. This presentation will explore the development of these processes, and seek to identify key lessons learned and promote discussion on the promotion of systematic training and support for all health and legal professionals. It will also explore the increasing acceptance of statistical evidence for systematic abuse and crimes against humanity.

### DEVELOPMENT OF FORENSIC EVIDENCE ANALYSIS IN ZIMBABWE

The provision of medical and legal services for victims has formed the cornerstone of collection of evidence of human rights abuses. Without access to dedicated services for treatment and legal redress for victims, much of the targeted violence and intimidation would have remained as hearsay and estimation.

The provision of these services has not been without challenge, and has required ingenuity, flexibility and courage on

the part of the service providers, who frequently are threatened, and are often reluctant to provide the forensic documentation required for legal services.

Training and awareness has over the years, improved the quality of evidence and assisted to create confidence that the evidence decreases impunity and assists in the prevention of further violence. The development of the use of the Istanbul Protocol<sup>5</sup> by health professionals working with victims of torture has created standards of treatment and documentation that are more easily quantified and qualified, laying the ground for development of relational data capture and analysis. This in turn has been an effective tool to analyse the direct causes and nature of the violence.

The development and protection of trust for the clients accessing services has also formed a critical pillar of the ability to accurately record the evidence of state abuse, and part of this trust had to be restored after inappropriate use of data for advocacy. The development of a secure and appropriately targeted advocacy strategy is a critical part of the long-term strategy around impunity.

Protection issues around data and data storage, and the development of a secure and stable relational database have formed a

core part of the work. The concurrent international acceptance of statistical analysis and proof of systematisation of human rights abuses by state and state security mechanisms has added confidence to the pursuit of this track of the work.

Political climate contributes significantly to activities that can be undertaken, and many of the bigger impunity issues within the country can only be effectively addressed once the legal framework for recognition of systematic targeted abuse by the current regime is created and enacted, and then used appropriately.

## CONCLUSION

The development of international instruments and conventions has greatly assisted the country to highlight the plight of human rights within the country, and the role of the state, and has created increasing difficulty for the security forces to easily continue with their agenda of oppression and violence to remain in power.

Over the next five years it is possible that the careful continued documentation and utilisation of legal instruments may start to produce the ultimate result for the country; that is the elimination of impunity for human rights abuses.

## ENDNOTES: Session Two: Concurrent Panels – Cases Related to Political Engagement

<sup>1</sup> Human Rights Watch, *Torture Redux: The Revival of Physical Coercion during Interrogations in Bahrain* (2010).

<sup>2</sup> *Report of the Bahrain Independent Commission of Inquiry*, 405 (Nov. 3, 2011).

<sup>3</sup> *Id.* at 406.

<sup>4</sup> Physicians for Human Rights, *Do No Harm: A Call for Bahrain to End Systematic Attacks on Doctors and Patients* (Apr. 2011); Human

Rights Watch, *Targets of Retribution, Attacks against Medics, Injured Protesters, and Health Facilities* (Jul. 2011).

<sup>5</sup> U.N. Office of the High Comm'r for Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)*, 2004, HR/P/PT/8/Rev.1, available at: <http://www.unhcr.org/refworld/docid/4638aca62.html>.

## EXAMPLES IN THE INTER-AMERICAN SYSTEM

### Remarks of Rafael Garrido Álvarez\*

#### INTRODUCTION

I want to excuse myself for not giving this presentation in English, but I hope that you will get the dimension of the problem that I am going to present to you. My presentation is going to be divided into two parts: the first part will explain how we conduct camp work, and the second will be on specific cases that we deal with.

#### THE WORK OF *RED DE APOYO POR LA JUSTICIA Y LA PAZ*

First, I want to explain that our organization is *Red de Apoyo por la Justicia y la Paz* (Support Network for Justice and Peace), and we are an NGO based in Venezuela. We work cases with victims of police and military abuse, cases related to violations of the right to life and personal security, and also to the integrity of the person. We deal with cases in which human rights are being violated. We label our model an “integral model” because suffering for human rights violations extend to the totality of the cultural or political abuses. It is suffering in general. This integral approach allows us to deal with victims of human rights violations on all levels of their personal, family and social life.

In dealing with cases that we treat, we have specialized teams of people that have a multi- and inter-disciplinary background. In this work, we go to assist victims, and primarily we start with medical assistance in case it is needed. In cases in which victims suffer damages to their person, or their rights have been violated, we can better deal with it. When we are providing medical attention, we primarily try to alleviate the trauma or physical damages that arise.

In this case, as we begin with medical assistance, we also are trying to document the ways in which these violations have been

produced, to further deal with problems caused by the violations and assist with the legal process moving forward. Also, we do psychological assistance, in which we first try to identify the emotional effects. Then, we proceed to document these problems and proceed to therapy where needed. This is the same as with medical assistance. Psychological assistance means to begin to identify the particular problems the victim presents, and then as we proceed to assist the person, we are also documenting the psychological effects. One of these methods that we use in dealing with the psychological problems is, in the first case, to detect the suffering. We determine the emotional and psychological effects, so that we can assist them with therapy as needed.

We do have legal assistance, so that we may seek justice and a remedy for the victims. In terms of the legal problems that we face, we work on the level of investigation and documentation—filing reports—as well as litigation before the courts. From this legal perspective, we can clearly see the inter-relationship of these various levels; that is, in litigating the case, we are also addressing the need of the victim to heal.

The other part of our model includes social assistance and pedagogical assistance. One of the things that we identify in instances of violations is that in consequence, people can lose jobs and can be isolated from the community or displaced by way of the community. On this level of social assistance, the other component is to educate people and to raise awareness of human rights and social and political rights.

Even though it looks like I am presenting different points for different stages, we emphasize the need to understand this process as interrelated, so that a lawyer who is interviewing a victim can immediately identify whether this person is presenting psychological or other type of needs. Once I have explained how we conceive this process as an interrelated process, I am going to advance and present the case of José Francisco Matheus.

#### THE CASE OF JOSÉ FRANCISCO MATHEUS

José Francisco Matheus suffered torture in the year 2000. He was arrested at home in his house in Maracaibo, Venezuela and was taken away in front of family members by the police without any legal order or arrest warrant. As the policemen didn't have handcuffs, they used rope to tie him up for transport in a most undignified manner. The excuse given by the authorities in this case was that he was being investigated in connection with a kidnapping case. Then he was transported to several points along the route in the city of Maracaibo, and as this continued

\* Rafael Garrido Álvarez (Venezuela) obtained his law degree (with honors) from the University of Margarita in 2006. He participated in the Inter-American Human Rights Moot Court Competition at American University in 2005, coached the team in 2006, and was the academic coordinator of the University of Margarita's Human Rights Center between 2005 and 2008. He earned a scholarship from the Andean Human Rights Program of the Universidad Andina Simón Bolívar for the Master of Human Rights and Democracy in Latin America, and obtained his degree in 2009. He also worked as a teacher in the Andrés Bello Catholic University, teaching international human rights systems in the Advanced Studies in Human Rights Program. He currently works as a lawyer in the NGO Red de Apoyo por la Justicia y la Paz, providing legal support to victims of human rights violations.

he realized he was being taken outside of the city. The interrogation process was not carried out in a police structure or official installation, but in a rural place far away from the city. Among the other things he suffered, he was burned several times with cigarette butts and hanged by the arms. He was also hooded several times, which prevented his breathing, and he received electric shocks to parts of his body including his testicles, and hooded policemen discharged firearms near his head in order to intimidate him. Constantly throughout this process he was being asked, “Where is ‘la china’ [the Chinese woman]?” which apparently was someone sought by the authorities.

After several days of this torture, he was transported to a detention center called El Marite, where he would spend the next eleven days. As he was detained in that place, he realized he was totally incapacitated due to the damage applied to his arms; he was unable to wash himself and totally incapable of taking care of himself. The detention place itself could constitute a violation of human rights; it was a humid, cold, dark place and was not conducive to any of the treatment that he needed. Shortly after his liberation, Matheus did an exposé of what happened to him and came to the *Red de Apoyo por la Justicia y la Paz* (Support Network for Justice and Peace). The office of the District Attorney took two years to investigate the case, and ultimately identified those responsible and presented an accusation. Later on, we can speak of impunity. It was not until preliminary hearing in the year 2004 that the magistrate determined that the police officials responsible for this should be tried. Up until today, the police officials who committed these crimes have not been tried. During all this time, not only the victim, but also the support network, have been seeking justice without any response. In 2009, Matheus and the *Red de Apoyo por la Justicia y la Paz* (Support Network for Justice and Peace) presented a recourse demanding that the responsible officials be brought to trial. Though this habeas corpus was granted, these officials have not been brought to trial.

Six months later, the victim and the support network decided to file a petition to the Inter-American Commission for Human Rights (IACHR) claiming that there had been unwarranted delay in rendering a final judgment, preventing the exhaustion of remedies. Since 2009, when the report was presented to Inter-American Commission for Human Rights, there has not been any communications regarding whether the case is admissible. We simultaneously maintain this case before the Venezuelan courts, claiming loss of justice. Last year, a group of forensic experts, part of a group called FEAT, were in Venezuela doing a report on Matheus. One of those experts is with us today,

Felicitas Treue, and is in charge of doing the psychological profile of Matheus and other victims.

In 2011, a judge in Venezuela dismissed the case, alleging that the statute of limitations had expired and those responsible could not be tried. The prosecutor appealed the case, and is trying to determine if the case is being dismissed without prejudice or whether it could be reopened. Whatever the outcome, the Venezuelan constitution sets no time limit for violations of human rights, so the case can still be prosecuted. One of the problems that we have had in this case and many others that occur in Venezuela is that lack of legislation that typifies torture. We are continuing to advocate in Venezuela for the passing of a law against torture, so we can have in Venezuela a system through which crimes like torture can be dealt with. And to finish with my last point, I want to talk about the benefits of our participation and collaboration with the FEAT project and how we are implementing in Venezuela.

Next to the training we received from the International Rehabilitation Council for Torture Victims (IRCT), we have better conditions to deal with these cases in Venezuela. We now understand that the best way of reinforcing our practices is through the use of the Istanbul Protocol.<sup>1</sup> And we also saw in this process the beneficial effects that this had in the victims, as other experts from other parts were taking interest in the cases. Jose Matthews and Manuel Mijares took renewed interest and hope that different people in other parts of the world were taking interest in the cases. They felt deeply that after their relation, once they felt all the avenues had been exhausted, there were renewed possibilities for the cases, renewed hope.

Because of the status of the cases in Venezuela, we can probably not use the report that was produced based on the victims, but we will use it at the IACHR. As soon as the Inter-American Commission for Human Rights determines the admissibility of the case we would immediately present the case and the report of José Francisco Matheus. We are very hopeful that once we present this case, we can set the precedent that we can also show at the Inter-American level that these cases can be brought to justice. I want to close with the other case, that of Manuel Mijares. In that case, the responsible officials were exonerated. And we were unable to obtain any kind of justice for the victim. That case was also presented to the Inter-American Commission for Human Rights, but today we have not had any acknowledgement of receipt. These are two cases that show clearly the presence of impunity: one the lack of process, and the other, absolution of those responsible. Thank you very much.



## Remarks of Silvia Serrano Guzmán\*

### INTRODUCTION

Thank you. I am going to make my presentation in two parts. First, I am going to present the legal framework in which forensic evidence is considered by the Inter-American Commission on Human Rights. Second, some important developments and difficulties resulting from recent cases with emphasis on the *Cabrera and Montiel* case against Mexico. Regarding analytical considerations in cases of torture, I want to mention the main objectives of evidence-gathering. These objectives are: (1) mainly to prove that torture actually occurred and (2) to define proper and adequate reparations in the specific case. I will focus this presentation on the first point since given the difficulties and challenges we face in cases with forensic expert evidence, but maybe in discussion we can open it up to the second point as well.

### LEGAL FRAMEWORK

The first legal aspect I want to mention is, standards of proof that the Court has defined in cases of torture. And there are two different standards I consider relevant in this context. First, when the Commission and the Court find evidence of a specific pattern of violation in a specific country over a specific timeframe by specific authorities, the analysis of medical or forensic evidence may be complementary. For example, in the Peruvian cases, the Commission relies significantly on the Truth Commission reports, which state that the Direction Against Terrorism [Peruvian National Police] used torture consistently over a period. In those cases, specific medical evidence of torture might be relevant, but not strictly necessary. In these cases, if a person's declaration is in line with the findings of the Commission, and there is other circumstantial evidence, it may be sufficient for the Commission to conclude that there was torture.

There is another standard of proof regarding persons under state custody. The Commission and the Court have consistently held that the State must present a satisfactory explanation for any harm to a person in state custody. That satisfactory explanation should be the result of an independent and serious investigation. If no explanation is given, the State can be held responsible



for that harm. It is the burden of the State to present such evidence to refute the presumption of torture. Consequently, in these cases the specific medical, physical evidence may be complementary to this analysis. Aside from these two types of cases, I want to mention some of the important developments and challenges from the lawyer's perspective dealing with these cases.

### CASES IN THE INTER-AMERICAN SYSTEM

Developments regarding the Istanbul Protocol<sup>2</sup> stem from the case of *Gutierrez-Soler v. Colombia*.<sup>3</sup> The first time the Court mentioned the Istanbul Protocol was regarding reparations in the specific case. In this case, the Court said investigations that might be conducted by the State after the judgment should take into account the Istanbul Protocol. Also, in the cases of *Fernandez Ortega v. Mexico*<sup>4</sup> and *Rosendo Cantú v. Mexico*<sup>5</sup> (these are the cases of rape by the Army as a form of torture), the Court went further with the Istanbul Protocol and said that all protocols of investigation, not just in the specific case, should consider the Protocol. And then in the most recent case on torture, *Cabrera and Montiel*<sup>6</sup> (which is very complex as I will mention later), the Istanbul Protocol becomes very much relevant and goes further because the Court considers the Protocol when analyzing the merits, not just during the reparations phase. For example, in that case, there were objections on the part of the State regarding the declaration of the victim. The State emphasized in specific inconsistencies regarding very minor inconsistencies—date, time, color of shirts—and the Court used the Istanbul Protocol to establish the validity of those declarations notwithstanding these minor inconsistencies. This is very important for the Inter-American system. Then, in

\* Silvia Serrano Guzmán is a Colombian attorney who graduated from the Universidad Autónoma de Bucaramanga and is an LL.M. candidate at Georgetown University. She has worked at the IACHR since 2006 in various posts as a human rights specialist, and since 2009 she has worked on the Litigation Group, which provides support in litigating cases before the Inter-American Court of Human Rights. She has a number of human rights publications to her name and has participated in various training seminars and courses for public officials and members of NGOs on the Inter-American Human Rights System.



this case, we had an expert report from Physicians for Human Rights. The State likewise objected to the validity of that report based on questions of impartiality, and to the passage of time between the facts and the time when the report was made. The Court again applied the Istanbul Protocol to say to the State that the report was valid and complied with the minimum requirements of the Protocol.

Those are important general developments. Now, I want to mention some difficulties that we usually find from the perspective of the lawyers when we receive different medical or psychological documents. There are different types of documents we usually receive. First, official or non-official medical reports describing injuries on the body of the victims. These usually do not have the specific aim to identify torture, and therefore there is no consideration of these reports regarding the consistency or inconsistency of the allegations regarding torture. In the cases in which we have only this type of evidence, we are faced with the difficulty of interpreting medical evidence sometimes without the expertise to do so. The second type of documents we receive, usually from the state, are official reports detailing the absence of injuries on the body of the victim. In some cases these reports have been named as ‘personal integrity reports’, usually to say that this person was presented before a doctor and has no injuries. The third type of document that we receive, and this is in the minority of cases, is an independent report from organizations, such as Physicians for Human Rights or IRCT, as in the *Cabrera* case. These reports usually include a complete analysis of the findings on the victim and its correlation with his or her specific allegations of torture. Of course, this is useful forensic evidence for factual determinations and conclusions. However, it is not very common to find them in the documents we receive.

An important challenge arises with these independent reports. These reports are usually drafted years after the person is released or years after the person was tortured. For example, in the *Cabrera and Montiel* case, the Physicians for Human Rights expert had to tell the authorities that he was a public defender, rather than a doctor, just to get into the jail and perform the evaluation. It is difficult to find independent reports very close from the moment of the facts. We understand this difficulty from the medical or psychological point of view, even though the effects are often permanent and ongoing. From the point of view of a judge or commissioner, when they receive this evidence, they may consider that it was performed four or five years after the facts and that it is therefore not weighty enough to declare that torture occurred. It might be useful that in these reports, the specific passage of time issue is addressed directly by the forensic expert. They mention how the evidence is still useful to address consistency or inconsistency with allegations of torture despite the passage of time, and how the extent of the injuries to the victim has ongoing effects. This could be addressed directly in the reports and could improve its relevance in the analysis.

This is what might have happened in the *Cabrera and Montiel* case. The Court had about fourteen reports on one side, and on the other side the independent report from Physicians

for Human Rights. The reports said the victims were in good physical conditions when they were evaluated; no harm and no injuries, and the others represented minor injuries or injuries related to their age or other health aspects. On the other hand, the Physicians for Human Rights report was performed one year after the facts. The Court made a distinction between the two reports, and that is important. The Court said the fourteen reports are not relevant to determine whether there was torture in this case because their objective was not to establish that there was torture, only to establish the health of the victim. The Court decided the relevant report was the Physicians for Human Rights report, which was performed in accordance with the Istanbul Protocol. At the end of the judgment, despite these distinctions that the Court made, the Court did not find there was enough evidence to issue a determination of torture in this case. The justification was the lack of investigation of this important evidence. There is an important debate on this judgment, however, because the Court did find cruel and inhumane treatment. Some might consider it difficult to understand that the Court could find proof of cruel and inhumane treatment but not torture, since the report was aimed not to find a different degree of violation, but to demonstrate simply that the violations had occurred. The *Cabrera and Montiel* case is relevant if you are interested in the standards of proof in cases of torture and the debates on what are the challenges for forensic evidence to convince a judge that torture occurred in a specific case.

The other types of reports that the Commission receives are psychological reports. I would say that in an important number of cases we receive psychological reports. Some are general and state only a diagnosis with no reference to the allegations of torture. Others are more specific and describe the acts of torture alleged by the victim, and make a statement on possible consistency or cause effect relation between the acts of torture and the psychological impact. A fewer number of reports make a stronger statement on the number of correlations between psychological impact and the alleged acts of torture. For us, psychological reports have been mostly used in the aspect of determining the appropriate reparations in the specific case. In our view, there is still a very important challenge in order to explore the weight of psychological, the psychological aspect of forensic evidence in the first objective I mentioned that is the proof that torture occurred. However, I want to mention with regard to the psychological reports that in the more recent judgments—in the cases of *Cantu v. Mexico* and *Ortega v. Mexico*, the rape cases by the army in Mexico—the Court relied on psychological evidence to establish with other elements of proof that torture occurred in these cases. The system might be getting closer to including psychological reports to prove that torture occurred and not only as an element to determine reparations, but I think that there are many challenges to address. Just one minute to mention that for the victim, it is almost a miracle that someone is listening to their story for the first time. It is very relevant for us in our experience, and to some degree frustrating that it is related to the judicial constraints that we have from the lawyer’s perspective. In some cases, when we have this process before the Inter American system—first before the Commission, then



before the Inter American Court—the relation with the victim is only at the end of the process. In many cases, we experience that the victim—for the first time, one day before the hearing—says everything, for example, that person was not only detained but tortured or raped. This is an experience that we have had in some cases.

A final comment is related to the procedural moment when we receive the expertise, in the case that Rafael was mentioning,

maybe the Commission will receive the expertise at the merits stage when the Commission can analyze the specific facts, but in many cases it's only before the Court that we have this expertise available. We have procedural obstacles in this matter because the Court considers the facts of the case as defined by the Commission. Then we will get forensic evidence only before the Court. It's an important challenge to balance the nature of the procedure before the Commission and the right of the states to defend them selves. By this moment, I can answer questions.

## ENDNOTES: Session Two: Concurrent Panels – Cases Related to Political Engagement

<sup>1</sup> U.N. Office of the High Comm'r for Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)*, 2004, HR/P/PT/8/Rev.1, available at: <http://www.unhcr.org/refworld/docid/4638aca62.html>.

<sup>2</sup> *Id.*

<sup>3</sup> *Gutiérrez-Soler v. Colombia*, Judgment of September 12, 2005, Inter-Am. Ct. H.R. (2005).

<sup>4</sup> *Fernandez Ortega v. Mexico*, Judgment of August 30, 2010, Inter-Am. Ct. H.R. (2010).

<sup>5</sup> *Rosendo Cantú, et al. v. Mexico*, Judgment of August 31, 2010, Inter-Am. Ct. H.R. (2010).

<sup>6</sup> *Cabrera García and Montiel Flores v. Mexico*, Judgment of November 26, 2010, Inter-Am. Ct. H.R. (2010).

## Remarks of Dr. Mechthild Wenk-Ansohn\*

### FORMS OF PROTECTION FOR REFUGEES IN EUROPE

There are different forms of protection for refugees in Europe, which have been laid down in the EU Council Directive (2005/85/EC),<sup>1</sup> which is presently reviewed. The forms of protection are mainly based on the Geneva Refugee Convention, which means that in order to get a title of protection a refugee has to make evident that he or she has a well-founded fear of future persecution. Medical reports documenting torture can support alleged former persecution and thus underlay a risk of future persecution. In Germany, there are some additional possibilities for titles of protection such as Political Asylum (§ 16 A GG) and various obstacles for deportation. One of those is that deportation would pose the refugee to a concrete and serious threat to health and life, or that the person is in need of treatment that is not possible or available in the home country (§ 60.7 Aufenth.G.). The question to be answered by medical doctors and psychotherapists in this case is of what concrete nature and how high might be the risk to health in the course and after deportation.

### FIGURES AND FACTS

About 40% of refugees suffer from posttraumatic stress disorder (PTSD) when they come to Germany, but of course not all victims of torture suffer from PTSD.<sup>2</sup> They might have other forms of psychological problems, also PTSD might occur with delayed onset. There are also victims of torture who do not have psychological symptoms at a level that justifies a diagnosis.

On the other hand, the statistics of the federal migration office (BAMF) show that only about 21% of the refugees

get a safe stay after the first interview and asylum procedure. Immigration officials often do not identify victims of torture. Even if they are trained, they are not able to identify torture victims or traumatized war victims in many cases. There is no guaranteed early access to specially trained (Istanbul Protocol) health professionals who are independent and would be capable to examine the persons. Victims of torture often have a very difficult time to present details of their traumatic history and thus they are at risk not to obtain the title of protection that they deserve. But for traumatized refugees, it is fundamental to their recovery to have a safe stay, and threat of deportation poses them to a high risk of re-traumatization. This is why in the Berlin Center for the Treatment of Torture Victims we do a lot of reports for asylum claims. Also, we do some reports for claims for compensation or for penal claims.

Physical scars after torture are not frequent and can be unspecific, also psychological torture is used more and more often. When we see refugees in our center, we see them not right after they come out of jail, so we rarely see fresh marks of physical violence like hematoma. We see the torture victims at least two months after the inflicted violence, after their flight and arrival in exile. Some come to treatment even ten years after release from jail—and at the intake they suffer from chronic posttraumatic syndromes and sometimes still don't have a safe stay. So often we do not see physical marks of torture, but on the other hand we see very often psychological trauma reactive syndromes, as they are frequent after torture or war-violence. Depending on where the assessed refugees come from, the prevalence of PTSD described in studies varies from about 30% to 70%—and the trauma reactive syndromes are often long-lasting, if not life-long. So the psychological and psychiatric evidence can be of central importance for the documentation of torture and its use in legal proceedings.

### PSYCHOLOGICAL/PSYCHIATRIC/MEDICAL ASSESSMENT AND REPORTS: METHODOLOGY AND CENTRAL QUESTIONS

The central questions for medical, psychological, or psychiatric assessment are: is the person actually presenting any psychological or physical symptom or damage, and if yes, what type? Do the psychological or physical findings give any, or a strong indication, that the person has experienced torture/persecution? Or are the findings rather related to other causalities? Is there an indication for treatment, and if yes, what kind? And the prognosis: what are the risks of deportation from a medical point of view?

Immigration officers and judges often pose the question of “credibility.” It is their job to examine the statements of refugees

\* Dr. Mechthild Wenk-Ansohn is a medical doctor and psychotherapist, special traumatherapy (DeGPT/ESTSS). Since 1994, a staff member at the Berlin Center for the Treatment of Torture Victims (bzfo/Überleben). Since 2006, head of the outpatient sector bzfo. Currently council member of IRCT. Main focus of work: diagnostics, medical reports, psychosomatically oriented treatment and psychotherapy with clients from various cultures who have experienced torture or violence in wars/civil wars - especially treatment of women who have suffered gender-specific violence. Member of the expert-group SBPM that established standards for Germany for medical expert opinions on psychotrauma in asylum cases (including the psychological part of Istanbul Protocol), certified medical expert in this field at the Berlin Medical Chamber of Doctors, supervisor. Experience in training also in the international field, lecturer at national and international conferences and dialogues with politicians, German immigration-authorities and judges, publications on diagnostics and treatment of trauma-reactive disorders in intercultural settings.



critically, but sometimes the eye of doubt seems to lead to a general mistrust. Also, our reports are often seen through the eyes of doubt. We have frequently heard: “the alleged traumatic incidence did not happen to this person, so your diagnosis of posttraumatic disorder is wrong,” “you are doing sweetheart reports, so we don’t have to take them into account.”

So we had to explain in discussion forums and seminars with immigration officials and judges our methodology and scientific background and what kind of evidence we can provide. We had to explain our possibilities and limitations. Important is to make clear that we are doing a *clinical* psychological report, and that it should not be confounded with the criteria-based psychological analysis of statements of witnesses for the prosecution. This methodology analyses witness-statements concerning the probability that the statement is reality-based, it is a criterion-based form of text analysis that has been developed for the necessities of criminal courts.<sup>3</sup> Clinical examinations take place in a different setting and with a different focus and methodology, they are not merely a text-analyses but an extensive clinical examination. But also clinicians evaluate the plausibility of the anamnestic statements of the client and their clinical findings critically. One of the goals of a psychological and medical evaluation is to assess the degree of consistency between an individual’s account of torture and the clinical findings observed during the course of the evaluation.<sup>4</sup> Based on their clinical findings medical doctors or psychologists can give an *indication* that the person has suffered a traumatic incident or sequency and thus a clinical report can serve as evidence for a history of persecution, torture or other forms of violence. We were not there, we haven’t seen it, but we can give an indication.

In Germany, we have adapted the psychological part of the Istanbul Protocol to the requirements and standards in Germany.<sup>5</sup> A working group has developed a modular training program for reports for asylum procedures in an inter-cultural setting—that means also with interpreters—and this was adopted by the German Chamber of Doctors and the German Chamber of Psychologists. We have had more than ten years of dialogue with immigration officials and judges, a lot of trainings, and still we are always again discussing, still reports sometimes receive no consideration even though there are higher court rulings since 2007 that a good enough report should at least decline further investigation. We made some progress but it is not easy.

### TRAUMAREACTIVE PSYCHOLOGICAL DISORDERS

The trauma reactive psychological disorders are diverse. Frequently, victims of torture and war violence including rape present symptoms of PTSD. After a potentially traumatic event with reactions of extreme fear and horror and helplessness, the person will present re-experiencing symptoms, avoidance symptoms, and hyper-arousal symptoms. The victims we see in our center have lived through man-made disasters and often repeated traumatic incidences, also after the traumatic events they have been living under difficult material and social conditions. Their

symptomatologies are often chronic and complex. The longer the traumatic process lasts, the higher is the rate of comorbid disorders: depressive disorders, somatoform disorders, anxiety disorders, substance abuse, dissociative disorders, and personality disorders. We don’t only have to see the clinical features, but also the level of impairment of social functioning, and working in rehabilitation centers we also observe the impact on the families and on the next generation.

### CLINICAL EXAMINATION AND STRUCTURE OF REPORT

When we are conducting a clinical examination in order to do a report, we will first study the pre-existing information and documentation. We begin the personal interview (with a specially trained interpreter), which in general will take various sessions by asking about the actual psychological and somatic complaints. Then we will do a profound biographic anamnesis and, when there is established a trustful enough relation, we ask the person to tell us about the trauma history as detailed as possible, depending on the clinical status of the person. To conduct a trauma anamnesis it is important to have clinical experience and to be able to make stabilizing therapeutic interventions if needed. We ask about reactions that occurred *during* the traumatic events in question, and the course of symptoms *since* the traumatic events. We will observe the actual mental status and the behavior and nonverbal communication in the course of the anamnestic interview. We eventually conduct psychological test diagnostics, which can underline what we see clinically—but the clinical examination is the one that is most important. In the report, we will discuss and evaluate the results, give the interpretation of the findings, discuss the diagnosis and differential diagnosis and discuss the possible relationship and consistency between reported events and reported symptoms and our clinical findings. At the end, we will give a prognosis and recommendations for treatment and answer to the specific questions the judge may have asked.

Central to the psychological assessment are the trauma anamnesis and the clinical features. We have to conduct a very detailed exploration of the symptoms because there might occur fabrication or exaggeration of symptoms as there is a lot at stake. The refugee wants to gain a safe stay and might have been briefed before what to say. We will be observing closely the behavior, the changing of the psychological rapport when focusing on the traumatic events. Do we see PTSD symptoms during the exploration? We note shame reactions, patterns of avoidance, defense mechanism, affective connotations, the changing of arousal, the changing of concentration and attention. We analyze the pattern of relationship within the assessment situation, the transference and counter-transference phenomena. We have to observe very closely if there are dissociative reactions, even flashbacks, and we have to stop such reactions with therapeutic interventions. We have to care for emotional overload when the examined person is eventually breaking patterns of avoidance. On one hand, we want to make a thorough assessment; on the other hand, we have to keep the risk of re-traumatization through our assessment as low as possible.

## CASE EXAMPLES

I would like to share with you a case example of a young man from Iran, a former patient of mine for whom I made a report for his asylum request. At the intake, two years ago, he was 26 years old. He had been working before in IT. When he was 17, he had been shortly arrested for the first time because he had consumed alcohol in a park. In June 2009, in the election riots, he took part in the demonstrations. He was arrested by civil police and Pasteran and then detained three weeks in a jail of the state securities in Tehran.

What he reported about forms of torture: beatings, falanga, suspensions by the arms (giving details of so called Palestinian hanging). He reported that once occurred a luxation of his left shoulder while he was torn up for hanging and that he must have been unconscious for a short time. That he woke up while his shoulder was repositioned by one of the guards, and he added, “my God, they must practice this very often.” Also he mentioned suspension by the feet, being blind-folded, sleep deprivation and forced position tied to a chair. Only in the third anamnestic session he mentioned, under visible shame reactions, also sexualized torture, that he was beaten in the anal region while hanging naked by the feet and that his testicles were squeezed. In a later (then therapeutic) session he was able to verbalize that he had been penetrated with a stick.

When he came to us, he reported severe sleeping problems and nightmares in which he would be seeing fragments of scenes from the torture, especially the hanging and the sexual torture. Also repeatedly he had intrusion of memory pictures of the demonstration where a friend was shot while he could run away. He showed feelings of guilt for having tried to save himself. He reported to wake up terrified out of such dreams, with strong heart palpitations. Also he reported flashbacks on his way to the treatment center. For example, when an ambulance passed by with a siren this made him recall a scene of one of the demonstrations. So in the moment of hearing the siren now here in Berlin he had lost contact to the current reality, had started to scream—as if the Demonstration would happen at the moment.

He reported that the first weeks after his release from jail, he had been feeling sort of numb. Then it started to change with feeling restless and agitation, he started to have nightmares and panic attacks and suicidal thoughts. When we see saw him in our center right after his arrival to Germany in some sessions he still appeared numb, acting and moving slow, not reacting much emotionally, not talking much. In other sessions, he was very nervous and shaky, started to cry. He showed a lot of avoiding behavior when we focused on his traumatic history, especially when touching the experience of sexualized violence.

During the physical examination he showed signs of heavy shoulder pain when lifting his arms. He mentioned that in the beginning, the first days after the torture, he had not been able to lift them at all. The left side shoulder, which he had reported to have been luxated, he could still lift less then the right side when arriving in Berlin. I was not able to make an ultrasound at that time but I took

photos to show the pain-reaction when lifting the shoulders. For the report then, its like a mosaic, you are putting together and evaluating the reported history and the physical findings and the psychological findings, the individual details the person gave. As diagnoses it was clear that the young Iranian was suffering from PTSD. At the intake, just two to three months after the traumatic experience, he had still shown a picture of acute PTSD with changing states of numbing and hyperarousal and tendency to flash-backs, heavy sleeping problems and nightmares. Then the PTSD changed to the chronical form, but in the frame of the therapy the symptomatology gradually got better.

In the case of this young man in the report we could show the consistency between the account of torture and the psychological and medical findings. The report supported his statements at the asylum hearing and he was granted asylum.

I would like to share a second case with you. The case of a Kurdish female from Turkey. This was a report requested from court. Besides the diagnosis and prognosis the central question in this case was: are there hints of limited ability to report torture experiences due to the symptomatology?

The woman originated from the east of Turkey, but she had already been living in Germany for ten years. In her first asylum hearing ten years ago, she had not told anything. She just had said: “everything that my husband says concerns also me.” One of the delicate details concerning the limitations to report was that her husband was present at this interview with the German officials—also she had not made an own asylum request (only together with her husband), there had been no lawyer involved. They were denied asylum and then went to court – but the same behavior of her part went on, and they were denied again. Over all the years in Germany she was of bad health condition and in psychiatric treatment for depression. And she had gone to many doctors for somatic complaints, like lower belly pain, headaches, back pain and so on. But there was never conducted a deeper anamnesis, not only because the psychiatrists did not look for trauma, but also because a friend of the family or her daughter had been translating; an independent interpreter never had been organized. Finally, when the family was threatened to be deported she made a suicidal attempt and was treated for weeks in a psychiatric hospital. A new request for obstacles against deportation was made and finally the case came into the hands of a judge who said, “OK, we have to review this case,” and he referred her to me for examination and an expert-opinion.

In the interview in our center, with translation by a female Kurdish interpreter, the 30 year old woman reported that her husband had been helping the Kurdish guerillas, like many Kurdish people did it in the east of Turkey. At that time, in the late 80s and early 90s, there were a lot of raids in the villages. Step by step, after having gained trust while talking about her childhood and her kids and being informed that the report would be handled confidential by the judge, she began to disclose her traumatic experiences. She had been taken five times to several local police and military stations around her village, and had been interrogated about the activities of her husband. At the last arrest, shortly



before they fled to Germany, she had been raped by two of the officers. With the trauma-anamnesis we had to really go slow, at the whole we had six hours of examination. Slowly she was opening herself more and more, talking about more details also of her symptoms like sexual problems and flashbacks during the intercourse. She mentioned concrete contents of her nightmares, and more details about the arrests and torture, she could verbalize that she was raped. She could describe how the two officers came into the room, and that then there had been a like a break of memory. The first thing she could remember thereafter was how she woke up in the cell and felt that she had been raped. She had difficulties to remember also details of the period after the rape, the hours after she was released. She didn't know some details of her way home. She also told us under tears that she made her first suicide attempt the day after the rape and release from the police station: "I was going down to the river. And then suddenly it came into my mind that, if I kill myself, my husband will know that I was raped. So I went back to the house."

In the report we documented her history, the clinical findings and her diagnosis. She had suffered from complex PTSD all these years with comorbid depression and somatoform disorders. The intrusive memories had again increased after the threat of deportation, the depression anxiety and distress had deteriorated. She had shown over the years a strong avoidance behavior, this also in our sessions, and manifested signs of shame. It was obvious, that because of the traditional concept of honor in her country, which she has internalized, she had not been able to talk about her traumatic experience of sexualized torture and that, to protect herself she had avoided to talk about the whole situation

of persecution. During the sessions she told us for example: "if my husband knows what happened to me, I couldn't live that. I suppose that he would leave me." Also she mentioned that she was very afraid to go back to Turkey and to her village, because may be persons in the village would know what happened to her, that she would rather die. So in the report we described the risks to her psychological health in case of deportation and discussed various aspects of limitations to her ability to report about her torture experience in the former asylum interviews. The judge granted an obstacle to deportation for health and humanitarian reasons. The symptoms of traumatization themselves, like lack of concentration, avoidance, shame, dissociative reactions and gaps of memory may lead to a fragmented, incoherent, and contradictory description of the traumatic events.

As a medical/psychological expert, the assessing professional finds himself/herself in-between two different worlds: the world of the legal authority and the world of the client. To be able to assess a traumatic history and the psychological or somatic trauma sequelae, we need time, respect, inter-cultural sensitivity, knowledge about psychotraumatology and transparency of the procedure for the victim. We have to build a trustful enough relationship to the client to be able to overcome individual, cultural, and communication problems. We need to have the ability and willingness of empathetic listening—combined with keeping boundaries. To write a report as an independent expert, we have to maintain the position of impartiality. We want to be as objective as possible, and we have to write our reports with transparency and traceability when answering the questions of the judge as critically as possible. Thank you for your attention.

## Remarks of Rodger Haines\*

### INTRODUCTION

In a sense, the first slide, which subtitles my presentation—credibility assessment and medical evidence—is something of a misnomer, in that the true message that my

*\* After being admitted to practice in 1972, Rodger Haines engaged for the first 11 years in Government litigation and prosecution work. Since 1983, he has practiced as a barrister specializing in administrative law, immigration law, citizenship law, refugee law, customs law, and extradition law. He is currently Chairperson of the New Zealand Human Rights Review Tribunal. When the New Zealand refugee determination system was set up in 1991 he was one of the original three appointees to the Refugee Status Appeals Authority and wrote many of its principal decisions. He remained a member of the Authority until it was disestablished in November 2010. In the period 1994 to 2010, he was Deputy Chairperson. Since 1993 he has lectured in Immigration and Refugee law at the Faculty of Law, Auckland University. In 2000 and again in 2003, he co-taught papers in Comparative Asylum Law with Professor James C Hathaway at The University of Michigan Law School, Ann Arbor. In May 1999, he was appointed Queen's Counsel.*



presentation carries is the issue of credibility and the responsibility of assessment.

The context in which I bring this to you today is that New Zealand is a party to the Refugee Convention and also to the Convention Against Torture (CAT) along with the International Covenant on Civil and Political Rights (ICCPR). New Zealand has domesticated not only the *non-refoulement obligation* in the Refugee Convention, but also that in CAT article 3 and the ICCPR articles 6 and 7, which address themselves to non-return to arbitrary deprivation of life or to a risk of torture or cruel, inhuman or degrading treatment (CIDT).

The perspective I bring is that of a decision-maker rather than that of a lawyer, although in the past I have represented refugee claimants. I take as my starting point the acknowledgment that medical evidence is extremely valuable. Where it is available it must be grasped firmly with both hands because it can be critical to the outcome of a case. But medical examinations perform different functions. For example, the examination of torture victims in the context of rehabilitation has a function and direction of its own because the focus is on the patient. A medical examination for the purpose of documenting torture and holding persons accountable for this acute violation of human rights may be framed in different terms. Then again, if the purpose of the medical examination is to support a claim for protection from *refoulement* by an individual who has been tortured the focus and function of the report is specific.

The German federal system is fortunate to have within its system persons and medical specialists who produce reports as carefully and as intellectually robust as the ones that have been described by Mechthild Wenk-Ansohn. But ordinarily, in many countries, the decision-maker and the protection claimant together face real problems for a number of reasons. First of all, the country of asylum is usually at a distance from the country of origin. This means that it is very difficult to get evidence of the kind courts are accustomed to using in the setting of civil and criminal proceedings. Second, a person who has been subjected to torture is not only physically distant from the country of origin, but also distant in time from the event. The utility of the medical examination may be marginal.

Third, the country of asylum may be a country where torture is not practiced, or if it is, it is a rare occurrence, so that decision-makers are unfamiliar with its symptoms and its context; medical witnesses may not know how to go about recognizing or documenting the sequelae. Above all, as the point was made this morning, a person subjected to torture does not get a certificate certifying to the time, place, and thoroughness of the experience. So someone “fortunate” to still have the physical marks and scars at the time of the medical examination is in this respect (ironically) at an advantage. But most often the enduring injuries experienced by torture victims are the “scars” of the mind and spirit therefore the more difficult to establish.

But in principle I do not dispute the potentially determinative significance that medical evidence can have in determining refugee and protection claims.

But there are necessary and substantial reservations. I ask you to consider whether there are dangers in raising expectations as to how far medical evidence can actually take the decision-maker. It is in that context that I will now turn first to a success story and then to the dangers inherent in holding false expectations as to how torture is to be proved.

### SUCCESS STORY

In New Zealand, we were most fortunate that, in the middle of 2011 we were visited by Professor Sebnem Korur and Dr. Thomas Wenzel. They conducted not only training of doctors and lawyers but also forensic examinations of individuals who were then going through the refugee and protection process.

One of the medical reports Sebnem and Thomas prepared resulted in the favorable outcome of a case which had initially been declined at first instance on credibility grounds. The case succeeded on appeal largely because the new forensic evidence established the credibility of the claimant. The appellate tribunal known as the Immigration and Protection Tribunal (IPT) commented upon the report in highly favorable terms as the slides which follow show.

First, the facts. The case is *AB (Mexico)* [2011] NZIPT 800025.<sup>6</sup> The claimant was from Mexico. One paragraph of the Tribunal decision describes his evidence as “problematic, disjointed, and at times prima facie inconsistent.” It was characterized by “considerable confusion and perversity.” The decision talks about the Tribunal being left from time to time in doubt. One can make the observation that this is the paradigm of the challenge confronting most decision-makers in most circumstances in most countries.

The decision goes on to describe at para [59] that the claim was ultimately accepted by the IPT because it found that the forensic evaluation was supportive of the core elements of the claim.

The IPT decision at one point describes the particular individual as being unable to present in a “clear, logical, and consistent manner.” This is a revealing comment signaling as it does that whenever a person goes to an interview, he or she will be clear, logical, and consistent. Just ask yourself whether that is a realistic expectation of an individual who is in front of a decision-maker he or she has never met before and when the evidence is given through an interpreter.

Moving on, the decision at the end of paragraph 59 refers to this individual’s lack of formal education, a point often overlooked by decision-makers. Once, at a time when I believed I was an experienced refugee decision-maker, I was taken aback while observing a refugee interview in Egypt. The first question

asked of the individual was, “When did you last eat?” I had never heard this question asked before but for the particular person being interviewed, the issue was critical. It drove home to me that we all have quite different preconceptions of what is relevant in the refugee context and how to go about an interview. Any medical practitioner will tell you that if you have low blood sugar levels or hardly any food in you, it will be very difficult to meet the paradigm of being clear, logical, and consistent.

A further question is whether the individual can adequately express him or herself, not just to the lawyer or forensic medical expert, but also ultimately to the decision-maker. The level of education is significant.

Let me get to the point—I am extremely pleased that Sebnem is in the audience today—the report that she and Thomas Wenzel presented was described by the IPT as being authored by two world-class professors. The IPT describes how it assisted in explaining many of the problems the particular individual had in the presentation of his evidence. It is the good luck story, the person who fortuitously had a refugee claim going through the system at a point in time when two eminent forensic experts were in New Zealand and available to carry out the examination.

But unfortunately, we do not have a flying squad of forensic experts who can go around and assist everyone. We are heavily dependent on training and the willingness of the local medical profession to be involved in cases like this. This is a big issue, as it is with lawyers, because it is very much *pro bono* hardship territory for most lawyers and medical professionals.

Note in the slides that reproduce paragraphs 66 to 63 of the decision that there is reference to the findings showing consistency with memory impairment and highly increased PTSD during interviews related to torture. So, again, it is just a pointer as to what medical experts may need to focus on.

The decision also noted that the physical and psychological findings in the forensic report were found by the medical experts to be “highly consistent”—not just consistent but highly consistent—with the patient’s history of torture during arrest and detention. The Tribunal states in paragraph 64 that the terms of this report “led us to accept the credibility of the appellant’s core claim.”

### DANGERS OF FORENSIC MEDICAL REPORTS

That is the success story. Now I must introduce the “downside” of forensic medical reports. Once decision-makers have been introduced to the luxury of making credibility decisions when aided by detailed forensic medical reports, they not unnaturally see such reports as the potential key to arguably the most challenging aspect of refugee decision-making (credibility). The absence of the forensic medical report is therefore inevitably noted, if not highlighted. One soon ends up with the situation where the response to the torture claim is: “So you claim torture? Where is your medical report?” It is a short step from there

for the decision-maker to reason that there being no medical report it follows that the claim to have been subjected to torture or to cruel, inhuman or degrading treatment or punishment is less than credible. Furthermore, if the report is “just” from a medical practitioner who is a general practitioner doing his or her best, but who has no exposure to or expertise in this area, the report will be regarded dismissively. The decision-maker is then driven back to making a decision exclusively on his or her subjective understanding of this person’s predicament, and that itself has difficulties.

It is not just a phenomenon that I have noted in the New Zealand context. It is also one that I see appearing in regional court decisions, even in decisions that are truly landmark and path-finding. I refer to the Grand Chamber decision of the European Court of Human Rights in the case of *MSS v. Belgium and Greece* (Application No. 30696/09, 21 January 2011) which found Greece in default of key elements of the European Convention on Human Rights and in addition Belgium was found to be complicit in sending people back to Greece to face awful conditions of detention in a refugee-determination system that actually does not function in any meaningful way.

In this case, the Grand Chamber referred in passing to the question of medical documentation in support of asylum claims. After mentioning allegations of brutality and insults during the second period of detention asserted by the claimant, the Grand Chamber observed that “these allegations are not supported by any documentation, such as a medical certificate, and that it is not possible to establish with certainty exactly what happened to the applicant.” This is a clear and unambiguous example of the courts assuming that if a person presents an account involving an allegation of physical or psychiatric or psychological violence, the absence of a forensic medical report leaves a big question mark over the credibility of the claimant. It is truly disappointing that a decision from a court of this stature should contain such an unhelpful, if not misconceived observation.

Finally, I want to talk about a decision of the CAT committee itself, namely the decision of *TI v. Canada* (Communication No. 333/2007, 15 November 2010). It involved an ethnic Tartar, who in 1995 was arrested and subjected to torture such as beatings, kicks, needles under the fingernails, sleep and water deprivation, solitary confinement, continuous exposure to light, and administration of psychotropic drugs. He had blood in his urine and lungs. The detention was about one month. He fled with his wife and daughter to the United Arab Emirates. An incident there caused him to flee to Germany under a false name. His refugee claim was rejected in Germany. He traveled to Norway. Again, his refugee claim was unsuccessful; it was under a false name. In September 2001, he entered Canada and then made his refugee claim. That claim failed on credibility grounds.

The Federal Government of Canada argued before the CAT Committee that there was no evidence to corroborate any of the allegations. Now remember, this man entered Canada in 2001 and was describing incidents which occurred in 1995. Ask



yourself, if you were required to produce or prove things that happened in your life six years ago in another country, how successful would you be?

The complainant's response was compelling. He said that he could not provide medical evidence of the injuries he received including blood in his urine and lungs. It was unrealistic for him to request his torturers for such a medical report. This was, after all, Uzbekistan. Reality had to intrude at some point. But the CAT Committee, in responding to this point, said at paragraph 75 that "despite several inquiries about medical or any other documentary evidence in support of his account of events in Uzbekistan prior to his departure, namely of his alleged arrest and ill-treatment in detention in 1995 which would corroborate his claim or possible effects of such ill-treatment, the complainant did not provide any such evidence." The question I pose is whether one can realistically expect victims of torture to have corroboration of the kind implicitly required by the CAT Committee? Can one assert that claims of torture are inherently weak without corroboration? General experience shows that it is the exceptional case only where corroboration of the kind required will be available. Implicit in the decision is an expectation that if you request corroboration it will be provided. They said: "Neither did he provide any report of a medical examination after his arrival in Canada." Well, if the question is what was in his lungs and urine in 1995, I am not sure that

any medical practitioner in Canada could help in 2001. The conclusion, stated by the CAT Committee was in the following terms: "In such circumstances, the Committee finds that he has failed to establish his claim that he would personally be exposed to a substantial risk of being subjected to torture if returned to Uzbekistan at the present time."

As to this I am reminded of the observation made earlier in these conference proceedings that the absence of evidence is not necessarily evidence of absence.

## CONCLUSION

The point of my presentation is that while medical evidence can be of critical importance in refugee and protection decision-making, there is a danger that we might inadvertently create an expectation that victims of torture "will and must" be able to prove their account by such evidence. Certainly, in my experience, it is rare for victims of torture to have access to medical practitioners specialized in the field of forensic medicine who will detect physical, psychological or psychiatric sequelae. While forensic medical reports can be of determinative significance to refugee and protection claims, we must resist the expectation that such reports be forthcoming as a matter of routine and that their absence reflects adversely on the credibility of the refugee or protection claimant.

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## Remarks of Christy Fujio\*

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### INTRODUCTION

Presenting from a legal and procedural perspective, these are the things that I would like to cover. First, I will describe U.S. immigration categories for survivors of

human rights abuses. Primarily, we are talking about asylum, but in the U.S. there are a number of other categories as well, for people who do not fit the strict asylum criteria but have suffered some sort of persecution or human rights violations. There are other categories they can apply for. Next, I will illustrate the value of the Istanbul Protocol as a tool for documenting torture and cruel, inhuman treatment for U.S. adjudicators. Finally, I will illuminate the clinician as an expert resource in immigration cases where human rights have been violated.

### U.S. IMMIGRATION CATEGORIES FOR SURVIVORS OF HUMAN RIGHTS ABUSES

The United States has incorporated the key points of the Refugee Conventions,<sup>7</sup> but one key differential is that U.S. applicants have to file within one year of coming to the United States. It's different in some other countries—some have shorter or longer deadlines, and others have no deadlines. The reason that this deadline is important in terms of medical evaluations, particularly with psychological evaluations, is that in addition to looking at all the other factors related to persecution and human rights violations, the psychological evaluator will also be looking to explain why the person may have missed the one-year filing deadline. Hopefully the person will fit within one of the couple exceptions to the deadline.

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\* Christy Fujio is the Director of the Asylum Program at Physicians for Human Rights, where she determines policy direction related to asylum and detention issues and oversees a network of approximately 450 health professionals who provide forensic medical evaluations to asylum seekers. Prior to joining PHR, Christy worked in private practice as an immigration attorney and volunteered at the Political Asylum/Immigration Representation Project. Previously, Christy was Chief of Staff at Hunt Alternatives, where she organized and conducted legal training and capacity-building seminars for women parliamentarians, executive officers, and civil society leaders from Rwanda, Liberia, Sudan, Bosnia, Serbia, Afghanistan, and Russia. She consulted directly with Liberian President Ellen Johnson-Sirleaf regarding the transitional justice hurdles Liberia faces in the wake of its civil war. In addition to her law degree, Christy has a Master's degree in International Policy Studies and a Bachelor's degree in East Asian studies. Her analyses have been published by legal journals at Georgetown University Law School, University of San Francisco Law School, and Michigan State University Law School.



The asylum benefits are pretty similar across countries: a grant of asylum provides security, support for people, a chance to get them back on their feet, possibility to bring their families over here, work, start their lives over again. And also the healing that comes with a grant of asylum—a feeling that victims' claims have been recognized—that the suffering they endured was legitimate and recognized by another country is important part of the healing process for them. To put it all in context for the United States, according to the UNHCR, we had over 36,000 people apply for asylum in the first half of 2011. The people came from over 100 countries, with China as the top sending country, perhaps simply because its population is so great. The approval rate of asylum claims for the U.S. is historically 30%, with many qualifications and factors, such as the geographic area, who the immigration judge is, the type of claim, etc. Lots of different factors influence whether a given asylum claim is approved.

Some of the other protective statuses that victims may be eligible for, if not for asylum, are T-Visa for victims of human trafficking; U-visa, which could also include trafficking victims but also other kinds of crime victims; Violence Against Women Act, for survivors who have endured domestic violence in this country; Special Immigrant Juvenile Status, for children—people under 18; and finally, relief under the Convention Against Torture<sup>8</sup> and the withholding of removal. Suffice it to say, there are other statuses if people don't fit the rigid asylum criteria. People in these categories also benefit from having physical or psychological evaluations to support their claims.

For a very simple affirmative asylum claim, there are several different points at which a person might request a physical or psychological evaluation. They could have it done shortly after arriving in the U.S., before they first apply for asylum and they can hand it in with the asylum paperwork. It might happen in-between submitting the asylum application and actually interviewing with the asylum officer. Or, it might happen after the asylum interview if they are not granted asylum and they are referred to an immigration judge.

### ROLE OF CLINICIANS

The role of clinicians is documenting harm caused by persecution and providing some sort of corroboration of the victim's narrative. Even though the evaluation itself is not proof, is an important corroborating piece of evidence and it is often the only piece of evidence that people have to submit with their asylum claims. There are three different types of evaluations that we provide through Physicians for Human Rights: physical evaluations, OB-GYN evaluations, and psychological evaluations. Some people might request all of those, and some people might request one or another. Of course, that depends on what harm the person has endured, what that person's attorney advises, and also what they're able to get in terms of a *pro bono* evaluation. Certainly we are limited by the number of clinicians we have, the time frame requested for the evaluations, and other logistical concerns.

There are four principal responsibilities that the clinicians have. Some people might ascribe more responsibilities to them, but these are the basic ones: (1) The provision of the medical-legal affidavit that will go to the adjudicator: the asylum officer or the immigration judge. (2) In many cases, live testimony will be requested in immigration court, a critical factor. We often have clinicians who will say they will evaluate the case, but will not have the time to do the live testimony. This is strongly discouraged. It is helpful to have the medical-legal affidavit, but if the immigration judge is not going to accept it because it cannot be authenticated, then it is essentially meaningless. It is like you are throwing someone a lifeline and then just as they're ready to be pulled it, you toss it back at them and don't hold on to it. The live testimony can be really important – it can make or break a case. (3) Another clinical responsibility is to obtain relevant information from that person that the attorney might not have gotten. Particularly, through a psychological evaluation—though it can happen with a physical evaluation as well—something the victim didn't tell their attorney that might be highly relevant to the asylum claim or to the another kind of immigration claim. The clinician doing the evaluation can share that information with the attorney. It can make a big difference in the strength of their claim. (4) Finally, to refer for treatment, because so many people coming over here who have suffered human rights violations need some sort of additional treatment.

Now here is the great statistic: 90% of our case outcomes are positive, compared to that national historical average of 30%. The big qualification to this stat is that all of the cases that we take through our network right now are represented through attorneys, and having good legal representation is a huge advantage for anyone applying for asylum or any of the other protective statuses. Of course, we believe that the health professional's evaluation is also critical and is a huge part of the success, but we cannot discount the role of the attorney when we consider success rates.

### VALUE OF ISTANBUL PROTOCOL

Again, the primary purpose of the evaluation: to establish the facts, and to evaluate and document the level of consistency with the victim's narrative. The Istanbul Protocol guidelines lay out all of the elements that should go in a report. I just want to highlight here again that not all people in the United States will have both the physical and psychological evaluation. Most only have one or the other – physical or psychological.

Levels of consistency: as the clinician is looking at the physical evidence and doing the clinical interview, she must rank each element, mark or scar, in terms of consistency with the story related to what the actual symptom is. She will state whether scars or other mark are "consistent with," highly consistent with," "not consistent with," or "not related" to the allegations in the victim's narrative.

There are several important considerations for written reports, and there are a couple of things I want to highlight.

Objectivity and impartiality are critically important. There is one but one wrinkle, however. Many immigration judges actually prefer and view more favorably evaluations that are done by the treating physician or the treating psychologist of that person. This is something that we struggle with, because objectivity and impartiality are so fundamental to the Istanbul Protocol. But some judges are saying, in short: “You have only talked to this person for a few hours, so it is not as valuable as the treating psychologist, who has spent twenty hours or more.” There is an interesting split among the judiciary, and we see many of the attorneys making the decision, based on the judge, whether they want to get an evaluation from the professional who is actually treating the client or whether they want to get an independent evaluation. It is something that we will continue to look at.

Finally, a slight deviation from the Istanbul Protocol Guidelines, which recommends that clinicians have knowledge of country conditions, knowledge of the torture practices, and knowledge of detention practices. Of course, if a clinician is in country, she should have pretty good knowledge of what is going on there. But in in the U.S, where we have clinicians who are seeing asylum-seekers and others from all different countries, we can’t really expect that they know about the particular detention, torture, country conditions of all the different places. We try, as much as possible, to familiarize them with all the country conditions, but we don’t want to be too rigid with our expectations or else we won’t have so many people volunteering to do them. So we relax this recommendation in regard to provision of forensic evaluations for asylum seekers in the U.S.

## CHALLENGES

The various challenges that the clinicians face are the typically the same across countries. One that I want to highlight that is particular to the U.S. is working with attorneys. Simply, the idea of working with attorneys is a significant challenge for many clinicians. I was surprised to learn that a lot of health professionals feel slightly antagonistic toward lawyers, towards the profession as a whole, because the fear of malpractice lawsuits is driven into them from the time they are in medical school. Given

that, working with attorneys is difficult for some clinicians at first. They need to put aside their fears, and attorneys need to try and be a little bit less bossy and a more understanding of the interpersonal dynamics at play.

Physicians for Human Rights’ asylum network in 2011 provided 432 evaluations for 382 clients, the differential representing the number of people who had both physical and psychological evaluations. While this a number that we are proud of, it is a drop in the bucket compared to the tens of thousands of people who have applied for asylum already in the country this year. Generally, we had about a 50/50 ratio between requests of women and men. They represented 89 countries, the largest numbers from Mexico, El Salvador, and Ethiopia. Those were also some of the top-sending countries, globally. We had 105 new professionals join the network, and we served the clients of 309 attorneys.

It is a system that has great merit, a lot of value. The people involved in the system—the attorneys, the clinicians, the clients—are all getting a huge benefit out of it. There are two significant challenges going forward, however. First, since the introduction of medical evaluations in court has been increasing in recent years, the expectations of adjudicators are also increasing. What is needed is advocacy and education for adjudicators, to reinforce that the absence of a medical evaluation certainly does mean that torture, persecution, human rights violations did not occur. Second, the huge number of unrepresented cases that we are not able to provide evaluations for is worrisome for us. It is something that we have been looking at a lot is how we can serve this *pro se* population—“*pro se*” meaning people who are representing themselves because they were unable to obtain legal representation. There are tens of thousands of them in the U.S. There are all sorts of problems with providing evaluations to *pro se* client: logistical problems, interpretation concerns, getting access to people who are in immigration detention. It is something that we are continuing to look at, and really want to figure out, so that we can widen the net of people that we are able to serve through these clinical evaluations. Thank you.

## ENDNOTES: Session Two: Concurrent Panels – Asylum Proceedings

<sup>1</sup> Council of the European Union, *Council Directive 2005/85/EC of 1 December 2005 on Minimum Standards on Procedures in Member States for Granting and Withdrawing Refugee Status*, 2005/85/EC (Jan. 2, 2006).

<sup>2</sup> See Ulrike Gabel et al., Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. *Zeitschrift für Klinische Psychologie und Psychotherapie*, 1, 12-20, 35 (2005).

<sup>3</sup> See M. Steller & G. Köhnken, *Criteria-based Statement Analysis*, in *PSYCHOLOGICAL METHODS IN CRIMINAL INVESTIGATION AND EVIDENCE* 217-245 (David Raskin ed., 1989).

<sup>4</sup> U.N. Office of the High Comm’r for Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Istanbul

*Protocol*), 2004, HR/P/PT/8/Rev.1, available at: <http://www.unhcr.org/refworld/docid/4638aca62.html>.

<sup>5</sup> Berlin Center for Torture Victims, *SBPM Standards 2001* (revised 2012).

<sup>6</sup> *AB (Mexico)* [2011] NZIPT 800025, available at [https://forms.justice.govt.nz/search/IPT/Documents/RefugeeProtection/pdf/ref\\_20111124\\_800025.pdf](https://forms.justice.govt.nz/search/IPT/Documents/RefugeeProtection/pdf/ref_20111124_800025.pdf).

<sup>7</sup> U.N. Convention Relating to the Status of Refugees, July 28, 1951, 189 U.N.T.S. 137; U.N. Protocol Relating to the Status of Refugees, Jan. 31, 1967, 606 U.N.T.S. 267.

<sup>8</sup> Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987.