Torture documentation inside detention centers

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Sir,

Concern has been raised about the quality of health care for asylum seekers in detention,[1] particularly in respect of mental health problems.[2] Here we write to highlight difficulties faced by clinicians preparing medico-legal reports as part of the process to document torture among detainees.

In the United Kingdom there are eleven detention establishments, known as ‘removal centres’.[3] Some detainees are held at centres a considerable distance from their previous residence and may have passed through more than one such establishment. Transfer can occur at short notice and overnight, a distressing phenomenon known as “ghosting”.[4] These realities pose logistical problems to accessing clients. Removal centres are often located a considerable distance from organizations specializing in torture documentation, thus necessitating additional travelling time for doctors and interpreters. Appointments must be arranged in advance and interview rooms may only be available for certain periods of the day. Limited time with clients may therefore compromise the quality of the medico-legal report. Entering the centre itself and clearing security is also a time-consuming process. On occasions, both of us have been fingerprinted prior to entry. The fate of these personal data is unclear: one of us was informed that records are erased ‘after a few months’.

It is routine for useful equipment to be confiscated for the duration of the visit. Even plastic rulers can be disallowed: a paper tape-measure will prove invaluable under these circumstances. The absence of a laptop or voice recorder compels the clinician to take handwritten, rather than electronic notes. This prevents the clinician from composing a report during the information collection and clarification phases and means that time is required later to enter data. We have been informed that a camera to document torture scarring is only permitted following a written request by the client’s lawyer and this must be made for each interview where photography may be necessary. The confiscation of mobile phones can make it difficult to contact a client's solicitor in order to discuss the case confidentially. For clinicians, it is equally inconvenient not to be contactable themselves during those hours spent in the centre.

Examination facilities may not be ideal, for example on account of poor lighting or low temperature. Clinical rooms are sometimes small and their physical layout unchangeable, forcing the client to face the

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doctor across a desk. There is often insufficient space to seat the interpreter in an optimal position for effective communication. When clinical examination rooms are unavailable, the 'interview rooms' provided by the authorities may lack privacy. Unlockable doors, sometimes containing windows for inspection from public spaces, can render examination impossible in such rooms. In addition, these rooms are used for other official interviews with clients and may be reminiscent of earlier stressful meetings about their asylum claim or even of interrogations in their own country. As such this may hinder the dynamic required for the disclosure of traumatic experiences. Under these circumstances accessing an appropriate chaperone for intimate examinations may also be difficult.

Detention centres are not large institutions. For example Dungavel, Scotland's only removal centre, has room for 190 people including children.[5] Maintaining patient confidentiality remains an important issue as we have noticed that some detainees discuss their consultations with peers inside the centre and with outsiders via mobile phone.

During the course of an examination for evidence of torture, clients may request a medical opinion. The visiting examiner is normally without appropriate clinical equipment or the means to prescribe and general medical problems should be passed to the responsible physician at the centre. However, not being able to respond to clients may leave them feeling unimportant, helpless and dismissed. Occasionally, dissatisfaction with the general medical care provided has been expressed to us, despite direct access to primary care doctors and nurses and other services, such as dentistry.

There are additional difficulties. One common problem is the psychological pressure on the visiting clinician of being considered the client's 'last hope'. Referral onto other services routinely available for torture survivors outside removal centres is not straightforward. This situation can be particularly challenging in circumstances where the client threatens hunger strike or suicide if their case is unsuccessful.

It will be clear from this brief note that medico-legal examination in detention centres presents a number of challenges to clinicians. Suitable rooms with appropriate equipment and access to a computer and mobile phone would make the collection of information and compilation of reports much more efficient. Optimal conditions would allow the clinician to bring a little bit of humanity to an otherwise tense situation. A greater appreciation of the role of the medical examiner by the authorities would be beneficial. Nevertheless, clinicians should not be discouraged from undertaking this important and rewarding work.

References

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