REDRESS

Seeking Reparation for Torture Survivors

RESPONDING TO THE NEEDS OF TORTURE SURVIVORS IN THE UNITED KINGDOM

Report of the Seminar for Frontline Service Providers
Palace Hotel, Manchester, 25 June 2004

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I. INTRODUCTION

On 25 June 2004, the Redress Trust (REDRESS) convened the meeting: "***RESPONDING TO THE NEEDS OF TORTURE SURVIVORS IN THE UNITED KINGDOM: A Seminar for Frontline Service Providers***" in Manchester. The meeting brought together a range of service providers that come into contact with torture survivors as part of their daily work, including asylum support workers, medical and trauma specialists, lawyers and other advice providers. Also present in the meeting were several torture survivors who had the opportunity to address the audience with their perspectives and to contribute to discussions throughout the day.

The meeting followed the official release of the National Edition of the "***TORTURE SURVIVORS' HANDBOOK: Information on Support and Resources for Torture Survivors in the United Kingdom and the Possibilities of Obtaining Reparation."*** The Handbook is a co-publication of REDRESS and the Medical Foundation for the Care of Victims of Torture,[1] and contains general advice and practical information for torture survivors wishing to access information and services in the UK, including contact details for many useful service providers throughout the country. The Handbook also sets out the ways in which torture survivors may obtain reparation. The Manchester meeting took place the day before 26 June, the United Nations International Day for the Support of Victims of Torture.

This report provides a summary of this meeting. It also analyses options for the way forward having regard to feedback from the participants.

1. OBJECTIVES

The meeting set out to achieve the following:

- To highlight and discuss the main challenges facing torture survivors in (re)-integrating into UK society;
- To map out strategies for all those who are involved in trying to help torture survivors;
- To discuss the difficulties service providers face in assisting torture survivors and how best to address these difficulties; and

[1] This publication, which is available in English, Arabic, Farsi, French, Russian Spanish and Turkish is accessible from Redress's website: http://www.redress.org/publications/Handbook_En.pdf. Copies may also be obtained by contacting REDRESS.

- To increase awareness of the ***TORTURE SURVIVORS' HANDBOOK*** and gather participants' comments on the same.

2. THEMES COVERED

Four main themes were covered in the agenda:

- Challenges which torture survivors face in the UK from the perspective of survivors themselves;
- Survivors' medical and psychological needs. In particular, an overview of specialised services and typical challenges facing front-line caregivers in the provision of medical and psychological support;
- Survivors' domestic legal needs. Issues discussed in this regard were how to obtain benefits for survivors and special issues affecting survivors who are refugees and asylum seekers.
- Survivors' rights and needs for reparation (including restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition). A special session focused on explaining and describing survivors' rights to reparation and the strategies for assisting them to obtain the same.

II. SUMMARY OF PRESENTATIONS AND DISCUSSIONS

After a welcome address by Kevin Laue of REDRESS, the organisation's Executive Director provided an introduction of REDRESS' mission, objectives and strategies. She noted that REDRESS' mission is to rebuild the lives and livelihoods of torture survivors and their families so that they become active and contributing members of society again, and to eradicate the practice of torture world-wide. Its programmatic objectives are to obtain reparation (including restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition) for victims of torture and, when appropriate, their families, anywhere in the world and to make accountable all those who perpetrate, aid and abet acts of torture. REDRESS accomplishes these objectives through a variety of activities and programmes relating to the UK and internationally, including seeking remedies on behalf of individual survivors; recommending changes to laws and practices at the domestic and international levels to enhance the access of torture survivors to justice and reparations; working with lawyers, activists, survivor support

agencies and other national bodies to improve torture survivors' access to justice and reparation in national contexts; and increasing awareness of the widespread use of torture and of measures to provide redress.

The demographic trends of torture survivors in the UK were explained. Torture survivors are not a homogenous group. They represent all segments of society – including refugees and asylum seekers and Britons tortured while working or otherwise traveling abroad. They have differing needs and face varying challenges.

1. CHALLENGES OF SURVIVORS IN THE UNITED KINGDOM FROM THE PERSPECTIVE OF THE SURVIVOR

Dr. William Sampson

Dr. Sampson was born in Nova Scotia, Canada to a British father and a Canadian mother. He is a chemical engineer with a PhD in biochemistry, and also obtained an MBA. In July 1998, he went to Riyadh, Saudi Arabia after securing a position with the Saudi Industrial Development Bank. On 17 December 2000, Dr. Sampson was arrested (along with several other Britons) and was accused of involvement in the bombing campaign against Westerners. During his period of detention he was brutally tortured and he was forced under torture to give a false confession that he was a spy. After a 'sham' trial, he was found guilty and sentenced to death by beheading and crucifixion. He was released after "two years, seven months, three weeks and two days," having spent all of this period in solitary confinement. Dr. Sampson spoke about the torture he endured, which included:

- At the time of his arrest, three police officers punched him in his stomach, crotch and back of the head and placed him in the back of a vehicle. Two of the police officers held his legs open, while the third officer hit the area around his crotch approximately 10 - 15 times with a heavy metal object;
- During his interrogation, he was repeatedly thrown around the room by three men. He was also pushed on the floor, kicked repeatedly in his backside, crotch and stomach areas. His head was held up and he was slapped on the back of the head and face and around the ears. He was threatened with electric shocks and was aggressively caressed and fondled. This initial

interrogation took place over eleven nights. During each day he was chained to the door of his cell, and deprived of sleep;

- He was occasionally placed in an upside down position and beaten on his buttocks, feet, and crotch with a pick axe handle;
- Threats were made against his family and friends, for instance that the Saudi Arabian authorities would imprison his father;
- At one point he experienced a beating for eight hours and was kicked in the kidneys.

As a result of the beatings and other forms of torture he suffered a heart attack, an attack of angina and a damaged spine.

Since his return to the UK in September 2003, Dr. Sampson and other UK torture survivors have relentlessly tried to seek reparation for what happened to them in Saudi Arabia. According to Dr. Sampson, the British Government has 'no desire to help them,' and has been reluctant to pursue claims against the Saudi Arabian authorities on the survivors' behalf. He, together with other survivors, is currently seeking a civil ruling in UK courts against the Saudi Government and named officials for the harm he suffered. On 28 October 2004, the Court of Appeal ruled that Sampson's and others' claim against named individuals would not be struck out on the grounds of State immunity – the Court noted that it is no longer appropriate to give blanket effect to a foreign State's claim to State immunity in respect of officials alleged to have committed acts of systematic torture.[2] There are several further procedural and jurisdictional hurdles, however, that Dr. Sampson and the other torture survivors will need to overcome before their claims can be heard on the merits.

In addition to the difficulties he continues to experience in seeking a remedy and redress for his suffering, Dr. Sampson likewise continues to face enormous obstacles in obtaining benefits. Social services and welfare agencies had little understanding of the debilitating nature of his trauma and refused to recognise him - a highly-educated and articulate British national – as a person needing assistance. He has had difficulty accessing health benefits and social housing, despite major heart operations and psychological trauma. In his concluding remarks, he opined that the British Government viewed him, and other British nationals tortured abroad, as an embarrassment.

[2] The full Court of Appeal judgement can be accessed from the REDRESS website at http://www.redress.org/news/Jones%20v%205audi%20arabia.pdf

Mr. Yasser Al Sayegh

Mr. Al Sayegh, originally from Bahrain, acquired British citizenship through marriage and residence. In 1996, he returned to Bahrain from the UK for a short period of time to work as a computer analyst in a Government ministry. He was accused by Bahraini authorities of distributing an unlawful pamphlet and was arrested. Although Mr. Al Sayegh was never brought to trial, he spent nine months in prison and during this time, he was severely tortured and witnessed the torture, rape and abuse of other prisoners. He spoke of his torture, which consisted of beatings all over the body with metal objects and being hung upside down and told to confess that he was a traitor and a British spy. As a result of his arrest and torture, he lost his British house and all of his assets as he was unable to make his mortgage payments.

After campaigns for his release were mounted on his behalf, the Bahraini authorities released him and ordered him to leave the country within 24 hours. He engaged a Bahraini lawyer who attempted to seek redress on his behalf. In consequence, the lawyer was arrested and severely tortured. As a result of the torture, the lawyer suffered a stroke, can no longer speak and is certified as disabled.

Upon Mr. Al-Sayegh's return to Britain he unsuccessfully tried to get help from the British Foreign and Commonwealth office and certain intergovernmental bodies. Unfortunately, there are few mechanisms in place for him to obtain a remedy and redress.

Questions and Answers

The participants were very interested to know the specific needs of the survivors, and the extent to which financial compensation would constitute sufficient acknowledgement of what they had suffered. Dr. Sampson explained that most of all, he needed to regain his lost dignity and wanted the world to be made aware of the behaviour of Saudi officials and the inaction of the British Government. He also "wanted his name back" as he has a criminal record in Saudi Arabia, which according to the UK government is valid. Mr. Al Sayegh implored that the perpetrators of torture must be made accountable for their actions – the near universal prohibition of the crime of torture must be implemented in practice. Concrete action was required, including the prosecution of perpetrators, which would go a long way towards acknowledging the reality of torture, and such a process would in itself help towards rehabilitation.

2. DEALING WITH SURVIVORS MEDICAL AND PSYCHOLOGICAL NEEDS

Dr. Mary Robertson: Typical medical and psychological needs of survivors

Dr. Robertson introduced her topic by referring to torture as a deliberate act meant to induce pain and mostly used to extract information. It is an attack on the body and mind aimed at destroying personalities and identities. It fosters a culture of fear and mistrust. Torture stifles dissent and opposition and silences individuals and communities. The end result is the maintenance of tyranny. She cited the following quotation, as reflective of the feelings of survivors:

> *My thoughts were frequently occupied by the loss of my humanity. What had I become? What had I descended to as I sat here in my corner? I walked the floor day after day, losing all the sense of the man I had been, in half trances recognizing nothing of myself.*[3]

She noted that:

- There is no typical torture survivor;
- There is no single torture syndrome - signs are largely dependent on a plethora of factors including culture and background;
- Torture wounds both body and soul;
- Psychological reactions are normal reactions to extreme stress though not all torture survivors need professional help; some may recover with the help of family, friends or other support;
- Torture is an assault on both the individual survivor and the community;
- There is a need to understand the torture experience within the context of being a refugee; for asylum seekers, torture is one more traumatic experience.

The most common psychological reaction for a torture survivor is post-traumatic stress disorder (PTSD), depression, somatic complaints (common pain) and changes in the personal value system.[4] PTSD, which is perhaps the most complex psychological reaction, is evidenced by the re-experiencing of the traumatic event, avoidance and numbing, and increased arousal. Other common reactions are

[3] Dr. Robertson quoting Brian Keenan.

[4] Ramsay, Gorst-Unsworth & Turner, (1993), *Psychiatric Morbidity in Survivors of State Organised Violence Including Torture: A Retrospective Series*, British Journal of Psychiatry.

low self-esteem, including feelings of shame and guilt and interpersonal difficulties (such as increased irritability, anxiety and impatience). Torture survivors may also experience panic attacks, cognitive problems (loss of memory and concentration), dissociation and substance abuse.

Physical reactions are specific to the type of torture that has been used. Common symptoms include problems with the muscular skeletal system, chronic pain and muscular tension, involuntary nervous symptoms, disorders in motor function, circulatory disorders, and skin and muscle changes. Some survivors sustain injury to tendons and ligaments, nerve and vessel injury and fibrosis in muscle injuries. Others suffer dental problems and head trauma. However, one should never lose sight of the fact that torture is never only a medical or psychological issue, and it must always be placed and understood in a broad political context.

Professionals coming into contact with survivors should be reminded that torture strips an individual's sense of trust and safety. Therefore, in their work they ought to focus on establishing a sense of trust and safety. Other principles of best practice include empowering the survivor and giving them a choice. When working with torture victims one has to take into account that one is dealing with individuals, and that there is a need for validation of their experiences, and flexibility and openness with respect to survivors' needs. Dr. Robertson also reminded participants of the need to acknowledge and respect cultural, religious and gender diversity. She noted that it is helpful for caseworkers to identify the strengths of the torture survivor and to build on the same. Interventions should not present painful reminders of the torture situation, and in this sense, an interrogatory style ought to be avoided and care should be taken to create a comfortable, welcoming environment.

She concluded by giving tips on how to address the needs of survivors. According to Dr. Robertson, interventions are needed on multiple levels. The first step would be to identify the primary concerns of torture survivors and the priority services or support that are required. For example, this could be social support and integration, or with asylum seekers the primary concern may be legal status. Furthermore, she underscored the importance of informing torture survivors of their rights and how to access health care. In situations where there is a need for trauma counselling, medication or other forms of medical assistance, a referral for specialist intervention is encouraged.

Dr. Petra Clarke: Rape as a method of torture

Dr. Clarke introduced her presentation by underscoring the horrific impact of rape, and its debilitating impact on the lives of survivors. There is no 'typical' woman that is likely to be raped. In her clinical work, she has encountered female rape victims from all strata of society and education, from diverse countries and faith backgrounds, women with six children and women who had been virgins. Most female survivors of torture fear rape more than any other form of torture. Dr. Clarke indicated that many female survivors have informed her that they resisted leaving their country of origin in spite of repeated physical violence and intimidation; however when it came to rape, even a single incident of rape triggered their flight from their home country.

As a result of its contact with rape survivors, the Medical Foundation has recently published a book entitled ***Rape as a Method of torture.***[5] The book considers the psychological and physical effects of rape on adults, adolescents and the family. It also provides a detailed legal analysis of rape as torture. In "*Women Who are Raped*," a chapter authored by Dr. Clarke, she describes an anecdotal study of 100 adult women who were raped and for whom Medical Foundation doctors had prepared medical-legal reports in 2002 - 2003.

While the study does not purport to be representative and cannot be translated into assumptions about the prevalence of torture among asylum seekers in the UK, nor about who is tortured in the world at large, Cameroon emerged as the most prevalent country of origin of the women in the study, followed by Uganda, Democratic Republic of Congo (DRC) and Zimbabwe. Dr. Clarke noted that in the reported cases that related to Zimbabwe and Cameroon many women were raped apparently because of their personal commitment to politics, while in Uganda and DRC it was as a result of the husband or a close family member's commitment to politics.

Dr. Clarke made the following observations regarding the 100 women's cases:

- The average age of the women at the time of the rape was 28 years old;
- 24% of the women indicated that they were educated to tertiary level and 36% to secondary level;
- 68 of the women had children, 17 of them (or 25%) had no knowledge of whether the children were alive or dead;

[5] Medical Foundation for the Care of Victims of Torture, *Rape as a Method of Torture*, ed. Dr Michael Peel, 2004.

- 11 women are said to have been virgins at the time of the rape;
- 35 of the women reported being raped by many men countless times; mass rapes usually occurred in detention centers or prisons;
- 15 women conceived as a result of the rape, and two women were pregnant at the time of the rapes and in both these cases the pregnancies continued.

Of the 100 women 23 had no physical scars. In the group of 77 that had scars only 7 were scarred in the genital area. Other evidence that may be present is long scratch marks running inside the woman's thighs where the rapist's fingernails could have dug in. Only nine of the women indicated that they had not been otherwise physically assaulted in addition to the rape. The most common forms of assaults include beating, burning, being cut, whipped and stamped on. One woman described how her hair was used to bash her head against the wall and to drag her along the ground. Of the 100 women, only one perpetrator from Burma was charged, convicted and sentenced. In 57 cases, the alleged rapists were detained then released. Most cases failed because of the absence of effective legal remedies for crimes of rape and sexual violence.

Dr Clarke concluded by giving a word of advice that the need for privacy extends far beyond the horrors of rape. Most women who have been raped are ashamed to make such a disclosure at the earliest opportunity, as they are required to do under asylum procedures. This may often work against them in the adjudication process. The hesitation to disclose acts of rape is not exclusive to female survivors; men are equally reluctant to disclose the fact that they had been subjected to rape. Dr. Clarke averred that sexual abuse of men is widespread and remains undocumented because of survivors' reluctance to come forward. While recognising the personal challenges for survivors to disclose their abuse, she noted the benefits of disclosure: first, it may help the survivor in taking his/her first steps on the path to recovery and second, naming the torturer may lead to their accountability which will in turn contribute to the prevention of recurrence.

Questions and Answers

Participants discussed the prevalence of rape amongst asylum seekers. In answer to a question whether there was a difference in ability to cope for those who have a decision as opposed to those who are still waiting, Dr Clarke said that the reaction of women indeed often depended on the status of their asylum application. Thus those whose applications had not yet been processed were greatly afraid of being returned to face further rape, and needed to feel safe in order to make disclosure;

however, the very fact that they were afraid made it difficult to get data and details from them which would be useful in their asylum cases. She also commented on some of the reactionary comments which have been made by male white judges in the UK with little understanding of the traumatic nature of rape, but added that some of the women adjudicators were equally to blame in these regards.

Dr. Sampson noted that one of the greatest fears of any torture survivor is the fear of not being believed.

Dr. Robertson reminded front-line caregivers of the importance for them to develop knowledge and understanding of other countries' problems in order to better understand and help torture survivors. This knowledge could be derived by enhanced communication and the sharing of information amongst service providers. Furthermore, Dr. Robertson indicated the importance for front-line service providers to develop their expertise in helping clients open up so that their specific needs can be identified and treated. Many GPs did not know how to deal with torture survivors, and do not or are unable to devote sufficient time to their special needs. Much work needs to be done in these regards.

3. DEALING WITH SURVIVORS' DOMESTIC LEGAL NEEDS

Ms. Helen Murshali: Obtaining benefits for survivors

Ms. Murshali commenced her presentation by referring to the diversity of torture survivors in the United Kingdom. She provided an overview of the benefits that asylum seekers are entitled to under UK law implementing the 1951 Convention on the Status of Refugees, and noted, with some concern, that cases such as Mr. Sampson would obviously not fall within the ambit of this protection.

Ms. Murshali made reference to the 1999 Immigration and Asylum Act, which ended the entitlement of asylum seekers to mainstream welfare benefits and access to local authority social housing. As of April 2000, accommodation and support to asylum seekers was being provided by the National Asylum Support Service (NASS). Furthermore, the Nationality, Immigration and Asylum Act 2002 was introduced to streamline the asylum process and make it firmer, faster and fairer. This Act introduced induction programmes, accommodation and removal centers.

These legislative changes introduced a two-tier system of support, whereby those asylum seekers who had been recognized as refugees were able to access all welfare benefits and mainstream services while those seeking asylum had only limited benefits through NASS. Ms. Murshali further noted that there is no system that caters for the basic needs of those who fall outside these stated criteria.

The types of interim benefits under NASS are based on the underlying criteria of destitution and these include:

- Access to primary health care;
- Secondary health care;
- Specialist services;
- Social services.

In order for front-line service providers to assist torture survivors to access benefits in practice, they need to know the detailed provisions setting out what torture survivors are entitled to. Ms. Murshali expressed disappointment that most professionals, including NHS staff, were ignorant of the nature and extent of benefits for asylum seekers. In this respect, she recognized that service providers needed to update themselves of changes in legislation, in order to be able to effectively assist access to accommodation and support services. Individual needs assessments ought to be carried out with each and every client. Appropriate referrals are equally important, and she encouraged front-line service providers to act as advocates and to follow up referral cases. Ms. Murshali concluded by highlighting some of the most common barriers which include:

- lack of information on the available services;
- language barriers and lack of interpreting skills;
- the dispersal of asylum seekers to areas where specialist services were not available;
- lack of knowledge about rights and entitlements.

Additionally, information sharing is key to overcoming all these obstacles.

Mr. Alan Brookes: Special issues affecting survivors who are refugees and asylum seekers

Mr. Brookes, himself a torture survivor, began his presentation by providing participants with his personal background and experience of torture in South Africa. He indicated that after being tortured for a period of ten days he could not even recognise himself, and for a long time lost all sense of concentration. He understood what "to be violated" really means.

Mr. Brookes focused his intervention on the process for seeking asylum in the United Kingdom, and the special impact the procedures have on survivors of torture. He noted that it is unfortunate that the Home Office, when assessing the credibility of asylum applications, places such a strong emphasis on consistent statements. In his experience with asylum seekers that had suffered particular trauma, such as survivors of torture, statements about what they had endured would often contain inconsistencies. Mr. Brookes noted that the usual presence of discrepancies in the recalling of traumatic events had been well-documented in clinical research.[6]

The official UK policy is to be "tough" on asylum seekers and not allow the law to be "abused" but if this is done without fairness and outside of the UK's international obligations the result can be injustice. Taking up on the issue of rape, he mentioned how often this was the key element in a woman's (and sometimes a man's) claim, and if it was left out the application would fail; nevertheless, because of family and cultural traditions (such as fear of being renounced by the husband) it was frequently very difficult to deal with but it was essential that it be brought out

He noted his disappointment in the skepticism the judiciary has towards information on mental health. Nonetheless, Mr. Brookes strongly recommended that support workers and front-line service providers take active steps to determine the state of mind of the survivor at the time of the questioning. He also stressed the importance of this type of information being included in an individual's asylum claim especially before the adjudicator.

[6] Mr. Brookes made special reference to two articles on the subject: Herlihy, Scragg & Turner, *Discrepancies in Autobiographical Memories - Implications for the Assessment,* British Medical Journal 2002; Dr Juliet Cohen, *Errors of Recall and Credibility – Can Omissions and Discrepancies in Successive Statements Reasonably be said to Undermine Credibility of Testimony*, Medico- Legal Journal, 69 (1) at 25-34, 2001. These papers can be found on the Medical Foundation's website.

Mr. David Rhys Jones: Medical-legal reports

Mr. Rhys Jones commenced his presentation by explaining that ever since the 1990s with the arrival of Kurdish and Turkish asylum seekers, the Medical Foundation for the Care of Victims of Torture started recording data relating to torture as a means to aiding the recovery of their clients. At present between 900-1000 medical-legal reports are drawn each year, and clear patterns of abuse in various countries have been revealed.

In accordance with the Home Office records, 10% of asylum seekers are survivors of torture. This is approximately 5 times less than the statistics of the Medical Foundation, particularly if organized violence is included. The difference in figures could be a result of the issue of the timing of disclosure by survivors. The Home Office has been accused of 'sympathetic indifference' as it does not ask asylum seekers any leading questions relating to torture.

Documented evidence of torture may be corroborative and relevant in the positive determination of an asylum claim. Adjudicators insist that medical evidence meets a certain threshold. This is particularly problematic where the victim has no physical scarring; in such cases the doctor would then be prompted to provide further explanation. From experience, it would appear that such expert evidence is often disbelieved by the adjudicators. Mr. Rhys Jones also drew attention to the Istanbul Protocol which lays down detailed guidelines for the role of lawyers and doctors who deal with torture survivors, and the Medical Foundations own guidelines. Sometimes doctors do harm by over-stating the case e.g. by asserting that scars could only have been caused by torture, instead of taking an objective approach.

Among other issues, the status of an asylum application is normally influenced by:

- The period taken by the applicant in making an application – the longer the delay between the date of entry and the date of application, the more detrimental;
- There is a general skepticism/cynicism on the part of the adjudicators.

Questions and Answers

The question of credibility was raised in the context of how difficult it sometimes is for torture survivors to remember specific dates and other details. This was confirmed, although it was

said that some survivors do have very good recall. There are cultural methods of description which differ from our (Western) chronological approach; thus a mother may recall the time by how many children she had at that stage, or their ages, or by the seasons ("it happened in the wet season"), while a man will refer to the job he had at the time.

It was pointed out that one of the aims of torture is to disorient the victim so that he/she does not have a clear concept of time.

It was mentioned that PTSD is still "suspect" in the eyes of some officials, despite the overwhelming evidence to the contrary, including research by Dr Stuart Turner who interviewed torture survivors *after* they had been granted asylum, and who therefore had no reason to change their stories or to fabricate. He found that there were significant variations with what they had said before, explained by the on-going severe disturbance to their psychological states. The question was raised as to whether specific reference should be made in medical-legal reports to such papers, and it was felt they could be used with care, as could others issued by the World Health Organisation. The government can always call its own experts to rebut the case put.

4. DEALING WITH SURVIVORS NEEDS FOR REPARATION (INCLUDING ACKNOWLEDGEMENT, JUSTICE AND COMPENSATION)

Ms. Carla Ferstman: Survivor's Rights and Access to Reparation

Ms. Ferstman introduced by pointing out that in its twelve years of existence REDRESS has been attempting to bridge the gap between the legal rights of survivors and their implementation in practice. In understanding the concept of torture certain images may immediately appear – that of the persecuted political opponent or ethnic minority. Yet, torture is prevalent around the globe and there is no limitation on whom might be subjected to torture.

Because of the ***specificity of torture*** and what it does to its victims, there is not usually a single 'remedy' that can make it all go away. ***Reparation*** refers to the range of measures that may be taken in response to an actual or threatened violation, embracing both the substance of relief as well as the procedure through which it may be obtained. In particular, reparation has the following functions:

- Restoration of dignity;
- Restitution and compensation;
- Rehabilitation;
- Psychological reparative function;
- Recognition that torture is a crime and the acknowledgement that a wrong has been done;
- Commemoration of the victim;
- Education, respect and tolerance.

The UN Convention against Torture, which has been widely ratified, obliges States to take effective legislative, administrative, judicial or other measures to prevent torture. It requires States to investigate allegations of torture and to punish those responsible. It also requires that a victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including as full rehabilitation as possible.

Having recognised the universal character of the crime – that an act of torture offends our common sense of dignity - international law outlaws safe havens for torturers. In other words, it requires that torturers be prosecuted wherever they are found, or extradited to face trial elsewhere. International law also recognises that it would be unlawful to return someone to a country where there is a reasonable likelihood that they may be tortured.

Within this context in the United Kingdom, there are at least three categories of survivors. These include:

- **Persons of foreign nationality who were tortured abroad** – they may be refugees or asylum seekers, temporary visitors or in some cases dual nationals. Many of the participants at the seminar would be most familiar with this category of survivor. The fact that they were tortured may have been revealed in the context of a refugee claim, or in their attempt to obtain specialised medical help or other services.

- **Britons who were tortured abroad –** they may have been working abroad or on vacation and for whatever reason, were detained and subjected to torture.

- **Persons who were tortured at the hands of British officials** – either British officials operating overseas or within the UK – here, we can think of the recent revelations of deaths

in custody in UK-controlled detention centers in Iraq, or to previous practices of security forces in Northern Ireland or elsewhere. Occasionally, these survivors will be in the UK, or seeking some form of remedy in the UK.

While all have similarly suffered, the nature of the remedies that are available in practice will differ, category to category, and within categories. The reason for these differences is because remedies for torture will depend, to a certain extent, on the international legal system in the place where the person was tortured and the international obligations that apply to that particular country. In addition, the UK government will have special obligations in relation to its nationals that were tortured abroad which do not apply to foreigners that are present in the UK, and apply only in a limited way to dual nationals.

At the national level (the place where the torture occurred), it may be possible to lodge a complaint with the police, but given that they may have been involved in the perpetration of torture, this avenue is not usually successful. In many countries, there are independent human rights commissions or ombudsman institutions, which may be able to assist, but usually there are significant backlogs. In some cases, it may be possible to bring a civil claim for damages. In the countries where torture is most prevalent, there are usually others problems relating to the independence of the judiciary, which may impede a successful resolution. Also, given that torture usually occurs behind closed doors, and victims rarely have the opportunity to seek medical attention right after the incident, it may be difficult to produce evidence of torture. Needless to say, seeking local remedies is a long and difficult process. Sometimes it will be years or decades before a case can be successfully resolved.

There are other remedies that may be sought in a regional or international context. In some parts of the world where there are regional human rights courts, victims can bring challenges here. The Torture Convention has also set up a complaints system, and this may be a possible forum. With the establishment of the International Criminal Court, the prosecutor will be able to take up cases of torture, where they occur in a systematic way and can be said to constitute crimes against humanity. It may sometimes be possible to seek a remedy in a third jurisdiction. In the UK, we have the example of the Pinochet case, where Spain sought Pinochet's extradition for torture that took place during the dictatorship in Chile, and the recent civil claims of the Britons tortured in Saudi Arabia.

Survivors may additionally call upon their government to pursue their claims against a foreign government or foreign officials on their behalf (diplomatic protection). The UK has not often sought remedies on behalf of its nationals who have been tortured abroad especially in cases relating to

those countries with whom it has a close relationship. REDRESS continues to seek clarification of the government's policy on diplomatic protection.

In conclusion Ms. Ferstman advised that the process of seeking redress is complicated and uncertain. In this respect, it is imperative that the objectives of survivors are known and understood and that survivors are made aware of the obstacles that they may face in the process. She informed participants of the importance of referring survivors for specialized legal advice.

III. GROUP DISCUSSION & FEEDBACK FROM RAPPORTEURS

The participants were divided into groups where the following questions were discussed:

- ***What strategies are there to improve the access of torture survivors to services in the United Kingdom***

Effective communication was seen as key to solving this problem. Service providers need to be aware themselves of the available services and to ensure that this information is passed on to beneficiaries and other care givers. Education and the provision of training materials on the available services were considered to be crucial to the success of information and outreach initiatives. The ***Handbook*** was seen as an important resource, and ways must be found to get it to those who need it. It is necessary to work with and develop good relations with local authorities, as well as with refugee communities

In order to do away with language barriers, a need for qualified interpreters was underscored. The Scottish approach with clearer links between health services and benefits was discussed and considered to be beneficial. Continued communication between service providers in different regions about best practice would be extremely beneficial. Because different service providers work in different compartments a more integrated approach is necessary.

Existing useful networks, such as those used by the British Red Cross, should be tapped into, as should those of faith-based institutions.

- ***How to identify what special help is needed***

The provision of information and training to both survivors and front line service providers would help identify what special help was needed. Participants felt that the starting point is for service providers to clearly understand that torture survivors are different people with different needs. Information sharing among service providers was also perceived to be essential as most problems could be attributed to lack of centralised knowledge.

Fundamentally, it was a matter of getting the survivors to talk. This required time on the part of GPs and other assessment experts. Some special needs were easier to identify than others (women, minors, child-soldiers). The question of those infected with HIV/AIDS was raised. There is often a difference in needs between political and non-political victims, and between isolated victims and those from within a community. There needs to be feedback to NASS on what it is getting right and where things can be improved.

- ***How to channel torture survivors' frustration in a positive way***

Group therapy, for example involving survivors in project work, is helpful in this regard. Legal remedies and the role of the media were also said to be equally important.

- ***How to continue to share experiences of best practice***

Increased networking and regular or at least occasional seminars could help in the sharing of experiences of best practice. Use can be made of web-page links and the spreading of information on the internet. More training on torture-related issues for lawyers could be pursued, as they are not well equipped to deal with torture survivors. Some are very good, others tend to pass the buck (e.g. to the Medical foundation, who must then fill the gap). There ought to be a torture module in the training of asylum lawyers, in which REDRESS could be involved. This would need to be done through the Legal Services Commission/Law Society. Where lawyers have failed to deliver a proper service there is a need to complain.

- ***What are the key challenges for frontline workers who deal with torture survivors***

A basic challenge is the disbelief of others as to what torture survivors have gone through. People who deal with torture regularly find it hard to talk to others about it. The attitude of the right-wing media is also stressful; asylum seekers have replaced earlier target groups (Blacks, Jews).

Frontline workers often find it difficult to grasp strategies for improving the access of torture survivors to services. It is difficult for them to cope with information. The link between frontline workers and other service providers is not strong. The immediate needs of new arrivals are demanding.

The other major challenge is stress of the workers, and compassion fatigue. This can be ameliorated through supervision and training.

IV. CONCLUDING OBSERVATIONS

The seminar provided a good opportunity to obtain comments on the ***Torture Survivors' Handbook*****,** a publication with information on support services and other resources for torture survivors in the United Kingdom and the possibilities of obtaining reparation. The participants were of the view that the ***Handbook*** is a clear and helpful publication, which has been well received by torture survivors around the UK. It was recommended that the ***Handbook*** be translated into further languages, including into Kurdish, Tigrinia, Swahili, Albanian and Portuguese.

Some participants expressed the view that the ***Handbook*** should have included information on the legal procedures for asylum applications and general information on what steps asylum seekers and refugees could take if they believed that they had been given ineffective/inadequate legal representation. The importance of this recommendation was noted. As the seminar illustrated, not all asylum seeking refugees are torture survivors, and not all torture survivors are refugees. However, asylum law cannot be ignored as it forms the basis for the particular regime of rights and benefits to which such persons are or should be entitled. From the perspective of torture survivors seeking asylum, the question is how to identify and then address the unique problems facing those who have endured torture within this welfare regime.

Overall, participants gave positive feedback on the seminar. All speakers gave pertinent and informative interventions leaving participants with greater knowledge about the needs of torture

survivors. One important issue that arose during the course of the seminar is that the affects of torture are manifested in many different ways and as a result torture survivors differ in their wants and needs, just as they differ in their personalities. However, they all have one thing in common: the need for assistance of one kind or another, and the need to be believed. As stressed during the seminar, awareness about the effects of torture, and understanding of the unusual and special problems faced by those who have survived torture is fundamental when assessing and providing for a survivor's needs. Not surprisingly, therefore, one of the key recommendations from the seminar was the need for better and further information on the effects of torture; in that the more front-line service providers become aware of the consequences of torture, the better able they will be to effectively help re-build shattered lives of survivors. Moreover, one of the most common effects of torture is physical and/or psychological impairment of some form or other which frequently results in disability, either permanent or temporary. Accordingly, it is crucial that law and practice adequately address this even though the context in which this need arises may vary from person to person.

Looking specifically at torture survivors who are refugees they are likely to be unfamiliar with their entitlements as they come from outside of the country. More often than not, they will be unaware that they may apply for financial and other assistance as a result of their disability. Moreover, this lack of knowledge is frequently compounded by their reluctance or inability to disclose their disability, physical or mental. The may even seek to hide, disguise or minimize their disability out of embarrassment or pride, or as a result of cultural mores, gender and so on.

For all torture survivors who are entitled to full benefits, and who find themselves negotiating their way around the complex benefits system, they usually encounter hurdles created as a result of current policy which appears to take no specific account of their particular predicament. Even though the survivor may qualify for additional benefits, such as the various disability allowances, the criteria are not designed for torture survivors but for 'everyday situations' which UK citizens face. Furthermore, survivors may encounter varying degrees of ignorance about torture and the effects of torture which give rise to a further need; the need for their front-line service providers to be their advocates, so that survivors receive a fair assessment for additional benefits. The matter is further compounded for those survivors who suffer from no obvious physical disabilities but whose impairment may be psychological. Added to this, certain benefits may be awarded at the discretion of the social services authorities, making the need for awareness and understanding of the effects of torture all the more crucial, especially as the application of the criteria can vary considerably from area to area. In addition to the need for better information, these hurdles facing survivors could also be overcome if there was a

specific policy recognisisng the particular effects of torture and the needs flowing from those effects. Demoralized by multiple hurdles, some torture survivors give up trying to obtain benefits which they need and to which they are clearly entitled.

In short, the seminar highlighted the need for better and further information on the effects of torture and the resulting needs together with the necessity for the dissemination of this information as one of the ways forward. Moreover, front-line service providers saw it as an important element of their work with survivors. Participants also recommended that more of such seminars should be held, and that consideration should be given to holding them with or within refugee communities themselves, and possibly in a less formal setting. In order to facilitate dissemination of information, it was suggested that more use might be made of handouts and other audio-visual techniques. Another positive suggestion was that officials from the Home Office needed to be encouraged to participate: this reflected the all-round agreement amongst participants and speakers that a multi-pronged and coordinated strategy is urgently required to deal with the needs of torture survivors in the United Kingdom.

V. LIST OF PARTICIPANTS

. Al- Sayegh Yasser, Student, Bolton
. Banwell Salah, Project Worker Welsh Refugee Council, Cardiff
. Berenjian Marzieh, Leeds Iranian Organisation, Leeds
Brookes Alan, London.
Carrol Colin, Appeals Team Leader, Refugee Legal Centre , Leeds
Clarke Petra, Medical Practitioner, Medical Foundation, London.
Dalliston Alex, Client Support Coordinator, Cambridge Refugee Support Group
Ege Mohamed, Mental Health Consultant, Somali Mental Health Project, Sheffield
Ferstman Carla, Legal Director, Redress, London
Fiagbedzi Linda, Project Manager, Cambridge Refugee Support Group, Cambridge
Ho David, Client Support Worker, Health Access Team, Leeds
Hopper Diane, GP, Health Access Team, Leeds
Howle Jane, Specialist Health Visitor, Asylum Seekers/Refugee Project, Stoke-on Trent
Jackson Ros, Health Visitor, Wakefield West Primary Care Trust, Wakefield
Jones-Said Amanda, British Red Cross, Salford
Laue Kevin, Project Coordinator, Redress, London
Lloyd Janet, Project Coordinator, North of England Refugee Services
McDonald Ann, Nurse Coordinator, Fernbank Health Centre, Glasgow
Miller Joanna, Health Advisor, Huddersfield Central PCT
Milliard Lennie, Counselor, Health Access Team, Leeds
Miraf Khamidun, Manager, Refugee Council Yorkshire and Humberside, Leeds
Mohamed Salah, Manager, Welsh Refugee Council, Cardiff
Moyo Khanyisela, Intern, Redress, London
Murshali Helen, Policy Adviser, Refugee Council, London
Neal Lesley, GP, Asylum Seeker and Refugee Health, Sheffield
O' Connor Annie, Volunteer, Medical Foundation, Manchester
Puch Laura, GP, ARCH, Birmingham
Richards Debra, Deputy Manager, Refugee Action North West, Liverpool.
Rhys Jones David, Advocacy Officer (Refugee Issues), Medical Foundation, London
Robertson Mary, Chartered Clinical Psychologist, Traumatic Stress Clinic, London
Rose- Sender Kate, Executive Director, REDRESS, London
Saimbi Hilary, Nurse, Community Development, ARCH, Birmingham
Saki Faimeh, Leeds Iranian Organization, Leeds
Sampson Bill, Client, c/o REDRESS, London
Thapa Mani, Officer, Refugee Action, Leeds
Turley Hilary, Project Coordinator, British Red Cross, Salford
Velemu Ronald, Development Worker, NICEM, Belfast
Walker Lynne, Case Worker, Refugee Action North West, Liverpool
Walsh Brian, Operations Manager, Specialist Mental Health, Flanshaw Centre Wakefield
Watts Patricia, Mental Health Nurse, Health Access Team, Leeds
Webb Wes, Chief Executive, Coventry Refugee Centre, Coventry

VI. BIOGRAPHIES OF SPEAKERS

Mr. Alan Brookes spent his formative years in Southern Africa where he was active in the anti-racist struggle in Rhodesia (as it then was) and South Africa, for which activities he was tortured and jailed in South Africa in the 1960s. After his release from prison he continued for many years to campaign for majority rule, and played leading roles in the British Anti-Apartheid Movement, the International Defence and Aid Fund for Southern Africa, and the Mozambique, Angola and Guinea-Bissau Information Centre (MAGIC). He has also worked in other African countries including Mozambique and Zambia, but has spent most of his adult life in the UK. A law graduate from the University of Cape Town, Alan recently retired from his work in a London firm of solicitors where he was working closely with refugees and asylum seekers.

Dr. Petra Clarke graduated from medical school in Liverpool in 1962. She has had a varied career practicing as an Obstetrician and Gynaecologist in Liverpool, Manchester (at St Mary's), London, Oxford and for 2 years in Uganda. She worked for government for many years in public health policy development. In the past 5 years Petra has worked for the Medical Foundation where she has prepared innumerable medico-legal reports for women who have been tortured, usually including rape.

Ms. Carla Ferstman is REDRESS' Legal Director. She was called to the Bar in British Columbia, Canada in 1994. She is the informal coordinator of the NGO Coalition for an International Criminal Court's Victims Rights Working Group, is an associate member of the Council of the International Criminal Bar and is a member of the British Foreign and Commonwealth Office's Expert Panel on Torture. Previously, she has worked with the UN High Commissioner for Human Rights Field Operation in Rwanda on legal reform and capacity building in post-genocide Rwanda, and in 1999, was appointed Executive Legal Advisor of Bosnia and Herzegovina's Commission for Real Property Claims of Displaced Persons and Refugees (CRPC). Carla has an LL.B. from the University of British Columbia and an LL.M. from New York.

Mr. David Rhys Jones has a legal background. He has worked in the asylum law field since 1986: first with the UK Immigration Advisory Service, then with the UNHCR in Hong Kong and Thailand between 1989 and 1994, and then with the Refugee Legal Centre in London, followed by private practice, before moving into the NGO field - first as National co-ordinator for Association of Visitors to Immigration Detainees, then Bail for Immigration Detainees. He has worked for the Medical Foundation for the Care of Victims of Torture as Advocacy Officer (Refugee Issues) since January 2002. Among David's duties is the proof reading (from a legal perspective) of medico-legal reports prepared by clinicians at the Medical Foundation. David is the editor of the Medical Foundation's *Guidelines to Writing Medico-Legal Reports Documenting Evidence of Torture.*

Ms. Helen Murshali is a refugee from the Horn of Africa, and has worked with refugee community groups in London for 10 years. She joined the Refugee Council in January 2000 as a Health Access and Development worker and is currently Policy Adviser on health access issues. Her brief includes advising voluntary and statutory agencies on health care entitlements and rights for refugees and asylum seekers. Helen also gives presentations to various groups and individuals on refugee and asylum seekers health issues.

Dr. Mary Robertson is a Chartered Clinical Psychologist, and since 2001 has headed the Traumatic Stress Clinic in London. Prior to taking up that post she worked for more than seven years in a senior capacity with the Centre for the Study of Violence and Reconciliation in Johannesburg, and was very actively involved in many aspects of post-apartheid developments concerning refugees and other victims and survivors of trauma. She has also played an active role in matters relating to trauma in

Rwanda, Northern Ireland and Mozambique, to name but some countries. Mary holds degrees from the University of Natal and the University of Witwatersrand.

Dr. Kate Rose-Sender is a public international lawyer, qualified in the United States. She has a background in human rights and humanitarian law. She was Professor of International Human Rights Law at the American University in Cairo where she also coordinated the International Human Rights Law Outreach Project and a Lecturer at Central European University in Budapest. She obtained her Juris Doctorate from DePaul University in Chicago, her LLM from University College London, and her PhD from the University of Westminster.

Dr. William (Bill) Sampson is a dual Canadian-UK citizen, resident in this country. He is a chemical engineer and holds a PhD and MBA from UK universities. While working in Saudi Arabia he was detained in December 2000 (along with several other British subjects) and brutally tortured for months, accused of involvement in bombings against Westerners. On the basis of false confessions extracted under extreme torture, and what could not even be dignified as a show trial, he was sentenced to death by beheading and crucifixion. After more than two years and seven months in detention, all of it in solitary confinement, he was released. Since their return to the UK last year, Bill and the other UK torture survivors have been seeking reparations for what happened to them.

Mr. Yaser Al Sayegh is a Bahraini national who also obtained British citizenship through marriage and residence. In the period 1996-1997 while working in Bahrain as a computer analyst in a government ministry he was accused of political activity and arrested and severely tortured. Although never brought to trial all charges were eventually dropped and he was released. Under threat of further detention and torture he fled the country, returning to live in the UK. Yaser is currently a student.

VII. AGENDA

9:15 – 9:30 Registration of Participants

9:30 – 10:15 Introductory Sessions

- Welcome Address and Overview of Torture Survivors in the UK: Needs and Challenges – *Dr Kate Rose-Sender*
- Challenges for Survivors in the UK from the Perspective of the Survivor – *Mr. Yasser Al-Sayegh & Dr. William Sampson*

10:15 – 10:30 Discussion

10:30 – 10:45 Break

10:45 – 11:30 Session II: Dealing with Survivor's Medical and Psychosocial needs

- Typical Medical and Psychological Needs of Survivors – *Dr. Mary Robertson*
- Rape as a Method of Torture – *Dr. Petra Clarke*

11:30 – 11:45 Discussion

11:45 – 12:30 Session III: Dealing with Survivor's Domestic Legal Needs

- Obtaining benefits for survivors – *Ms Helen Murshali*
- Special issues affecting survivors that are refugees and asylum seekers – *Mr Alan Brookes*
- Medical - Legal Reports – *Mr. David Rhys Jones*

12:30 – 12:45 Discussion

12:45 – 14:00 Break

14:00 – 14:45 Session IV: Dealing with Survivor's Needs for Reparation (including acknowledgment, justice and compensation)

- What are survivor's rights to reparation and what are the strategies for assisting them to obtain them – *Ms Carla Ferstman*

14:45 – 15:00 Discussion

15:00 – 16:30 Session V: Group discussions

16:30 – 17:00 Session VI: Closing

- Report back from groups
- Closing remarks

17:00 End