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Monitoring and evaluation of remote medico-legal report assessments when documenting evidence of torture for asylum seekers detained on Diego Garcia

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Abstract

Introduction: Between 2022-2023, Freedom from Torture produced remote medico-legal reports for 19 asylum seekers unlawfully detained on Diego Garcia, an island in the Chagos Archipelago. *Aim:* To ascertain clinical challenges and effectiveness of remote assessment of evidence of torture for individuals held in quasi-detention on Diego Garcia as compared to UK-based individuals not in detention. *Previous audits:* At the start of 2020, Freedom from Torture audited telephone assessments undertaken with individuals in the UK, to assess the extent to which telephone assessments can safely evaluate evidence of torture. Results were published in the Torture Journal (Cohen et al., 2021). Between 2020-2021 we conducted a further audit of appointments with individuals in the UK by (i) video assessment only (ii) a combination of video and face-to-face assessments and (iii) face-to-face assessment only. *Method:* We collected feedback from doctors following video assessments with individuals on Diego Garcia. We compared this with the feedback from previous audits. *Results:* Doctors carrying out Diego Garcia video assessments felt less able to make a full assessment of the impact of torture or to complete a full psychological assessment, compared with assessments of UK-based individuals. They were less able to obtain as full an account and establish rapport. Substantially more challenges and safeguarding concerns were reported. *Conclusion:* Remote medico-legal assessments of asylum-seekers held in detention-like circumstances are less likely to be able to fully document and evaluate evidence of torture than remote assessments of asylum-seekers not in conditions of detention.

Keywords: medico-legal, torture, asylum, remote assessment, Diego Garcia, detention

Introduction

Freedom from Torture is a human rights charity in the UK, and one of the largest torture rehabilitation charities in the world. It provides therapy, support and medico-legal reports (MLRs) for survivors of torture. Freedom from Torture's remit criteria are based on and adhere to the UNCAT definition of torture.

The MLR Service is a specialised expert witness service producing independent medical evidence of torture for survivors to use in their asylum claims. Freedom from Torture MLR writers follow the methodology set out in the Istanbul Protocol (United Nations, 2022). This process includes taking a first-hand account of the person's past experiences of torture and other trauma and the physical and psychological consequences of this, a physical examination to document any lesions or injuries attributed to torture, a mental state examination, and a psychological assessment. The doctor will then correlate the degree of consistency between clinical findings and the allegations of torture or ill-treatment, applying Istanbul Protocol definitions regarding different levels of consistency as outlined in Paragraph 380 of the Protocol. Other significant factors may also be considered, such as clinical reasons for differences in an individual's account, whether the individual is a vulnerable wit-

ness, the risk of suicide or self-harm, or any health care needs and subsequent recommendations.

The MLR writing doctor has dual responsibilities. As an expert witness, they have an overriding duty to the court, inferring an obligation of impartiality; as a doctor, they have an ethical responsibility to 'do no harm', which confers responsibilities such as taking reasonable action to safeguard individuals and to ensure that immediate health needs are met.

The COVID-19 pandemic understandably heralded an increase in remote health care assessments. Since the lockdown lifted, hybrid or fully remote services have become a part of normal processes in many healthcare settings. A body of research now exists evaluating the safety of this new way of working, although few studies relate to asylum seekers and even fewer to the documentation of torture.

A study from the United States surveying clinicians following remote appointments with asylum seekers found that "*remote evaluations were relatively easy to perform and acceptable to clinicians*" (Pogue et al., 2021). A further study which looked at the experiences of doctors carrying out cross-border remote evaluations for asylum seekers in migrant encampments in Mexico, pre-pandemic, found: "*Despite multiple challenges, and while perceived as less ideal than in-person evaluations, clinicians felt that remote evaluations -- even across international borders and in an unstable setting -- achieved their intended goals and were "better than having no evaluation done" at all"* (Mishori et al., 2021).

Prior to the COVID-19 pandemic, Freedom from Torture assessments were carried out face-to-face. During the pandemic, Freedom from Torture developed remote telephone assessments. Research published in Torture Journal (Cohen et al., 2021) monitored the safety and quality of remote MLRs by telephone. It concluded that MLRs can be safely produced by telephone assessment and that these reports can adhere to Istanbul Protocol principles. However, it was found that they were more likely than face-to-face assessments to be incomplete in terms of both full disclosure of torture experiences and psychological assessments.

In 2023 a paper was published that compared 10 face-to-face and 11 video interviews to document torture carried out in Spain during the time of the Covid pandemic, which found that: "*Remote assessment is a valid alternative to face-to-face interviews in specific cases*," although human and therapeutic aspects indicate that "*whenever possible, face-to-face assessment should be preferred*" (Galán Santamarina et al., 2023). The paper concluded that the two methodologies "*have specific issues to be studied and addressed*." We are not aware of any further studies considering remote assessments of medico-legal assessments carried out for the purpose of documenting torture.

Since the 'lockdown' ended, Freedom from Torture has largely been carrying out assessments using a new hybrid model: a face-to-face appointment followed by a video or telephone appointment. Freedom from Torture continued to audit these appointments, collecting data to monitor safety and quality for telephone-only, video-only and face-to-face assessments.

Background to Diego Garcia and the presence of asylum seekers

Diego Garcia is an atoll in the Chagos Archipelago in the Indian Ocean. Since 1965, it has been part of the British Indian Ocean Territory (BIOT), but its ownership has long been disputed, with the International Court of Justice ruling that it should be returned to Mauritius. Only 30km^2 in area, the island is currently leased to the United States for use as a military base. In May 2025, a treaty to transfer sovereignty from the UK to Mauritius was signed, with a provision that the military base would remain under UK control for at least 99 years.

Between October 2021 and December 2024, a group of asylum seekers were stranded on Diego Garcia after the boats they were travelling in fell into distress. On arrival, they identified themselves as in need of international protection. Some had recently left Sri Lanka, some were from refugee camps in India, and most were Tamil.

BIOT is not a signatory to the Refugee Convention, and no system existed to consider an asylum claim from Diego Garcia. The BIOT commissioner initially declined the group's request to be transferred to another country, instead developing a process for consideration of claims based on non-refoulement (Nelson, 2023).

In the meantime, the group was housed in large tents, separated from the military base by wire fences. They reported that they were not permitted to leave the camp area, which was roughly the size of a football pitch. UNHCR undertook a monitoring visit to the camp in November 2023 and issued a report in February 2024 (UNHCR, 2024) which raised concerns about the conditions, including: restrictions on freedom of movement within the small camp area (including for children); inadequate accommodation including leaking tents, rats, and folding army cots; a lack of privacy including use of mixed gender tents for unrelated individuals (until July 2023); a lack of recreation facilities and insufficient shade or air conditioning; a lack of cooking facilities or culturally appropriate food; and no access to internet. There were reports of sexual assault and a high prevalence of self-harm. The conditions were described as "arbitrary detention." Following this visit, 47 asylum seekers were granted bail, enabling them to leave the camp and visit other parts of the Island (The Commissioner for the

British Indian Ocean Territory v The King (on the application of VT & Ors), 2024).

In 2022 and 2023, Freedom from Torture was instructed to produce 19 medico-legal reports for individuals located on Diego Garcia, in the context of the process developed by the BIOT commission for the consideration of claims. All 19 individuals were referred via their legal representatives. The instructions were to carry out a psychological and, where possible, a physical assessment related to an allegation of torture. Photographs of scarring were provided with some of the referrals. Our usual practice is to conduct a face-to-face physical examination.

At the time of our assessments, we considered the conditions under which the individuals were held to be a form of 'quasi-detention' on the basis that many of the features found in detained settings were replicated, similarly to those sites examined by the All-Party Parliamentary Group on Immigration Detention in its inquiry into quasi-detention: "*Large-scale and institutional in nature, the sites replicate many of the features found in detained settings – including visible security measures, surveillance, shared living quarters, reduced levels of privacy and access to healthcare, legal advice and means of communication, and isolation from the wider community. In the APPG Inquiry Panel's view, they are most accurately described as 'quasi-detention'*" (All-Party Parliamentary Group on Immigration Detention, 2021).

Although not officially considered detention at the time, we believed many of the potential health impacts of detention may apply. In December 2024, the Supreme Court of the British Indian Ocean Territory (BIOT) ruled that the conditions on Diego Garcia amounted to unlawful detention, finding that the Tamil asylum seekers held in the camp on Diego Garcia had been unlawfully detained for more than three years, rejecting the Commissioner's argument that they were "free to leave" (The King (on the application of VT) (Sri Lanka) v Commissioner for the British Indian Ocean Territory, 2024).

Ethics

Our clinical team expressed concerns that the potential for re-traumatisation of torture survivors on Diego Garcia was increased due to the conditions of their detention, the nature of their accommodation and the remote nature of the assessment.

Several issues arise out of the circumstances in which the cohort was held. First, a quasi-detention or a detention setting can remind a torture survivor of past detention in their country of origin and trigger an increase in re-living symptoms related to past traumatic experiences, including torture. Re-traumatisation is the "*reactivation of trauma symptoms via thoughts, memories, or feelings related to the past torture experience.*" (Schippert et al., 2021). As a result of re-traumatisation, a survivor of torture may become psychologically unwell before (anticipatory), during or following an assessment appointment. This can cause a decline in mental health with an increase in symptoms of post-traumatic stress disorder, anxiety, low mood and insomnia. An increase in risk of suicide and self-harm might occur. The Istanbul Protocol (2022, paragraph 280) cautions that "*Despite efforts to prevent and mitigate retraumatisation, torture survivors are likely to experience some level of distress during a clinical interview. Clinicians, together with the individual, should balance the potential traumatic effects of an interview with the potential benefits of a comprehensive medico-legal evaluation. When the interviewer suspects that retraumatisation has occurred, it would be important to acknowledge the concern, mitigate ongoing retraumatisation (such as with breaks, breathing exercises and redirection to less emotional topics), offer psychological support and refer the alleged victim to appropriate follow-up care.*"

Second, in our previous unpublished audit, doctors conducting remote video assessments cited safeguarding concerns, vulnerability and isolation, and ill (including mental) health as hindering their assessment in 61% of consultations. It is common for an MLR doctor to 'safety net' individuals after an assessment, and this would involve writing a letter to their General Practitioner, which might include recommendations for care. If an individual was felt to be very unwell, an urgent or same-day appointment might be arranged, a referral to safeguarding teams made, or an urgent accident and emergency assessment performed. At the time of referral, we were uncertain what medical care was available for individuals detained on Diego Garcia.

Other published research considers a similar ethical issue. Febles Simeon & Cuneo (2023) published a case study in which clinicians faced the dilemma of assessing an individual across borders with limited information and in an environment that exacerbated pre-existing trauma. The clinicians involved found that "*While these considerations must be weighed carefully, the need for remote evaluations of cross-border clients [...] is great,*" emphasising the need for forward planning, identifying best practices and providing a pathway for formal training and mentorship.

We were mindful that we were unlikely to be able to complete full (physical and psychological) MLRs in this situation. There was, therefore, an additional risk that a partial report may be submitted for an asylum application and refused when a full report might have been able to better demonstrate evidence of torture and risk of future harm. Furthermore, later disclosure in a subsequent in-person assessment might lead to an adverse credibility finding against a person.

In the face of these concerns, Freedom from Torture considered declining these referrals; however, there were compel-

ling reasons for proceeding. Medical evidence was required to prevent refoulement and to support efforts to relocate the group to a more appropriate setting. Legal representatives referred with some urgency, as they had become increasingly concerned regarding the conditions in which their clients were being kept. An assessment by an MLR doctor might enable the identification of urgent health care needs and assist in providing care for them.

After discussion, Freedom from Torture decided to cautiously proceed with assessments, balancing the individual's need for medico-legal evidence with the clinician's 'first do no harm' responsibility. This guided a cautious approach regarding the risk of re-traumatisation and exacerbation of mental health problems of those examined remotely. In short, proceeding with caution was assessed as the 'least worst' option. We caveated our reports as 'interim' and outlined their limitations. We collected audit data to evaluate the safety and effectiveness of our approach. As the assessments proceeded, our doctors reported several concerns about the individual's safety. These mostly involved an increased risk of self-harm and suicide, although other issues were raised, such as access to appropriate medical care.

For the first Diego Garcia individuals assessed by Freedom from Torture, no medical records were available, and there was no direct way of raising concerns with the Diego Garcia medical team. Initially, it was not clear what local medical support was available, and there was no system to enable us to communicate directly with the medical team, so we had to send all communications through the BIOT administration. Although this improved as the assessments continued, the time difference between Diego Garcia and the UK and the impossibility of speaking to the medical team by phone remained hindrances to safety netting for these individuals.

Of the individuals assessed, 17/19 were found to have expressed a wish to self-harm at some point (12 of those were documented as having expressed a wish prior to interview, and eight individuals expressed during their interviews that they had a wish to self-harm). MLR doctors would generally respond to such disclosures by ensuring procedures were in place to reduce the risk of self-harm and suicide. This was challenging for the Diego Garcia assessments due to the difficulties in communicating with the medical team.

The reports of self-harm and attempted suicide were so high that Freedom from Torture were ethically compelled to take further action. Concerns were passed from the medico-legal reports service to the charity's advocacy department who wrote private letters highlighting the clinical concerns. On 15th December 2023, Freedom from Torture wrote to the Commissioner of the British Indian Ocean Territory, setting out our concerns regarding the reported conditions that asylum seekers were being held in, the limited healthcare facilities on Diego Garcia and risks inherent in remote assessments.

Method

Previous audit

The previous audit (surveys of doctors who completed assessments for UK-based individuals) was conducted between May 2020 and June 2021. Multiple stakeholders were surveyed using different surveys (doctors, torture survivors, medical reviewers, legal reviewers, and interpreters). Slightly modified surveys were carried out for different types of MLR assessment.

Template development and training

A new report template was developed for doctors conducting assessments of individuals on Diego Garcia. This recognised that the assessments were likely to be shorter and have a limited physical component. A specialist team of doctors was identified. These doctors all had experience in psychological assessment and had undertaken training in medico-legal report writing. The doctors were advised to undertake a risk assessment early in the appointment and to adjust their approach accordingly.

Ethics approval

The Freedom from Torture research ethics committee approved each step of the project.

Preparation and Risk Assessment

Legal and medical documents (when available) were requested from the legal representative and examined by an MLR legal officer and a senior doctor before the appointment to identify any potential increased risk. A case file was prepared by the legal officer, and the MLR doctor was briefed before the appointment. When high risk was identified, MLR doctors were advised to proceed with particular caution.

Sample

All MLR assessments of individuals on Diego Garcia were conducted between September 2022 and October 2023. A team of doctors and interpreters conducted 19 assessments. Some worked with a single individual, and others conducted assessments on more than one individual. The average age of individuals undergoing assessment was 29 years (range 21-49). All except one individual were male. The individuals had travelled from India, but all were Sri Lankan nationals, except one Indian national, and all were of Tamil ethnicity. Some were born in Sri Lanka, while some were born in refugee camps in India.

Process

Each assessment was carried out via video call with an experienced interpreter. The individual was asked about their gender preference for the doctor and interpreter. The average number of assessment appointments was 1.4 (7, or 37%, of cases required more than one appointment). The average total appointment time was 170 minutes (range 120-270 minutes), including breaks. Following a risk assessment, the doctor continued to consider torture where possible and to document the physical and psychological impact of that. If the individual had lesions (scars or marks) that were easily visible on the video connection, the doctor documented them to the extent possible. The doctor produced a draft of the report. If the doctor had safeguarding or other concerns, they would write an email to Diego Garcia's medical staff with the individual's consent.

Consent

All individuals gave consent for both the MLR process and the use of their anonymised data.

Review

Each draft report was reviewed by a legal officer before the doctor completed the report.

Audit

Feedback was collected from the doctors following their final appointment with the individual. This was done through a survey comprising a mix of open and closed questions mirroring the questions and structure of the feedback surveys from previous audits, with additional questions added on self-harm and the observation of physical lesions. It was not considered safe or practicable to collect feedback from survivors or other stakeholders in the Diego Garcia cases, so we focused on the experience of doctors conducting the appointments. We also conducted in-depth interviews with a sample of 5 doctors who carried out the assessments.

Analysis

Data were analysed and compared with data from the previous doctors' audit for UK-based individuals.

Results

The results for the initial 20 telephone assessments undertaken with individuals in the UK were published in the Torture Journal (Cohen et al., 2021). Results from the continued audit of appointments with individuals in the UK by (i) video assessment only, (ii) a combination of video and face-to-face assessments, and (iii) face-to-face assessment only, have not been previously published.

The following responses were received from doctors in the previous audit (surveys of doctors completing assessments for UK-based individuals between May 2020 and June 2021):

1. Interim remote MLR assessment – 68 responses (18 of those in relation to video-only calls)
2. Update to interim MLR assessment (face-to-face) – 28 responses
3. Full new hybrid model MLR assessment (combination of remote and face-to-face) – 26 responses

Table 1 summarises doctors' feedback responses comparing the Diego Garcia video assessments (2022-2023) with the different types of assessments in the previous audit.

Our previous research showed that when remote assessments were undertaken by video in normal settings, doctors expressed that they were able to make fuller assessments than by telephone, with greater ability to establish rapport and fewer areas that individuals were unwilling to disclose. However, 57% still reported being unable or only partially able to read body language, which they found hindered the assessment.

By comparison, doctors carrying out Diego Garcia assessments felt least able to make as full an assessment of the impact of torture (16%); to make as full a psychological assessment of the current condition (32%); and to consider consistency of psychological symptoms with the torture account (26%).

In terms of the level of both abilities to obtain a full account (21%) and the inability to establish rapport/build a trusting relationship (63%), doctors carrying out Diego Garcia assessments were on a par with those carrying out remote telephone interviews. Assessments were consequently less complete than those carried out by video or face-to-face with individuals in the UK.

Table 2 summarises the findings that were felt to hinder the assessment of the Diego Garcia video assessments compared with those from the previous audit.

The frequency of hindrances reported was considerably higher for Diego Garcia appointments overall as compared with other video appointments. While the top difficulties reported by doctors carrying out those appointments were technical difficulties on the call and difficulty reading body language/lack of cues, safeguarding concerns were more frequently cited by doctors carrying out Diego Garcia appointments (68%) than normal video assessments (47%), and doctors more frequently expressed a difficulty in establishing and building a report for Diego Garcia appointments (47% versus 27%). The individu-

Table 1. *Survey of doctors completing MLR assessments*

	Diego Garcia survey (2022-2023) % (n)	**Results from the previous audit (UK-based individuals, 2020-2021)**		
		Telephone % (n)	Video % (n)	Face-to-face % (n)
Ability to obtain as full an account*	21% (4/19)	17% (8/48)	44% (8/18)	76% (19/25)
Ability to make as full an assessment of the impact of torture*	16% (3/19)	24% (12/49)	53% (9/17)	69% (18/26)
Ability to make as full a psychological assessment of the current condition*	32% (6/19)	34% (17/50)	59% (10/17)	73% (19/26)
Ability to consider consistency of psych symptoms with torture account**	26% (5/19)	55% (27/49)	82% (14/17)	85% (22/26)
Unable to establish rapport/build a trusting relationship to the same extent*	63% (12/19)	64% (32/50)	53% (9/17)	N/A
Areas the client is not ok to disclose	16% (3/19)	42% (14/33)	11% (2/18)	20% (5/25)
Unable/only partially able to see body language, and this hindered the assessment	63% (12/19)	94% (16/17)	57% (8/14)	N/A

* Compared to as if I had met the individual in person
** Completely or partially

al's isolation and vulnerability were also cited as a hindrance by substantially more doctors carrying out Diego Garcia appointments (63% versus 40%).

Physical observations: 33% (6/18) of doctors were able to make limited physical observations of individuals on Diego Garcia, and 67% (12/18) were unable to make any physical observations. Of the 33% who made limited observations, only one doctor was able to assess the consistency of physical findings with the account of torture.

Due to the unique nature of the Diego Garcia assessments, we added additional questions to our original survey, presented in Table 3. Observations from the in-depth interviews are referenced in the discussion below.

Discussion

Freedom from Torture's previous research indicated that medico-legal reports can be produced safely through remote assessments, but are less likely to be complete than those produced through face-to-face assessments.

The audit of remote assessments for Diego Garcia individuals, compared with the previously unpublished audit of UK-based individuals, indicated that remote assessments for this cohort of individuals were more hindered by concerns about safeguarding, vulnerability, and ill health than UK-based remote assessments, and that the assessments may also be less complete.

Challenges to completing the assessments

The individuals on Diego Garcia were unlawfully detained in conditions that the UNHCR consider contributed to "elevated levels of distress, suicidal thoughts, and behaviour and a '*rising hopelessness*'" (paragraph 109, The King (on the application of VT) (Sri Lanka) v Commissioner for the British Indian Ocean Territory, 2024). The impact of detention on the mental health

***Table 2**. Most common hindrances to assessment cited by doctors:*

	Diego Garcia survey (2022-2023) n=19 n (%)	**Previous survey for video assessments (UK-based individuals, 2020-2021) n = 15 n (%)**
Technical difficulties (including poor video or audio quality)	16 (84%)	5 (33%)
Difficulty reading body language/lack of cues	14 (74%)	4 (27%)
Safeguarding concerns (e.g. the need to self-censor to avoid re-triggering or flare-up of symptoms in the absence of clinical support)	13 (68%)	7 (47%)
Client's isolation and vulnerability	12 (63%)	6 (40%)
Difficulty establishing rapport remotely	9 (47%)	4 (27%)
Client's ill health (including mental ill health) arising during the assessment	8 (42%)	3 (20%)

***Table 3**. Additional survey questions*

Percentage of doctors able to make physical observations	6/18 (33%)
Percentage of doctors able to assess (to a limited degree) consistency of physical lesions with the account	3/18 (16%)
Percentage of doctors who contacted Diego Garcia staff urgently during or following the appointment	4/19 (21%)
Did the individual express a wish to self-harm prior to or during the interview?	16/19 (79%)

of asylum seekers is well established in clinical research (Shaw, 2016). A 2018 systematic review of the mental health of immigration detainees found that detention was an independent risk factor for PTSD (Steel et al., 2005). Detention or quasi-detention conditions are reminiscent of many of the contexts in which they were tortured. Asylum seekers may therefore be more vulnerable to becoming re-traumatised whilst giving their account. Freedom from Torture does not currently assess asylum seekers in UK detention: the individual would, in ideal circumstances, be released from detention before undergoing the full MLR process and giving a detailed account.

For the Diego Garcia individuals, this was not possible. Our clinicians faced a choice in which, in our view, the 'least worst' option was to proceed with remote assessment. Under these circumstances, doctors will have been on guard for early signs of an individual becoming traumatised, and it is likely that this affected their approach to the assessment. For example, one doctor reported, "*I did not feel I could push questioning too much given his acute psychological state and the uncertainty of how much support was available to him*". Another stated that "*I was wary of going into too much detail about his torture experience in case of re-traumatising him.*" The majority of doctors reported being unable to take as full an account (79%) or make as full an assessment of the impact of torture (84%), compared to seeing the individual face-to-face.

The assessments of the Diego Garcia individuals were conducted by video; therefore, it might have been reasonable to expect results similar to those of video assessments of individuals based in the UK. In reality, the number of doctors who felt able to make as full an assessment was far lower (16% compared to 53%). This appears likely to have been because of concerns about the mental health of the individuals being affected by conditions on Diego Garcia. Comments from the in-depth interviews with doctors support this theory.

> I hadn't realised how subtle some of the cues are and how I depend on them – for example pupils dilating, sweating a little bit. If a client is becoming distressed then there is a very fine tremulousness in the voice which you would get face-to-face but not in a remote consult... When you have done it for 100 years, you don't really think about it – but when you have the remote consult you realise you don't have it – it's a loss of control as you don't have that early warning. [Doctor comment in open interview]

> I was concerned that as I was not in the same room as him it would have been difficult to use grounding techniques or anxiety management strategies if he became distressed during the assessment. This limited the extent to which I felt able to push for details about his experiences. [Doctor comment in open interview]

There is a particularly marked difference in the ability to consider the consistency of the psychological symptoms with the torture account, with only around a third of doctors feeling able to do so in the Diego Garcia assessments, compared to almost two-thirds in the previous video assessments with UK individuals. This is not surprising given that the living conditions on Diego Garcia were, in the opinion of the BIOT Supreme Court, "*adversely affecting the physical and mental well-being*" of those detained there (paragraph 104, The King (on the application of) VT (Sri Lanka) and others v The Commissioner for the British Indian Ocean Territory, 2024). It would therefore be harder for doctors to assess which symptoms were due to previous torture and which were due to the situation at the time.

Technical difficulties and privacy

Another possible reason for the difficulties in completing the Diego Garcia assessments is that the quality of the video call negatively impacted the appointments. A total of 16 doctors (84%) had technical difficulties, with 15 (79%) reporting that poor video quality was a hindrance and 12 (63%) having problems with sound quality. However, those doctors who did not experience technical difficulties still found that they were less able to assess the impact of torture or make a psychological assessment as fully as if they had met the client in person, which suggests that other factors were more significant.

As well as video quality, doctors raised concerns about the areas where individuals were placed for their appointments and the privacy of those areas. Two doctors reported that others walked into the room while the individual was on the call.

> He said there were guards all around listening, outside the room. He showed me the room and there was no one outside. But when the link went out, he knocked and the guard came in immediately – almost like someone was standing next to the door right outside. You are aware that you do not know who else is there listening. [Comment from doctor in open interview]

Privacy is essential for disclosure. The Istanbul Protocol, paragraph 325, includes a lack of privacy among potential communication barriers that can hinder assessment: "*Environmental barriers, such as lack of privacy, uncomfortable interview setting or inadequate time for the interview.*"

Rapport

The Istanbul Protocol defines rapport in this context as meaning a 'working relationship between the interviewer and interviewee' and states that it is essential to conducting an effective interview. The doctors assessing Diego Garcia individuals were particularly experienced in psychological assessment, in contrast with groups involved in previous surveys, and skilled at building rapport during MLR assessments. The interviews were conducted several years after the pandemic, during which Freedom from Torture implemented a new hybrid face-to-face/remote assessment model. As a result, the doctors had experience in conducting remote assessments, although the standard practice was for the first appointment to be conducted face-to-face, thereby allowing rapport to be established before follow-up remote appointments.

The doctors were asked whether they were able to build rapport and establish a trusting professional relationship with the client to the same extent as if they had met in person. The majority of doctors conducting Diego Garcia assessments felt less able to build rapport (63%). This was a higher proportion than amongst doctors conducting video-only assessments with individuals in the UK (53%), but similar to those conducting assessments by telephone (64%).

Other factors may have affected rapport. The individuals on Diego Garcia had not had face-to-face access to their legal

representatives and may not have been adequately prepared for the MLR process. The time difference between the two countries may have affected it: Diego Garcia is 5 hours ahead of UK time. Appointments running into the afternoon UK time may have been carried out at times when individuals were tiring or hungry. Lack of privacy (see above) may have also been a barrier to trust. Several doctors commented that having only one appointment also makes it harder to build rapport.

Physical assessment

The Istanbul Protocol (2022) sets out the internationally agreed guidelines for the clinical evaluation of torture and ill-treatment.

The physical examination aims to document scars, marks and other injuries that may have been caused by torture (collectively referred to as 'lesions') as well as any physical symptoms that may bear relevance to an individual's experience of torture. While it is recognised that not all methods of torture leave physical lesions (Istanbul Protocol, 2022, paragraph 399), many survivors of torture do have physical lesions as a result of their mistreatment.

A survivor of torture may not always be aware of the presence of lesions on their body. Our practice is to fully examine a torture survivor, examining the whole body. Further, the carefully managed process by which a survivor of torture provides attributions for the various lesions on the body can manifest the psychological impact of their mistreatment.

There are limitations in carrying out a physical assessment over a remote video link or via photographs of lesions. Photographs or videos are often not of sufficiently high quality to enable assessment and may restrict assessment to only those lesions the individual identifies, rather than providing a full picture. Additionally, examination of the physical consequences of torture does not solely depend on viewing lesions. The texture of lesions and signs, such as localised tenderness, loss of sensation or strength, and reduced range of movement, can all provide important information. In video assessments, it is usually not possible to obtain a clear image in sufficient close-up, but in some cases it may be possible to gain additional information by comparing the appearance on video with a clear photograph, or by asking the individual to describe the contour and surface of the lesion or to place an object beside the lesion to provide scale. Torture can result in a wide range of physical consequences across many organ systems of the body, such as abdominal or pelvic pain, joint damage or neurological deficit, and an in-person physical examination is necessary to assess these fully.

Many survivors of torture report sexual assault and rape. The skin of the ano-genital region is fast-healing, and so the absence of lasting injuries is common (Istanbul Protocol, 2022, paragraph 467). This, however, increases the significance if such injuries are found. Therefore, in ideal circumstances, survivors of sexual violence would be offered an intimate examination.

The assessment of any one lesion is best made not in isolation but as part of a holistic examination, including consideration of the pattern and distribution of lesions on the body. As an example, a single lesion on an ankle might appear unremarkable, but a collection of circumferential lesions on both ankles might suggest that a person was tied at the ankles. Assessing photographs may therefore give an inaccurate representation of the physical evidence. The Istanbul Protocol guidance provides an overall framework for evaluating all clinical findings when assessing allegations of torture (paragraph 424).

For some of the Diego Garcia individuals, we were provided with photographs of lesions attributed by individuals to ill-treatment. In others, we were asked to assess lesions remotely over video link. The assessment conditions on Diego Garcia, including a lack of privacy, meant that requesting an intimate examination by medical staff or photographs of intimate areas would have been inappropriate.

Our doctors found that it was rarely possible to correlate the level of consistency between physical findings and the allegation of torture or ill-treatment based on the provided photographs or over a remote connection. It is likely that, if attempting to assess lesions based on poor-quality images, it may only be possible to apply a lower level of consistency (e.g. "consistent" or "highly consistent"), whereas additional features may be discerned with an in-person examination that may have raised the level.

Only one doctor was able to assess the consistency of the physical findings with torture with reference to paragraph 418 of the Istanbul Protocol. In this case, individual lesions were not assessed, but an assessment of the consistency of the overall physical findings with torture was made. The individual in question may have had other lesions on their body which were unable to be documented, but which may have altered the overall consistency level.

The majority of doctors felt unable to make any assessment of lesions at all. Reasons for this were explored in the open interviews. They included poor-quality photographs, poor video quality, low lighting in interviews, the setting not being adequately private, feeling less appropriate to ask the individual to undress due to difficulty forming rapport, and not being able to see the body as a whole, and so understand the pattern of injuries. Comments included:

> He had many scars. Some of these I couldn't see at all due to the dim lighting in the room. Some I could see exist-

ed but not well enough to describe in detail. I was not able to look at scars closely, from different angles or to measure them. Furthermore, it felt awkward to ask him to undress or reveal parts of his body via video. This may seem counter-intuitive - perhaps it would have been easier for the individual to do this via video than in person ..but... Even if he had I'm not sure how clearly I would have been able to see them, and even if the lighting had been better, I couldn't have measured them and done the full assessment, so was it fair to ask him that when I don't know how much use it would have been? [Comment from doctor in open interview]

He said there were guards all around listening, outside the room. He showed me the room and there was no one outside. But when the link went out, he knocked and the guard came in immediately – almost like someone was standing next to the door right outside. You are aware that you do not know who else is there listening. [Comment from doctor in open interview]

Risk and safeguarding

Ensuring the safety of the individual is not an 'add on' but an essential element of the doctor's role. The MLR doctor is often the only person to have spoken at length to an individual and they may disclose things in this setting that they do not disclose elsewhere. Carrying out an MLR interview with no adequate way to escalate safeguarding concerns represents an unsafe way of working.

In the open interviews, our doctors used words such as *'Shell-shocked', 'Hair-raising' and 'Loss of control'* to describe the experience of assessing individuals in this manner. Further comments from open interviews and surveys included:

Straight off the bat when I asked him how he was he told me he wanted to die, and I instantly readjusted. It was within five minutes. It was UK mid-morning but later Diego Garcia time and you didn't know what services were around. [Comment from doctor in open interview]

I think it was because of the risk involved in questioning - the client was in relatively unknown circumstances and I did not know what support was available after the appointment. I feel this is true of all remote appointments to some extent, but in the UK at least I know they have a GP and can access any A&E department and can signpost accordingly. [Doctor response from survey]

Doctors described how, presented with an increased risk of re-traumatisation and concerns about how they could safeguard individuals, they adapted their interview style correspondingly.

There were times when I felt that he was hinting at things that happened [...] that had had a huge impact on him. Since we weren't in the same room I knew that if I pushed him for details and if this caused re-triggering of his trauma I would be less able to contain or manage his anxiety or any reaction, hence I did not explore details in the same depth I would otherwise have done. [Doctor response from survey]

I went very carefully around the outline of what happened to him, let him dictate what he wanted to tell me. ... I was aware from one of the medical letters that he had a dissociative episode after one of the immigration interviews that they did, so I had to tiptoe very carefully, I couldn't get as full a history as I would have wanted to get. It was incredibly anxiety-inducing to have to do that, because I was constantly trying to weigh up getting enough detail to write up a report and the risk of triggering one of these episodes again. [Comment from doctor in open interview]

...It was better than nothing, we managed to get through it ok, I was able to do a report that I hope was helpful, but I had to be very careful that I didn't make any unguarded remark and phrased questions carefully, and not ask some questions and discontinue others as he was starting to get upset. I couldn't make more complex diagnoses because of the limitations. [Comment from doctor in open interview]

He was becoming distressed and angry and I terminated it at that stage as I couldn't let it get out of hand. I said I think we should all have a bit of a break now, Do you want to go and stretch your legs and we can carry on. It occurred to me he might not come back but he did. Had we been face-to-face I might have pursued it further but in those circumstances I couldn't risk it. [Comment from doctor in open interview]

Despite these concerns about safeguarding, only 4 doctors (21%) contacted Diego Garcia staff urgently during or after the appointment. This might be because of the constraints in contacting staff mentioned earlier.

Limitations of the study

Stakeholders: Because of the remote location and concerns regarding the living conditions of individuals being held in detention-like circumstances, as well as the frequency and severity of mental health issues, we did not consider it safe or practicable to collect feedback from survivors, who had been a key stakeholder for previous audit research. It was therefore not possible for us to include results relating to survivor-reported safety and distress. We did not collect feedback from any other stakeholders, as we preferred a direct comparison between the experiences of doctors carrying out the appointments collected in surveys across the different types of assessment, supplemented by more qualitative information from doctors carrying out the Diego Garcia assessments, who could also reflect on prior experience carrying out different types of assessments. This allowed for a more focused view from a clinical perspective, although it may also be regarded as a limitation of the study, given that most quantitative outcomes reported herein are based on doctors' self-reported perceptions rather than independent coding of indicators in the reports.

Numbers: This study reports on survey responses, which were limited in number by the number of interviews that Freedom from Torture were instructed to carry out. Findings are limited to these relatively small numbers and this medium, limiting the extent of data analysis, although supplemented by additional qualitative information from five in-depth interviews.

Demographics: Our cohort consisted mostly of Tamil men.

Physical assessments: As noted in the results and discussion, it was largely not possible to assess physical marks, lesions, or other physical symptoms; it is therefore unknown what impact including a full physical assessment might have had on the reports' conclusions.

Due to the real-world, changing circumstances of Freedom from Torture's work to carry out remote assessments in the context of the COVID pandemic and the Diego Garcia detentions, our research was inherently reactive and constrained by those circumstances. Without the benefit of hindsight, we were unable to consider all factors that might later become relevant. This has, in part, limited the scope of our audit and analysis, but we believe useful conclusions can be drawn, nevertheless.

Conclusions

There are only a handful of previous studies looking at the effectiveness of remote assessments for asylum seekers. This is the first systematic documentation of remote Istanbul Protocol-based MLRs conducted with asylum seekers in an offshore quasi-detention setting and the first study to compare multiple modalities (telephone, video, hybrid and face-to-face). It is also the first study to specifically consider safeguarding issues in either a cross-border or quasi-detention setting. Whereas earlier studies primarily addressed hindrances such as technical issues, difficulties building rapport, and limitations of physical examination during remote assessments, we have specifically considered the ability to assess the degree of consistency of the findings in line with the Istanbul Protocol methodology.

This research found that the clients' vulnerability, their remote location, and their conditions of quasi-detention limited the extent of medico-legal assessments. In particular, doctors' concerns about re-traumatisation and suicidality limited the extent of the history taken and evaluation of current psychological conditions. As might be expected, it was only possible to document very minimal, if any, physical findings.

Assessments were felt to be necessarily partial and incomplete, to a greater degree than for those in a previously audited group of UK-based clients

As large numbers of people continue to flee torture and other forms of harm, the housing and processing of asylum seekers represents political 'high stakes' across much of the world. In the UK, the asylum estate comprises housing, hotels, and large ex-military sites. Offshoring, which often involves some form of detention, continues to be debated worldwide as a potential solution to both the number of people requiring housing and the political ramifications of doing so. The use of large ex-military sites for housing asylum seekers has been described as 'quasi-detention' (All-Party Parliamentary Group on Immigration Detention, 2021), and such a description may apply to other current and future institutional accommodation sites.

This research is important for ensuring a safe medico-legal assessment of vulnerable asylum seekers, especially those accommodated in detention or in conditions of quasi-detention, and where remote evaluation is the proposed mode of assessment, or indeed the only option. Remote assessment is, for example, increasingly being proposed as the method for a psychological evaluation of those in prison or immigration detention in the UK.

We maintain that, in some circumstances, it may not be possible to complete a full assessment remotely, even when a psychological-only report is requested.

According to our findings:

- Face-to-face consultations are generally preferable for physical assessments of scarring and other potential sequelae of torture, particularly where detailed visual and tactile examination is important.
- Where a remote assessment is undertaken, it is important to ensure the individual has access to a private, well-lit, and safe space for the duration of the appointment. Safeguarding the

privacy of communications can be supported through appropriate and secure use of technology.
- It is advisable to undertake a risk assessment that considers the individual's current environment and living arrangements, and to weigh whether a remote format is appropriate in the circumstances.
- Clear arrangements are helpful so that the assessor can rapidly contact the healthcare professionals responsible for the asylum seeker's care if concerns arise during or after the appointment.
- Medico-legal reports can usefully include explicit caveats describing any limitations of the assessment (including those linked to modality, setting, or access to examination), so that findings are interpreted in context.

Where possible, Freedom from Torture follow-up outcomes of our medico-legal reports. The outcomes of the asylum cases for the Diego Garcia cohort, as assessed by our doctors, are not yet known for all cases. One individual was voluntarily re-patriated and two received refugee status. The remainder have now been brought to the UK, where their cases are ongoing. Freedom from Torture has been instructed to complete full assessments for some individuals who were previously assessed remotely. We hope that this will enable us to reflect on the extent to which the earlier assessment process was re-traumatising and on the ethical decision we made to proceed.

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APPENDIX – SURVEY QUESTIONS

1. Your name (first name and surname):
2. MFID number:
3. Date of last remote appointment:
4. How many appointments did you have?
5. Were your calls made with video or voice only?

Please provide further details if relevant:

6. To what extent were you able to obtain an account of torture?

Please provide further details if you are able to:

7. To what extent were you able to make an assessment of the impact of torture?
   Please provide further details if you are able to:
8. 8. To what extent were you able to make a psychological assessment of the current condition?

Please provide further details if you are able to:

9. To what extent were you able to consider consistency of the current psychological condition with the account of torture given?
10. If your answer to the above question was that you were not able or were only partly able to consider consistency of the current psychological condition with the account of torture given, do you believe this is because you were not able to meet with the individual in person?

Please provide further details if you are able to:

11. To what extent were you able to make physical observations?

Please provide further details if you are able to:

12. Were you able to assess the consistency of any physical findings with torture?

Please provide further details if you are able to:

13. Were photographs provided and if so, were they of sufficient quality?
14. To what extent were you able to address other specific instructions from the legal representative, such as unfitness to give evidence?

Please provide further details if you are able to:

15. If your answer to the above question was that you were not able to address some or any of the legal representative's instructions, was this a result of not being able to meet with the individual in person?

Please provide further details if you are able to:

16. What factors helped or worked well in the assessment? For example, having a pre-briefing, taking breaks, a second/follow up call, or other tips?
17. What factors, if any, hindered the assessment?
18. Did the client identify any areas they did not feel ok to disclose or discuss remotely?

Please provide further details if you are able to:

19. Did you feel that you were able to build rapport with the client and establish a trusting professional relationship with the client to the same extent as if you met in person?

Please provide details if possible, including any positive factors that enabled you to build a rapport, such as having a second appointment booked.

20. To what extent do you feel the assessment was hindered by inability to observe body language / visual cues / demeanour?

Please provide further details if possible:

21. Did the individual express a wish to self-harm?

Please provide further details if possible:

22. Did you at any point need to contact the Diego Garcia staff as a matter of urgency? If so please provide details about the level and frequency of contact and the response.
23. Do you have anything else that you would like to note? This might include specific measures you took to assess and manage risk, and any comparison with other remote assessments that you might have carried out?

FRAMEWORK FOR STRUCTURED INTERVIEW

1. A brief narrative explaining the specific circumstances of the interview (further questions asking for detail about the appearance of the interview room);
2. The specific challenges that you experienced during the process of conducting the MLR assessment;

3. Any safeguarding concerns that may have been / were raised by the circumstances prior, during and following the interviews
4. Further question regarding retraumatisation/difference between interviews if there was more than one interview;
5. How you managed risk;
6. Steps you took to prevent or minimise re-traumatisation;
7. 9. Whether you were able to make any physical observations;
8. 10. Anything further that you think it might be important for us to note (including whether you were able to compare with other remote assessments).