The medico-legal assessment of asylum seeker victims in Italy

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Key points of interest

- Enhancing multidisciplinary approaches when undertaking clinical evaluations of asylum seekers could improve the quality of investigations on the origin of physical scarring and on subsequent decisions regarding refugee status.
- Psychiatric, psychological and social approaches are also crucial to assess people who claim severe physical violence with no physical signs.

Abstract

Introduction: Changing patterns of migration has required states and governments to respond to the specific medical and legal needs of asylum seekers. Based on medical assessments undertaken at the University Institute of Legal Medicine, the present study aims to describe the cases of asylum applicants who have suffered from physical violence, including torture, and the variables involved. *Methods*: Over a 10-year period, 225 survivors were examined by clinical forensic professionals from the University Institute of Legal Medicine. *Results:* 85% of asylum applicants came from Africa, 87% were male, and the most common age group was 26-40 years old. 46% of applicants fled their country for political reasons. Blunt force injuries were reported in 45% of cases, the trunk was the most affected area of the body (40%), and applicants presented with an average of two different mechanisms of lesions and an average of four lesions each. *Discussion/conclusion:* Assessment of physical violence on asylum seekers requires the cooperation of professionals with different skillsets and training.

Keywords: Clinical forensic medicine, asylum seekers, physical assessment, medico-legal assessment, violence, Istanbul Protocol

Introduction

A person forced to abandon their country of origin faces many difficulties and has often experienced physical and psychological violence, including torture. Italy is a destination country for many people forced

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to flee their homes and is one of the highest recipient nations of migrants in the Mediterranean. Once in Italy, migrants usually either continue their journeys onwards to Northern European countries or remain in Italy in the hope of attaining refugee status. The legal processing of asylum applicants for refugee status in Italy follows international regulations, as stipulated by the European Union and United Nations High Commission for Refugees (UNHCR). Applicants are examined through detailed interviews with the Territorial Commission, the Italian First Instance Determinative Authority, to decide whether the asylum seeker meets the criteria to be granted international or national protection.

Medical reports can decisively influence the result of the application (Asgary et al., 2013; Peart et al., 2016). Medical examinations are fundamental to demonstrating the vulnerability of an asylum seeker in all its forms (e.g., medical, personal, linked to familiar issues) and assessing the credibility of their narratives when an asylum seeker claims to be a victim of torture or other severe forms of violence in their country of origin. The Istanbul Protocol provides critical guidelines for physical and psychological medical assessment.[1] It details the circumstances in which an alleged victim of torture should be interviewed, outlines ethical considerations, and explains the process of thorough medical examination for symptoms of torture.

The Istanbul Protocol has been applied in multiple contexts, such as: in Sweden (Edston and Olsson, 2007; Moisander and Edston, 2003), in Denmark (Arge et al., 2014; Masmas et al., 2008; Leth and Banner, 2005), in Egypt (Ghaleb et al., 2014), in Kyrgyzstan (Moreno et al., 2015), and for documenting abuse and psychological symptoms of child soldiers in different contexts (Afana, 2009; Guy, 2009). However, only a limited number of studies have focused on the methods for assessing scars (cf. Pfortmueller's, 2012; Sheather et al., 2015; Thomsen, 2000).

This study primarily focuses on the Italian experience in the Metropolitan city of Milan and is concerned with the medico-legal evaluation of asylum seekers who have suffered from physical violence, including torture as well as the variables involved. This study draws on 10 years of clinical forensic medicine experience and provides a description of physical evaluations of asylum applicants in Italy for the first time.

Background to study

The Municipality of the Metropolitan City of Milano and the University Institute of Legal Medicine have made the medico-legal assessment of victims of violence a key priority, as part of a broader project aimed at protecting vulnerable people. A team—composed of experts in clinical forensic medicine, ethno-psychiatry, anthropology, psychology and social work—are responsible for examining asylum seekers and assisting with their applications for asylum.

In September 2013, the Municipality of Milan approved a new Protocol by Municipal Decree, which established an operational network in the Milanese territory that was tasked with assisting and caring for asylum seekers and vulnerable subjects in particular. The members of the Protocol meet on a monthly basis to exchange information on interventions,

[1] See Istanbul Protocol: Manual of Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Submitted to the UN High Commissioner for Human Rights on 9 August 1999.

aiming to improve needs assessments of the traumatized and enable service providers to deliver adequate levels of assistance and protection.[2]

The University Institute of Legal Medicine actively collaborates with this Protocol by performing two types of evaluations. The first evaluation is of scars and lesions in asylum applicants who have declared themselves to be victims of physical violence, to determine the consistency between allegations of physical violence and evidence of healed wounds. The second evaluates the age of asylum seekers. A thorough report is written on each evaluation and presented on the day of the hearing at the Territorial Commission. Following this, the Commission decides whether applicants meet the criteria to be granted international or national protection. The data used in this study is taken from physical examinations undertaken during this process.

Materials and methods

Between 2008 and 2018, 225 asylum seekers underwent physical examination. Following the Istanbul Protocol, full medical examinations of the alleged victims were performed during the clinical assessments. Final reports were drafted on the consistency between the allegations of physical violence and the results of the external examinations, and submitted to the Territorial Commission. In all cases, individuals were examined by forensic specialists. Interviews were conducted (often using a mediator or translator) to gather an initial history of the person, including the reasons they fled their country, detailed accounts of violent and/or traumatic events, and their health status.

A judgment on the degree of concordance between the narrative and the lesions investigated was undertaken in accordance with the Istanbul Protocol, based on the following criteria: "not consistent," "consistent," "highly consistent," "typical of," and "diagnostic of" (cf. Franceschetti et al., 2017).[3]

Results

Year of Examination

The number of the evaluations increased over the years (Table 1) with two examinations of asylum seekers both in 2008 and 2009, five in 2010 and 2011, followed by 17 (2012), 15 (2013), 20 (2014), 24 (2015), 38 (2016), and 29 (2017). In 2018, the number rose to 68 and is further increasing in 2019.

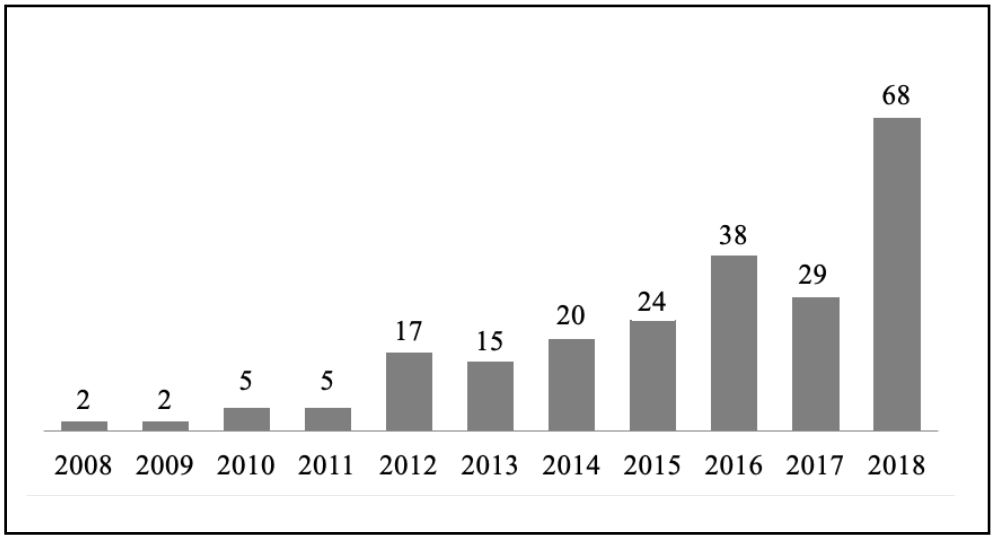
Background Characteristics

Asylum applicants predominately came from African (192 individuals) and Asian countries (32). Figure 1 captures this regional representation, which is predominately comprised of the following countries: Nigeria (35), Ivory Coast (28),

[2] The signatory members are also concerned with promoting scientific and multidisciplinary initiatives to fundamentally improve the treatment of trauma in asylum seekers, developing knowledge and tools, carrying out specific core activities to enable a collaborative approach, and providing a comprehensive caring service to those involved.

[3] In this investigation, the degree of concordance, the pattern of mechanism of the lesions, the final judgment of the Territorial Committee, and their correlations were not described in detail. Considerations and analysis of these topics were already remarked on in a previous paper; see Franceschetti et al. (2019).

Table 1: *Number of asylum seekers undergoing medical examination in Milan from 2008 to 2018*



Somalia (24), Gambia and Mali (12 each), Senegal (10), Togo (6), and Algeria (5), Pakistan (20), Afghanistan (9), and Iran (3).

104 individuals (46%) fled their country of origin due to political reasons, 37 (16.5%) due to religious conflicts, 14 (6%) due to belonging to an ethnic minority, 26 (12%) due to family violence, 9 (4%) due to gender-based discrimination, and 35 (15.5%) due to other reasons.

133 persons (87%) were males, a figure that echoes the data provided by UNHCR.[4] Asylum applicants were predominately young or middle aged: 19 persons (12%) were 16-18 years old, 45 persons (29%) were 19-25 years old, 84 persons (53%) were 26-40 years old, and none were older than 60 years old.

Findings from Physical Examinations

Most of the wounds observed were related to blunt force injuries (363 – 45%),[5] followed by sharp force injuries (180 – 22%) and thermal injuries (169 – 21%) (Table 2).

The most affected area was the trunk (321 – 40%), which is commonly associated with subjects attempting to defend themselves against assailants.[6] There were also other typical defense-related injuries, such as lesions on the hands and forearms. 96 lesions (12%) were observed on the cranial and cervical area. Finally, the number of scars mostly ranged from 2 – 4 lesions (Table 3).

4 See UNHCR operational portal on refugee situations: https://data2.unhcr.org/en/situations/mediterranean

5 This includes different methods of harm, such as beating, kicking, punching, the use of blunt objects, and ligatures.

6 Physical disorders strictly related to the injuries suffered during assaults can also result in osteomuscular lesions, leading to chronic pain or impairment that have a negative effect on the subject, even from a psychological point of view (Moisander and Edston, 2003; den Otter et al., 2013; Castagna et al., 2018).

Figure 1: *Countries of origin represented between 2008 and 2018*

Table 2: *Mechanisms of lesions in percentages*

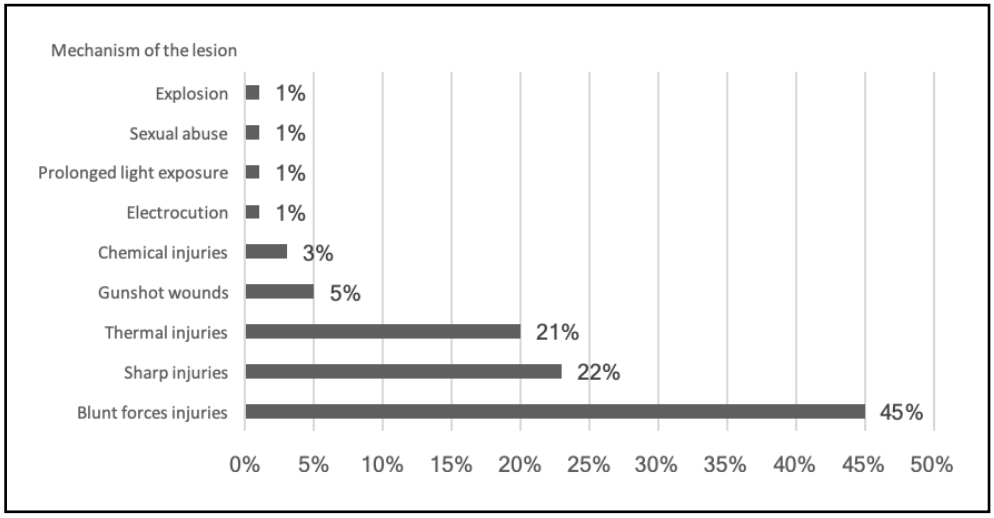
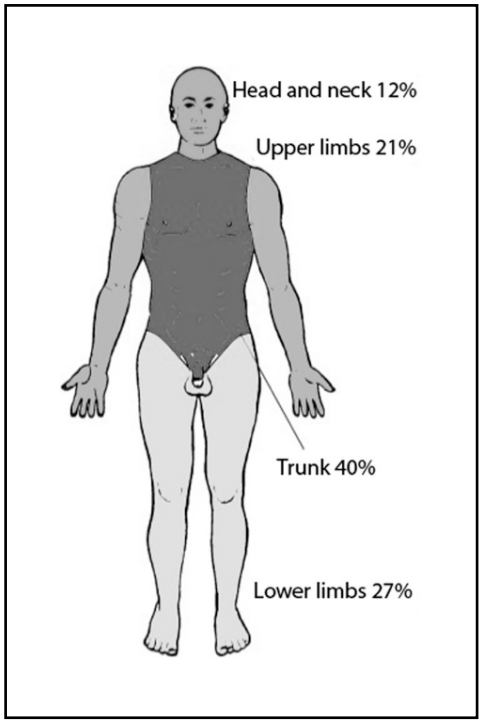


Figure 2: *Percentages of lesions on the body*

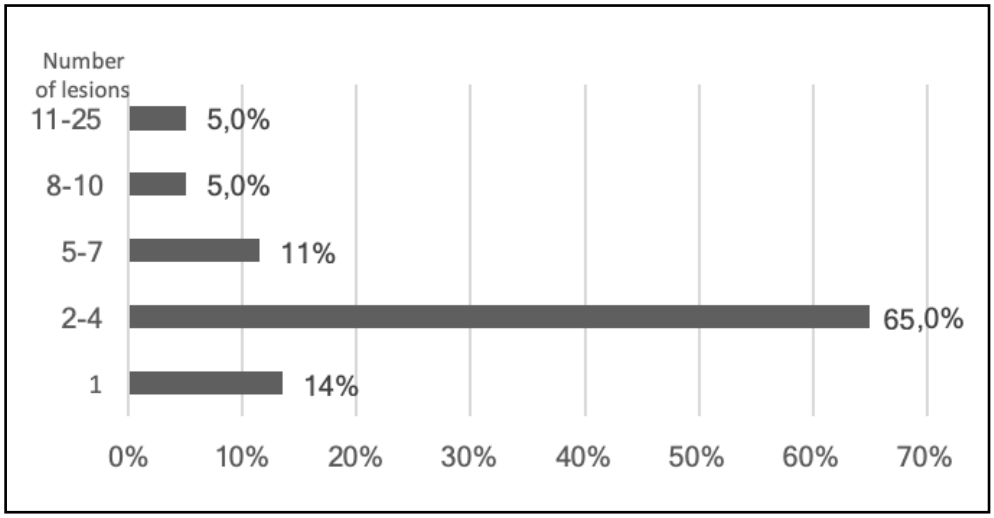


Degree of Concordance

In a previous study concerning the degree of concordance between reported events and physical findings, it was identified that only 1.8% was "not consistent," 49% was "consistent," 42.1% was "highly consistent," 5.3% was "typical," and 1.8% was "diagnostic" (Franceschetti et al., 2019). It was also observed that there was a positive association between higher levels of consistency and the frequency of protection being granted. In particular, the Commission observed:

- *When not consistent:* 100% humanitarian protection.
- *When consistent*: 56.5% asylum, 26% humanitarian protection, 14% subsidiary protection, and 17.8% denial-of-asylum.
- *When highly consistent:* 50% asylum, 8.3% humanitarian protection, 33.3% subsidiary protection, and 8.3% denial-of-asylum.
- *When typical*: 66.7% asylum and 33.3% denial-of-asylum.
- *When diagnostic*: 100% asylum.

Table 3: *Number of lesions over the body by person in percentages*



Discussion and conclusion

The assessment of symptoms of physical abuse has important limits. Firstly, the detailed characterization of scars often does not enable a "high consistency" judgment with the narrative reported by the victim. Current literature mostly focuses on comparisons among single case reports or series and it is predominately based on anecdotal data (Clément et al., 2017; Leth and Banner, 2005; Masmas et al., 2008; Moisander and Edston, 2003; Pfortmuller et al., 2012). Secondly, a limited percentage of asylum applicants are actually examined despite frequently reporting torture; consequently, the exact incidence of torture symptoms is unknown (Moisander and Edston, 2003). In addition, the decision to undertake an assessment of physical signs of torture among asylum seekers is strictly linked to geographical contexts and birthplaces of asylum applicants.

This study has revealed key characteristics of asylum seekers, discerned certain conditions that precipitated migration to Italy, detailed common mechanisms of physical torture, and identified common areas of lesions as a consequence of torture. To our knowledge, there is no other data concerning the latter two variables investigated in this study.[7] Although this information may appear somewhat anecdotal, we maintain that it is useful in the assessment of physical symptoms to achieve a more thorough medical examination and such detail may prove consequential in the final judgment of the Territorial Commission. For example, a person that, regardless of the grade of consistency, reports at least 10 scars has a higher probability of obtaining some kind of benefice that another one that reports one scar. Similarly, the application of an individual that has scars related only to blunt forces could receive a negative judgment by the Territorial Commission compared to an individual that reports scars inflicted by different mechanisms. The limited number of women in our study prevents the ability to undertake a meaningful comparative analysis between males and females.

During the medico-legal evaluations, mandated by the Municipality of Milan, a number of lessons and challenges were identified. Firstly, forensic instrumental examinations should be included in the ordinary clinical examination when investigating the origin of scars. X-rays are helpful when assessing the presence of bone calluses or metallic fragments and echography could provide a better evaluation of scar depth (Clément et al., 2017). Indeed, these subjects often suffer from psychiatric and organic disorders, which would require (expensive) specialized examinations (Mladovsky et al., 2012). In addition, migrants who have health needs often face challenges in accessing the required health care partly because of language difficulties, social isolation, administrative obstacles, and poor knowledge of the legal environment.

Torture survivors are entitled to rehabilitation independently, regardless of whether there is a positive or negative risk assessment (Bhugara, 2004; Kinyanda et al., 2010; Rechel et al., 2011; WHO Regional Office for Europe, 2010). The lack of information concerning countries of

[7] In our previous study (Franceschetti et al., 2019), it was observed how these results related to the type of outcome. The percentage of refugee status recognition increased with the number of injuries by up to 57% when more than 10 scars were observed. Equally, when three or more different mechanisms of lesion were observed in the same individual, negative outcomes never occurred.

origin sometimes prevents examiners from providing a correct differential diagnosis of the observed scars. In cases where the healing process has the tendency to produce unusual scars, especially among dark skinned persons (Fuentes-Duculan et al., 2017), such as hypertrophy or abnormal scarring, the involvement of other professionals, such as specialist dermatologists, may well be beneficial. A multidisciplinary approach could facilitate an improved forensic evaluation, thereby reducing errors when assessing the presence of these confounding factors (Clèment et al., 2017; Moisander and Edston, 2003).

In Milan, a critical consideration concerns survivors who underwent violence and torture but the consequences of which are not physically evident. Psychiatric, psychological and social approaches are therefore crucial.

The Istanbul Protocol plays a key role for investigating allegations of torture and other forms of ill-treatment and specifies that any evaluation of torture should include a psychological assessment. In 2000, the ASST Grande Ospedale Metropolitano Niguarda established the Ethno-psychiatry Service in response to increasing migration flows. For each hearing of the Territorial Commission for the Refugee Status recognition, a report is drawn up for each applicant, following the guidelines provided by the Istanbul Protocol. The Ethno-psychiatry Service is also one of the signatory members of the above-mentioned Protocol of the Municipality of Milan and increasingly close cooperation is anticipated. Ongoing work aims to guarantee that all professionals involved co-sign a single final report, instead of two separate documents, to build an accurate description of events and establish a more consistent result.

References

Afana, A. H. (2009). Weeping in silence: the secret sham of torture among Palestinian children. *Torture Journal*, *19*(2), 167-175.

Arge, S. O., Hansen, S. H., & Lynnerup, N. (2014). Forensic odontological examinations of alleged torture victims at the University of Copenhagen 1997-2011. *Torture Journal*, *24*(1), 17-24.

Asgary, R., Charpentier, B., & Burnett, D. C. (2013). Socio-medical challenges of asylum seekers prior and after coming to the US. *Journal of immigrant and minority health*, *15*(5), 961-968. doi: 10.1007/s10903-012-9687-2.

Bhugara D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, *109*, 243–258.

Castagna, P., Ricciardelli, R., Piazza, F., Mattutino, G., Pattarino, B., Canavese, A., & Gino, S. (2018). Violence against African migrant women living in Turin: clinical and forensic evaluation. *International journal of legal medicine*, *132*(4), 1197-1204. doi: 10.1007/s00414-017-1769-1.

Clément, R., Lebossé, D., Barrios, L., & Rodat, O. (2017). Asylum seekers alleging torture in their countries: Evaluation of a French center. *Journal of forensic and legal medicine*, *46*, 24-29. doi: 10.1016/j.jflm.2016.12.011.

den Otter, J. J., Smit, Y., dela Cruz, L. B., Özkalipci, Ö., & Oral, R. (2013). Documentation of torture and cruel, inhuman or degrading treatment of children: A review of existing guidelines and tools. *Forensic science international*, *224*(1-3), 27-32. doi: 10.1016/j.forsciint.2012.11.003.

Edston, E., & Olsson, C. (2007). Female victims of torture. *Journal of Forensic and legal medicine*, *14*(6), 368-373. doi: 10.1016/j.jflm.2006.12.014

Franceschetti, L., Magli, F., Merelli, V., Muccino, E., Amadasi, A., & Cattaneo, C. (2017). The medico-legal evaluation effect: asylum grant rate in the metropolitan city of Milan. *La Revue de Médecine Légale*, *8*(4), 186.

Franceschetti, L., Magli, F., Merelli, V. G., Muccino, E. A., Gentilomo, A., Agazzi, F., ... & Cattaneo, C. (2019). The effect of the medico-legal evaluation on asylum seekers in the Metropolitan City of Milan, Italy: a pilot study. *International journal of legal medicine*, *133*(2), 669-675. doi: 10.1007/s00414-018-1867-8.

Fuentes-Duculan, J., Bonifacio, K. M., Suárez-Fariñas, M., Kunjravia, N., Garcet, S., Cruz, T., ... & Tirgan, M. H. (2017). Aberrant connective tissue differentiation towards cartilage and bone underlies human keloids in African Americans. *Experimental dermatology*, *26*(8), 721-727. doi: 10.1111/exd.13271.

Ghaleb, S. S., Elshabrawy, E. M., Elkaradawy, M. H., & Welson, N. N. (2014). Retrospective study of positive physical torture cases in Cairo (2009 &2010). *Journal of forensic and legal medicine*, *24*, 37-45. doi: 10.1016/j.jflm.2014.03.005.

Guy, K. M. (2009). Child soldiers as zones of violence in The Democratic Republic of Congo: three cases of medico-legal evidence of torture. *Torture Journal*, *19*(2), 137-144.

Kinyanda, E., Musisi, S., Biryabarema, C., Ezati, I., Oboke, H., Ojiambo-Ochieng, R., ... & Walugembe, J. (2010). War related sexual violence and it's medical and psychological consequences as seen in Kitgum, Northern Uganda: A cross-sectional study. *BMC International Health and Human Rights*, *10*(1), 28.

Leth, P. M., & Banner, J. (2005). Forensic medical examination of refugees who claim to have been tortured. *The American journal of forensic medicine and pathology*, *26*(2), 125-130.

Masmas, T. N., Student, E. M. M., Buhmann, C., Bunch, V., Jensen, J. H., Hansen, T. N., ... & Student, J. S. M. (2008). Asylum seekers in Denmark. *Torture Journal*, *18*(2), 77-86.

Mladovsky, P., Ingleby, D., & Rechel, B. (2012). Good practices in migrant health: the European experience. *Clinical medicine*, *12*(3), 248-252.

Moisander, P. A., & Edston, E. (2003). Torture and its sequel—a comparison between victims from six countries. *Forensic science international*, *137*(2-3), 133-140.

Moreno, A., Crosby, S., Xenakis, S., & Iacopino, V. (2015). Implementing Istanbul Protocol standards for forensic evidence of torture in Kyrgyzstan. *Journal of forensic and legal medicine*, *30*, 39-42. doi: 10.1016/j.jflm.2014.12.009

Peart, J. M., Tracey, E. H., & Lipoff, J. B. (2016). The role of physicians in asylum evaluation: documenting torture and trauma. *JAMA internal medicine*, *176*(3), 417-417.

Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M (Ed.) (2011). *Migration and health in the European Union*. Open University Press.

Sheather J, Beynon R, Davies T, Abbasi K (2015) Torture and doctors' dual obligation – Health professionals need support to put the wellbeing of detainees first. BMJ. 350-589. doi: 10.1136/bmj.h589.

Thomsen, J. L. (2000). The role of the pathologist in human rights abuses. *Journal of clinical pathology*, *53*(8), 569-572.

World Health Organization. (2010). How health systems can address health inequities linked to migration and ethnicity. Copenhagen: WHO Regional Office for Europe.