Name: Ms Peace Abilowale
Date of Birth: 14/08/1990
Nationality: Ugandan
Religion: Christian
Languages: English, Luganda
Interpreter: Not required

Examination by Dr. Elaine Forrest on 30/07/2015

Documents Read:	**Dates**
Screening interview	20/03/2014
Asylum interview	07/08/2014
Reasons for Refusal	22/05/2015
Witness statement, Ms. A	15/06/2015

Instructed by: **Paine Mendes llp**

Preamble

This is the account of Ms. PA's history as related to me, and of my findings on examination. Where her demeanour changed during this account, I have recorded this. Direct quotes are recorded in quotation marks. The history recorded is restricted to those aspects I consider relevant to physical or psychological findings. The absence of reference to an incident in this report does not necessarily mean that it was not related to me, and nothing in my summary of Ms. A's history should be taken as a finding of fact in relation to her asylum claim.

In formulating my opinion I draw upon my experience as set out in my biography and other appropriate sources. I have read the Immigration and Asylum Chambers of the First-tier Tribunal (Immigration and Asylum Chamber) and the Upper Tribunal (Immigration and Asylum Chamber) Practice Directions as they relate to expert evidence. I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

History

H1) Ms. A states that she was born and brought up in Kampala, Uganda. Her parents are secondary school teachers. She has a younger brother and an older sister. She attended primary and secondary school, before starting a course in Computer Sciences in Makindye.

H2) In her first year at university, she formed a relationship with a postgraduate student of economics, who was a parliamentary candidate for the opposition party, the Forum for Democratic Change (FDC) in the national elections of 2006.

H3) In the run up to the election, she took part in demonstrations, some of which were violently broken up by the authorities, but was not injured at that time.

H4) After graduation, she took up employment with a local telecommunications company, and continued her activities for the FDC, becoming chair of the women's section of her local branch. On two occasions, she was interviewed on national radio.

H5) In 2008 she married her partner in a traditional ceremony.

H6) On 07/02/2011 In the runup to the elections later that month, she was arrested from their home, along with her husband by five armed police officers. She denies any injuries to herself during the arrest itself, but witnessed her husband being hit on the head and knocked unconscious. She was handcuffed, put in a vehicle and driven to a local police station. This was the last she saw of her husband.

H7) Here she was interrogated about her and her partner's political activities, the names of their close colleagues and plans for a forthcoming demonstration. When she refused to name colleagues, she was beaten with batons.

H8) She was put in a cell in solitary confinement, where she was held for five days, and allowed only water and dry bread once per day. She had to sleep on the ground and use a bucket for a toilet.

H9) On the last night, three officers entered her cell, ripped off her clothing and raped her at knifepoint. She sustained lacerations on her thighs from the blade and to her breasts from their fingernails.

H10) The next day, she was transferred to Luzira women's prison, where she was held for a further two weeks. The cell held about 20 women and was too small for them to all lie down at once. Prisoners were escorted to toilets at the whim of guards. Food consisted mainly of rice and beans, provided twice a day.

H11) Shortly after the election, she was released without charge. She obtained painkillers from a local clinic.

H12) The following day, she was visited by a senior police officer accompanied by two members of his staff. They warned her to have no further dealings with the opposition movement, and that if she did, things would go badly for her and her family.

H13) She returned to work and spent the next few months looking, without success, for information about her husband's whereabouts. She also continued her activities for the FDC.

H14) In late 2011 she started receiving anonymous threatening phone calls. Her husband's wedding ring was found in a parcel on the doorstep, along with a photograph of his dead body. Attached to it was the message "You're next."

H15) She fled to the UK arriving in March 2013.

Current Medical Problems

M1 Prior to her arrest she was fit and well, and had sustained no significant injuries which left scars or other visible marks (except as cited above and below) nor major illnesses or treatment. I specifically enquired for, and she denied, any previous history of automotive, sporting, domestic or occupational accidents causing lasting scarring or damage, or any lifethreatening experiences other than those cited above.

As is my standard practice I first invited her to list any medical symptoms of which she was currently aware.

She spontaneously described sleep disturbance, nightmares, hearing voices, and pelvic and low back pain.

I then proceeded to a full assessment of her physical and organic symptomatology using a standard systems approach, which yielded the following concerns:

M2 Respiratory: She was diagnosed with tuberculosis in 2014 in the UK but is now symptom-free having completed a course of standard anti-tuberculosis chemotherapy.

M3 Alimentary: Her appetite is poor; she has lost about 7kg in weight over the past year. She is subject to sharp upper abdominal pain after meals and episodes of nausea and vomiting which she related to stress.

M4 Urogenital: Her menstrual periods were previously normal but have become irregular, heavy and painful since her detention in Uganda.

M5 Central nervous: No abnormality disclosed.

M6 Cardiovascular: episodes of palpitations, accompanied by shortness of breath, tremor and sweating; these are brought on by intrusions (see below).

M7 Musculoskeletal: She has low back pain, without radiation to the legs; this impairs her ability to lift heavier objects.

M8 Psychological:

a) Her sleep is limited to about four hours on a typical night. She is kept awake by thoughts about what happened to her in prison and is woken by nightmares about being raped and about the beating of her husband. During the day she is subject to intrusive memories of and visual, flashbacks to those events. She is subject to bouts of unprovoked anger.

b) These intrusions are triggered by the sight of violence on television and loud noises, which she tries to avoid. She prefers to be alone, but when in company, she has been witnessed to become absent and unresponsive.

c) Her mood is “sad”. She can not envisage a future for herself and has been troubled by thoughts of suicide, but has made no attempts to kill herself.

d) Her short term memory is impaired – she frequently mislays everyday objects and misses appointments. Her concentration is impaired (for example, while reading she has to return to the beginning of paragraphs again and again because she loses the thread.

M9 She is registered with a general practitioner. She was admitted as an involuntary patient for assessment during an episode of severe mental illness in early 2015, but appears improved as compared with her behaviour as described by the hospital at that time. She is currently prescribed olanzapine (an atypical antipsychotic agent) and citalopram (an antidepressant). These drugs are commonly used for both depression and posttraumatic stress disorder.

On Examination

Physical findings

E1) On the right breast there are two vertical linear pale scars (S1,2) both 3mm wide, one 8 and one 10 cm in length. On the left breast there are four lesions (S36) of similar appearance and width; these range from 712cm in length. Palpation of the scars reveals a moderate degree of stiffening of the underling skin as compared with surrounding normal tissues.

E2) On the inside of the left thigh there are three narrow linear scars. The upper one (S7) is transverse in orientation and measures some 3x0.2 cm. A similar scar (S8) is seen just

beneath it. The lower (S9) is oblique and is some 7x0.2 cm. Both show more marked fibrosis than S16.

E3) There is a small ovoid scar over the left knee cap (S10). It measures 0.8 x 0.6 cm in maximum dimensions.

E4) All of the above scars are quiescent.

E5) The external genitals were normal to inspection.

E6) The tendon reflexes are grossly hyperdynamic.

E7) **Psychological findings -** Mental state examination (MSE):

MSE1 Appearance and behaviour: appropriately groomed and dressed. No tics or overtly abnormal activity.

MSE2 Speech: normal in tone and content except when describing the rape; during this time she broke off all eye contact and became tearful and very quiet.

MSE3 Mood: low

MSE4 Thought: no current evidence of thought disorder

MSE5 Perceptions: although she can recall command hallucinations around the time of her hospitalisation

MSE6 Cognition: Alert and orientated for time, person and place

MSE7 Insight: intact

MSE8 Risk: I would assess her current risk of suicide as low and her risk to others as minimal.

Opinion (for a definition of underlined terms, please see notes below)

O1) Scar E1-6 have the appearances following laceration of the breasts with human finger nails. It is difficult to imagine any other circumstance which could have left lesions of this kind at these sites. No medically plausible form of injury (whether occupational, domestic, sporting or transport would be expected to create such a result. Nor is this a common site or mechanism for self harm. These scars are typical of the cause she averred.

O2) Scars E7-9 are the results of cuts with a sharp object such as a blade. The deeper scarring (as compared with E1-6) accord with this causation. Young women rarely sustain three such lacerations to the inner thigh from any benign sort of injury. These scars are typical of stab wounds (E7,8) and slashing (E9), and are located as would be expected during a sexual assault, aimed at forcing her to open her legs.

O3) The quiescent nature of the above scars indicates that the causative injuries occurred at least one year before my examination. There currently exists no method of medical examination or scientific investigation by which the ages of scars resulting from injuries more than one year prior to assessment can be established with confidence.

O4) The normal genital examination does not exclude rape – only about 5% of women examined more than one month after such an event show injuries to the genitals themselves. However, her scars are those to be expected after sexual assault of the kind described. Her demeanour was that I have witnessed among other torture survivors whose experiences were accepted by the courts.

Psychological formulation

O5) I base my diagnostic conclusions on my objective clinical observations of her behaviour, speech and demeanour and not merely on the symptoms she described to me, as explained above.

According the criteria of the International Classification of Diseases (10th edition ICD10) there are five criteria for the diagnosis of Posttraumatic stress disorder (PTSD). Although there are subtle differences between ICD10, the Diagnostic Statistic Manual (version V) and those of the UK Department of Work and Pensions, these all rely on the following five features:

a) Exposure to the stressor(s)

b) Onset and persistence on symptoms

c) Hyperarousal

d) Avoidance of reminder stimuli

e) Emotional numbing or blunting

I base my diagnosis of PTSD on the presence of the following clinical features:

She gives a history of having experienced relevant stressors (rape and beating). She has intrusion phenomena (flashbacks and nightmares) She has avoidance related behaviour in the form of avoiding reminder stimuli such as the sight of violence on TV. She has negative alterations in cognitions and mood in the form of depressed mood and numbing. She has alterations in arousal and reactivity of which the hyperdynamic reflexes are evidence – these are not under voluntary control. The duration of her symptoms has been more than a month. Her symptoms have functional significance to the extent of interfering with activities of daily life. There is no evidence that her core PTSD symptoms are attributable to medication, substance misuse or other illness. PTSD can result from any life threatening experience over which the subject has no control. The list of common causes includes torture, warfare, natural disasters, industrial and automotive accidents, rape, and child abuse. I explicitly enquired about, and she denied, any such experience other than those described in the history above. She also displays features of depression, which is often found to accompany PTSD.

The Istanbul Protocol requires rapporteurs to explicitly consider the possibility that examinees may have inaccurately described, or even confected parts or all of the history given. In the present case, all of the clinical finding accords with the history of abuse that she described and none is in conflict with it. It is noted that she did not recall any cause for scar S10 and made no attempt to pass it off as due to torture or abuse. The Istanbul protocol requires a medical rapporteur to make an overall evaluation of the likelihood that some or all of their clinical findings are due to torture. In the present case, this is as follows: It would be unusual for a woman to show the extent and types of pathology seen in this case she had not survived organised violence of the kind she described. The medical evidence makes it more likely than not that she has indeed been harmed in the ways she described and has severe physical and psychological damage as a result.

Notes

From the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, P35

“...(b) Consistent with: the lesion could have been caused by the trauma described, but it is nonspecific and there are many other possible causes;

(c) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes;

(d) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes;

(e) Diagnostic of: this appearance could not have been caused in any way other than that described.

187. Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.” http://www.phrusa.org/research/istanbul_protocol/ist_prot.pdf Accessed 22/3/2006

ICD-10 diagnostic criteria for PTSD at:

http://www.who.int/classifications/apps/icd/icd10online/

From: Arnold F. Wounds and Scars of Torture.

Bulletin of the European Tissue Repair Society (14, 8) 2007.

http://www.etrs.org/bulletin14_3/section8.html

“It is sometimes important for legal purposes to be able to estimate the time since a particular wound was inflicted. Having discussed the matter with many eminent members of the ETRS and WHS, I have reached the conclusion that it is only possible to distinguish approximately between the various appearances...

Fresh wound: 1-3 days old

Early healing: 3-10 days

Later healing: 10-21 days

Early maturing: 21-42 days Intermediate maturing: 42-180 days Mature: 180 days-1 year

Quiescent: > 1 year"