Medical Evidence of Torture in The International Protection Process in Ireland:

An Exploratory Study

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Authorship and Acknowledgements

Dr Clíodhna Murphy, Associate Professor at Maynooth University's School of Law and Criminology was the lead researcher and is lead author of this report. Louisa O'Connell, PhD candidate, was a research assistant on the project, completing literature reviews, transcribing interviews, and finding and categorising International Protection Appeals Tribunal (IPAT) decisions. Natasha Wall was a research assistant on the project, contributing to the research design and finding and categorising IPAT decisions. She is now Traveller and Roma Outreach Officer at Maynooth Access Programme.

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Executive Summary

Background

Medico-legal reports (MLRs) play a vital role in asylum processes worldwide, by providing objective medical evidence in relation to a torture survivor's application. This report explores the role and impact of medical evidence of torture within the Irish international protection process, drawing on the findings of a socio-legal research project conducted at Maynooth University, in partnership with Spirasi, the national centre for the rehabilitation of survivors of torture. The research was funded by Research Ireland.

Research objectives and methodology

This report presents an exploratory study on medical evidence of torture in the Irish international protection process. First, we assess the impact of MLRs within the work of the International Protection Appeals Tribunal (IPAT) by analysing relevant decisions. Second, we explore stakeholders' perspectives on the role of medical evidence of torture through in-depth interviews with 13 institutional stakeholders including physicians, legal practitioners, and decision-makers. The research aims to facilitate knowledge exchange between stakeholders and promote a consistent, human rights-based, approach to medical evidence of torture.

Findings

Key findings of the review of IPAT decisions and the interviews include the following:

- Our review of IPAT decisions shows that MLRs had a clear 'positive' impact in the majority of cases that we examined in which an MLR had been submitted. The next largest cohort of cases were those in which the MLR was considered by the Tribunal but its impact was 'outweighed' by factors related to credibility, evidence, or other individual features of the case. In the remainder of cases, the impact of the MLR was 'unclear', or we classified the treatment of the report as 'negative'.
- Separately, we used 2023 as a 'snapshot year' to explore success rates. Within the group of 2023 decisions that we considered, appellants with a medico-legal report had a much higher rate of success (67.8% for international protection appeals) than the general success rate at the IPAT (30% for international protection appeals). This data echoes research findings in the US, the Netherlands, and Italy. We do not suggest that the fact of having a medico-legal report alone results in an increased chance of success on appeal.
- IPAT members frequently articulate the value of MLRs in supporting their decision-making, even in cases in which the appeal is unsuccessful. The interviews similarly revealed the often-crucial role of MLRs in the protection process, with many interviewees highlighting the lack of early access to MLRs as the most pressing problem in this area.
- Interviewees also raised issues related to - inter alia - retraumatisation of victims of torture within the international protection process; the treatment of psychological findings by decision-makers; the importance of continuous and in-depth training for all stakeholders; and mutual expectations of professional stakeholders.
- Interviewees highlighted undignified practices within the international protection process; poor living conditions within reception centres; difficulties with accessing healthcare in isolated locations; and limited access to early legal advice as rights protection gaps experienced by survivors of torture.

Summary of recommendations

Building on the research findings, we present a set of practical recommendations to promote timely access to protection for torture survivors, support decision-making, and enhance transparency within the international protection system. The key recommendations can be summarised as follows:

1. Further research to understand the lived experiences of survivors of torture within the Irish protection system is urgently needed; these perspectives were not captured within this study.
2. The timely availability of medico-legal assessment - including at first instance - should be ensured. Important factors include:
    a. Early identification of victims of torture through comprehensive vulnerability assessments at the earliest possible stage.
    b. Access to early legal advice in the international protection process.
    c. Recognition that individuals may disclose torture very late in the protection process: there must be a mechanism to ensure that a referral for an MLR can be facilitated at all stages if necessary.
    d. A functional mechanism for decision makers (at first instance or on appeal) to directly request an MLR.
    e. A strategy to train and retain more doctors to conduct medico-legal assessments and provide MLRs if necessary. In practice, this will require adequate funding, sufficient time to conduct the evaluation, and general respect for MLRs within the system.
3. Applications for international protection that are likely to be well-founded, including by those who produce an MLR, may currently be prioritised for interview at first instance.[1] It should be considered whether this prioritisation should be extended (i) beyond the scheduling of interviews, to potentially eliminate the need for an interview in some cases, (ii) to those who may not have an MLR but who have been assessed as a possible survivor of torture, and (iii) to the appeal stage.
4. Continuous training for all stakeholders is needed, in particular in relation to mutual understanding of stakeholder roles and processes; the role of MLRs in the context of the credibility assessment; medical evidence in respect of psychological injuries; and trauma-informed practice.
5. Consider ways to reduce the need to obtain/provide MLRs, particularly in cases that may be supported by other strong evidence.
6. Consider clarifying the precise role and weight of MLRs in decisions other than standard international protection appeals (e.g. transfer to another EU Member State, or inadmissibility decisions). This recommendation will be particularly important in the context of the implementation of the EU Pact on Migration and Asylum and consequent overhaul of the international protection system.

1. See "Prioritisation of International Protection Appplications under the International Protection Act 2015 (as amended)", available at https://www.ipo.gov.ie/en/IPO/IPO%20Prioritisation%20Statement%20Final%2014.06.21%20Website.pdf/Files/IPO%20Prioritisation%20Statement%20Final%2014.06.21%20Website.pdf.

Chapter One: Introduction

Medico-legal reports (MLRs) play a vital role in asylum processes worldwide by providing objective medical evidence in relation to a torture survivor's application.[2] The importance of this evidence within the Irish international protection process is demonstrated by a long line of High Court case-law[3] and the adoption of "Chairperson's Guidelines on Medico-Legal Reports" by the International Protection Appeals Tribunal (IPAT).[4] However, there has been no research into the use of MLRs in practice in Ireland. This report explores the role and impact of medical evidence of torture within the Irish international protection process, drawing on the findings of a socio-legal research project conducted at Maynooth University, in partnership with Spirasi, the national centre for the rehabilitation of survivors of torture and their families and a provider of MLRs. The research was funded by Research Ireland through its New Foundations scheme.

The researchers reviewed relevant decisions of the International Protection Appeals Tribunal - the domestic appellate body - to gain insights into the impact of MLRs in the work of the Tribunal (Chapter 3). We also interviewed stakeholders about their perspectives on medical evidence of torture in the protection process (Chapter 4). This work was complemented by a review of relevant international, EU, and Irish law, and a literature review.

Building on the research findings, we present a set of practical recommendations to promote timely access to protection for torture survivors, support decision-making, and enhance transparency within the international protection system (Chapter 5).

The research has been conducted at a time of increased media, political and public attention on the Irish international protection system. While Ireland has a strong legal framework to deal with forced migration, refugee advocates have criticised the operation of the protection system, including in the context of homelessness amongst international protection applicants and the pausing of individual vulnerability assessments for protection applicants for a period in 2023-24.[5] By addressing the lack of information on how expert medical evidence of torture is handled in practice, this research speaks to wider concerns regarding transparency and decision-making standards within the protection system, and the safeguarding of human rights. This collaborative project aims to open up this unexplored area of academic inquiry in an Irish context, while recognising the limits to what the law of international protection can achieve when it comes to rehabilitation and recovery for survivors.

Finally, this is a period of intense change within the legal framework. The legal measures comprising the EU's Pact on Migration and Asylum apply from June 2026, with domestic implementation providing for a truncated 'asylum border procedure', expanded detention and restrictions on

2. The international research is discussed at Chapter 2. See also, D. Rhys-Jones and S.V. Smith "Medical Evidence in Asylum and Human Rights Appeals" (2004) 16 (3) *International Journal of Refugee Law* 390.
3. As summarised in *A.S. v. IPAT [2023]* IEHC 53, and further discussed in Chapter 2.
4. "Chairperson's Guidelines on Medico-Legal Reports" Guideline 2017/6, as replaced by "Chairperson's Guideline 2025/2 On Medical Evidence and Medico-Legal Reports."
5. See, for example, Irish Refugee Council, "Two Years of Homelessness for International Protection Applicants," 4 December 2025, available at https://www.irishrefugeecouncil.ie/media-centre/press-releases/two-years-of-homelessness-for-international-protection-applicants/. See generally, M. Gilmartin and C. Murphy, "A Small Country with a Huge Diaspora, Ireland Navigates Its New Status as an Immigration Hub" (2024) *Migration Information Source, the online journal of the Migration Policy Institute*, at https://www.migrationpolicy.org/article/ireland-diaspora-immigration.

movement, as well as the establishment of a new second instance (appeals) body and a compressed deadline for appeals.[6] The rights of victims of torture, as well as other international protection applicants with specific vulnerabilities, may be at risk in this more restrictive legal environment.[7] We have endeavoured to state the law as at 5th January 2026, at which date the full text of the International Protection Bill had not yet been published.

A note on terminology

In the context of this report, the term 'torture' is understood to encompass torture and other forms of ill-treatment. For the purposes of the research, a medico-legal report (MLR) is "a written report carried out by a clinical expert that includes a physical and psychological evaluation of the victim, and the clinician's interpretation as to the probable relationship of the physical and/or psychological findings to possible torture or ill-treatment."[8]

These terms are further defined, along with other important terms, in the Glossary contained at Appendix 3.

Spirasi's role in this project

The research has drawn on the knowledge and experience of Spirasi's Rehabilitation Manager, Paula Quirke, including in relation to devising the research questions and the analytical categories for the review of IPAT decisions; making introductions to relevant stakeholders; and sense-checking the overall research design. The researchers collaborated with Paula on the design of key documents for the interviews such as the participant information sheet, consent form and interview guide. Please note that Spirasi has not had a role in the research interview process (i.e. contacting the research participants, conducting the interviews or analysing the interview data). Likewise, Spirasi has not had a role in drafting this report or its recommendations, other than to provide comments on the initial draft.

In the context of this report, the term 'torture' is understood to encompass torture and other forms of ill-treatment.

Information on Spirasi, as well as independent MLR physicians, is contained in Appendix 1.

Research objectives

This report presents an exploratory study on the role of medical evidence of torture in the Irish international protection process. The study aims to assess the impact of MLRs within the work of the International Protection Appeals Tribunal by analysing relevant decisions; and explore stakeholders' perspectives on the role of medical evidence of torture and the interpretation of MLRs. In doing this, we hope to facilitate knowledge exchange between stakeholders and promote a consistent, human rights-based, approach to medical evidence of torture.

6. See General Scheme of the International Protection Bill 2025, including at Head 122 and 110.
7. See the submissions of civil society summarised in the *Joint Committee on Justice, Home Affairs and Migration Report on Pre-Legislative Scrutiny of the General Scheme of the International Protection Bill 2025.*
8. Chairperson's Guidelines 2025/2, at para. 2.

Methodology

This research seeks to understand the impact of MLRs in everyday practice in the Irish system. Gill and others note that in general, "more attention is given in research on refugee law to the 'rules of the road' as opposed to how the car is driven, meaning that non-legal or socio-legal perspectives can be drowned out."[9] This research responds to this gap, using a socio-legal research methodology designed to take into account the specificities of the Irish system and the publicly available data. This report does not focus on the "rules of the road," although it briefly sketches the legal and factual context in Chapter 2. Rather, it focuses, in Chapters 3 and 4, on "how the car is driven."

In addition to a literature review and a review of relevant international, EU and Irish law, the methodology has three main components:

1. Co-creation of research, including through the stakeholders' forum

This project is based on a partnership model. The professional experience of Paula Quirke has been central to the research design process, as outlined above. More broadly, the project team has engaged with stakeholders throughout the research cycle. In May 2025, a stakeholders' forum was hosted at Maynooth University. This involved 'brainstorming' on the key issues, and consulting with stakeholders on the effectiveness and feasibility of the research design. Participants included MLR physicians (from Spirasi as well as independent MLR physicians), legal practitioners, members of the project's Advisory Committee, representatives of the Department of Justice (now the Department of Justice, Home Affairs and Migration), the International Protection Appeals Tribunal, the Irish Refugee Council, and Spirasi, among others.

In May 2025, a stakeholders' forum was hosted at Maynooth University.

The stakeholders' forum demonstrated that robust and open dialogue is possible within this small field of expertise, with diverse and critical perspectives aired and discussed. The 'Chatham House Rule' applied to the forum, meaning that participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.

2. Review of IPAT Decisions

The team identified and reviewed relevant IPAT decisions from 2024, 2023, and 2022, with the aim of (i) classifying the decisions according to the apparent impact of the MLR on the decision, and (ii) gleaning insights from the decisions themselves on the treatment and interpretation of MLRs by decision-makers. More detail on the methodology for this strand is contained in Chapter 3.

3. Interviews

The research team conducted semi-structured interviews with 13 key stakeholders with experience of dealing with issues relating to medical evidence of torture within the international protection process. Participants included:

- Medical professionals engaged in writing MLRs.
- Legal professionals who are engaged with advising international protection applicants.

9. N. Gill, N. Hoellerer, J. Hambly, D. Fisher, *Inside Asylum Appeals: Access, Participation and Procedure in Europe* (Routledge, 2025), at p.8; referring in turn to H. Evans Cameron, *Refugee law's fact-finding crisis: Truth, risk, and the wrong mistake* (Cambridge University Press, 2018), at p. 5.

- UNHCR employees who have experience of MLR-related issues.
- Civil/public servants who are, or have been, engaged with this issue from a policy or a decision-making perspective.

A full list of the interviews is available at Appendix 2. The questions focused on stakeholders' perspectives on the role of medical evidence of torture in an international protection claim, the evidentiary weight of MLRs, and the consistency and quality of MLRs in the Irish system. The experts were intentionally selected to represent diverse perspectives on medical evidence of torture (legal, medical, administrative) and the interviews reflect this positionality. Prior ethical approval for the interviews was obtained from the Maynooth University Ethics Committee. All data was transcribed and anonymised before dissemination.

Limitations of the research

It should be noted that this is a relatively small-scale project with limited resources. The report presents an exploratory study that aims to provide initial insights into the key issues, rather than offering definitive conclusions.

As regards the review of IPAT decisions, given that the decisions analysed are appeals decisions, our review does not provide a direct insight into how MLRs are used and interpreted in first instance decisions. Such decisions are not publicly available. It is also important to note that we do not have sight of the MLR itself. Additional limitations of the review of IPAT decisions are detailed in Chapter 3.

There are also several limitations relating to the semi-structured interviews. For example, the participants are drawn from the small pool of experts working in this area in Ireland. This could mean that they could feel inhibited in expressing their views in circumstances where colleagues may be able to attribute those views to them.
The majority of interviewees are experts in their fields and are independent of Spirasi. The involvement of Spirasi as a partner in the project may nonetheless be seen as an inhibiting factor for some interviewees (e.g. doctors who are employed by or work on a contractor basis for Spirasi). While some interviewees could have some reservations about appearing to criticise Spirasi and/or their interests, the framing of the interview questions has sought to minimise the impact of this. In addition, Spirasi has had no role in relation to the interviews other than to suggest potential suitable participants, has had no sight of interview transcripts, and all data has been de-identified as far as possible.

Chapter Two: Medical Evidence of Torture and the International Protection Process

A high proportion of asylum applicants worldwide have experienced torture, with the prevalence of torture amongst this group estimated to be at least 30%.[10] In essence, a medico-legal report (MLR) substantiates claims of torture and ill-treatment in the country of origin by reporting on the consistency of injuries with the contention of abuse. International human rights courts and bodies such as the European Court of Human Rights and the United Nations (UN) Committee Against Torture have consistently emphasised the importance of MLRs from a human rights perspective, although they have failed to provide "clear guidance" to states on their evidentiary weight in the adjudication of protection claims.[11] Broadly speaking, MLRs may assist a decision-maker to determine (i) whether past persecution or serious harm has occurred; and (ii) the potential risk should a person be returned to a particular country.[12]

The UN's *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ('Istanbul Protocol') sets out international guidelines on how effective legal and medico-legal investigations into allegations of torture should be conducted. According to the Protocol, medico-legal evaluations of torture in the asylum context provide a "clinical interpretation of the degree to which clinical findings correlate with the alleged victim's contention of abuse, and a clinical opinion on the veracity of such claims, and the possibility of torture."[13] The levels of consistency for such correlations are commonly expressed as follows:

a. **"Not consistent with":** the finding could not have been caused by the alleged torture or ill treatment;
b. **"Consistent with":** the finding could have been caused by the alleged torture or ill treatment, but it is non-specific and there are many other possible causes;
c. **"Highly consistent with":** the finding could have been caused by the alleged torture or ill treatment and there are few other possible causes;
d. **"Typical of":** the finding is usually observed with this type of alleged torture or ill treatment, but there are other possible causes;
e. **"Diagnostic of":** the finding could not have been caused in any way other than that described.[14]

10. See R. Horn, "Human Rights Abuse Amongst People Seeking Asylum: Brief Review of Literature on Prevalence" (Torture ID, November 2024), available at https://tortureid.org/wp-content/uploads/2024/11/HUMAN-RIGHTS-ABUSES-LITERATURE-REVIEW-12.11.24-TORTUREID.pdf; R. M. Duffy et al, "Demographic Characteristics of Survivors of Torture Presenting for Treatment to a National Centre for Survivors of Torture in Ireland (2001–2012)" (2017) 34(2) *Irish Journal of Psychological Medicine* 34(2) 111 at 113.
11. M. Reneman, "Evidentiary Value of Forensic Medical Evidence in Asylum Procedures: Where Can the CJEU Bring Light into the Darkness?" (2020) 2 *European Journal of Migration and Law* 224.
12. See generally, Chairperson's Guidelines 2025/2, at para. 3.
13. Office of the UN High Commissioner for Human Rights, *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Istanbul Protocol Professional Training Series No. 8, Rev. 2, 2022), at para. 268.
14. The level of consistency denoted by "typical of" is not commonly used to assess psychological evidence of torture or ill treatment as psychological findings tend to depend on individual factors. In addition, the level of consistency denoted by "diagnostic of" is used more frequently in the interpretation of physical evidence of torture or ill treatment and is rarely used in the interpretation of psychological evidence.

> A focus on medical evidence to document torture and ill-treatment could lead to "the expert's voice erasing and substituting the victim's, raising the evidentiary threshold for recognition."

In the context of asylum proceedings, the Protocol provides that decision-makers must not adopt opinions on clinical matters for which they are not qualified and must not dismiss clinical evidence on the basis of having made a prior negative credibility finding. In relation to past harm, the Protocol states:

> "Clinical evidence of past torture or ill-treatment is typically a strong indicator of a real risk of persecution or torture upon return. The lack of clinical evidence does not establish that a person has not been tortured or that the claim of a person alleging torture lacks credibility."[15]

In the Irish context, section 28(6) of the International Protection Act 2015, transposing the EU's Qualification Directive,[16] provides:

> "The fact that an applicant has already been subject to persecution or serious harm or to direct threats of such persecution or such harm, is a serious indication of the applicant's well-founded fear of persecution or real risk of suffering serious harm, unless there are good reasons to consider that such persecution or serious harm will not be repeated."

Importance of MLRs and difficulties with the handling of medical evidence in practice

A focus on medical evidence to document torture and ill-treatment could lead to "the expert's voice erasing and substituting the victim's, raising the evidentiary threshold for recognition."[17] However, international research suggests that independent medical evaluations "may be critical in the adjudications of asylum cases when maltreatment is alleged,"[18] leading to higher success rates. A seminal US study which evaluated data from 2000-2004 found that 89% of cases in which asylum seekers received an evaluation from a clinician at Physicians for Human Rights resulted in a grant of asylum, compared to the national average of 37.5% over the same four-year period.[19] A later study analysed 2584 cases from 2008-2018 that included forensic medical evaluations, finding that 81.6% of such cases had a positive outcome: the applicants were granted various forms of immigration relief.[20] Among the study's cohort, the

15. Istanbul Protocol, at para. 265.
16. Article 4(4) of Directive 2004/83/EC. See also Article 4(4) of the Qualification Regulation (EU) 2024/1347 (repealing the Qualification Directive), the terms of which are identical.
17. E. Cakal, "Cruelty and Corpo-reality: Connecting Technologies and Practices Integral to the Infliction and Investigation of Torture" (2022) 14 *Journal of Human Rights Practice* 1021, at 1033.
18. S.L. Lustig, S. Kureshi, K.L. Delucchi, et al, "Asylum grant rates following medical evaluations of maltreatment among political asylum applicants in the United States" (2007) 10(1) *J Immigr Minority Health* 7, at 7.
19. *Ibid.*
20. H. G. Atkinson et al, "Impact of Forensic Medical Evaluations on Immigration Relief Grant Rates and Correlates of Outcomes in the United States" (2021) 84 *Journal of Forensic and Legal Medicine.*

majority (73.7%) of positive outcomes were grants of asylum.[21] Emerging research in the European context suggests similar patterns.[22]

> Lengthy legal appeals negatively impact torture survivors' prospects of rehabilitation from torture and are costly to the State.

The MLR may therefore form a crucial part of the evidence submitted by a torture survivor in their international protection application. However, the evidentiary value of expert medical evidence within asylum procedures worldwide is highly contested, and there can be serious difficulties with the handling of MLRs by national decision-makers.[23] For example, a 2016 Freedom from Torture report on the UK system highlighted, "recurring and systematic errors in Home Office handling of expert medical evidence of torture."[24] The consequences of such errors are significant: lengthy legal appeals negatively impact torture survivors' prospects of rehabilitation from torture and are costly to the State.[25]

What is the purpose of an MLR?

According to the IPAT Chairperson's Guidelines on Medical Evidence and Medico-Legal Reports ("IPAT Guidelines"),[26] the purpose of a medico-legal report is:

- To substantiate claims of torture or ill-treatment;
- To establish a correlation between physical and psychological injuries and the alleged torture or ill-treatment;
- To reduce the need for the Appellant to give testimony about traumatic events;
- To address the possible effect of removal and return to the country of origin upon a person's physical or mental well-being; and
- To explain an Appellant's difficulties in giving evidence or recounting events by providing possible explanations for inconsistencies within the Appellant's narrative of events and by providing possible explanations for reticence or reluctance in divulging a full account of events.

21. Other positive outcomes included the categories of granted asylum, granted relief (unspecified), granted withholding of removal, granted VAWA relief, granted voluntary departure, granted U-Visa, granted T-Visa, granted cancellation of removal, granted CAT relief, granted special immigrant juvenile status (SIJS).
22. R. Aarts et al, "Expert medico-legal reports: The relationship between levels of consistency and judicial outcomes in asylum seekers in the Netherlands" (2019) 29 *Torture Journal: Journal on Rehabilitation of Torture Victims and Prevention of Torture* 36; H.L. Franceschetti et al, "The effect of the medico-legal evaluation on asylum seekers in the Metropolitan City of Milan, Italy: a pilot study" (2019) 133 International Journal of Legal Medicine 669, 671. However, see M. Jühling et al, "Impact of (forensic) expert opinions according to the Istanbul Protocol in Germany—results and insights of the in:Fo-project" (2023) 137 *International Journal of Legal Medicine* 863.
23. A. Sinon and J. Lejeune. "The Use of Medico-Legal Reports in Asylum Processes in Belgium. European Journal of Migration and Law" (2023) 25(4) *European Journal of Migration and Law* 449.
24. Freedom from Torture, "Proving Torture: Demanding the Impossible - Home Office Mistreatment of Expert Medical Evidence" (2016), at p. 14.
25. *Ibid.*
26. Chairperson's Guideline No. 2025/2 on Medical Evidence and Medico-Legal Reports, available at https://www.protectionappeals.ie/wp-content/uploads/2025/08/Guideline-2025-2-on-Medico-Legal-Reports-29-08-2025.pdf (last accessed 9th December 2025).

For its part, the Istanbul Protocol states that, in the context of asylum proceedings:

> "The purpose of the medico-legal evaluation of alleged or suspected cases of torture or ill treatment is to provide a clinical interpretation of the degree to which clinical findings correlate with the alleged victim's contention of abuse, and a clinical opinion on the veracity of such claims, and the possibility of torture, based on all relevant clinical evidence, and to effectively communicate these findings, interpretations and conclusions to the judiciary or other appropriate authorities."[27]

The emphasis thus differs slightly in the legal versus the medical guidance. Most importantly, the Istanbul Protocol specifically envisages that the purpose of the medico-legal evaluation is to provide a clinical opinion on the veracity of the torture claim. Assessing the "veracity" of the torture claim does not directly feature in the legal guidance and it will be seen in Chapter 4 below that legal practitioners and decision-makers do not necessarily perceive this as a role for the report. Chapter 4 outlines stakeholders' perspectives on the purposes of MLRs in practice.

Key legal principles in respect of the use of medical evidence of torture

In Ireland, High Court case-law has established general principles relating to the evidentiary value of MLRs and how they should be dealt with by decision-makers. The key principles were helpfully summarised by Faherty J in *MM v. Refugee Appeals Tribunal*[28] and adopted by Phelan J in *AS v. IPAT*,[29] as follows:

- In considering any assessment of an applicant's credibility, decision makers are obliged to consider the medical evidence in total before them;
- The medical evidence must be put into the totality of the evidence to be assessed and must not be tangential or peripheral to such assessment;
- It is always a matter for the decision maker to assess the probative value of the contents of such reports;
- Where an applicant provides a story which might be true and the medical evidence tends to confirm his or her story then it is axiomatic that an overall assessment of the evidence should weigh in the applicant's favour;
- If medical evidence is to be rejected, it is incumbent on the decision maker to give reasons;
- A summary consideration of medical evidence by a decision maker may be upheld where the medical evidence uses phrases of low probative value;
- Where an examining physician reports on objective findings and uses phrases which attach a higher probative value to those findings, the medical evidence should be treated as providing potentially objective corroboration of the claim;
- If such evidence is to be rejected, the reasons for rejecting the reports must be more fully addressed in the decision;
- The requirement to more fully address reasons for rejecting medical reports which attach a higher probative value to clinical findings may be less where the balance of the evidence is overwhelmingly in favour of a finding of a lack of credibility.

27. Istanbul Protocol, at para. 268.
28. [2015] IEHC 158, at para. 28.
29. [2023] IEHC 53, at para. 58.

However, the application of those principles in individual cases and issues relating to medical evidence of torture continue to generate litigation.[30] We explore additional guidance available to decision-makers at first instance and on appeal in Chapter 4.

Finally, in *X v. IPAT*[31] the Court of Justice of the EU confirmed that the State's duty of cooperation with the applicant requires the determining authority (here, the IPAT) to obtain an MLR on the applicant's mental health, where there is evidence of mental health problems resulting potentially from a traumatic event which occurred in the country of origin and the use of such a report is necessary or relevant to assess the applicant's need for international protection.

> In Ireland, High Court case-law has established general principles relating to the evidentiary value of MLRs and how they should be dealt with by decision-makers.

30. See, for example, *GL v IPAT and Minister for Justice* [2025] IEHC 185; *AHH v Minister for Justice and IPAT* [2025] IEHC 298 (both refusing leave to seek judicial review); and *SM v Minister for Justice* [2025] IEHC 629.
31. Case C-756/21 X v *International Protection Appeals Tribunal and others* [2023] ECLI:EU:C:2023:523 (29 June 2023).

Chapter Three: Medico-Legal Reports in the International Protection Appeals Tribunal

This chapter sets out key findings of our review of relevant International Protection Appeals Tribunal ('IPAT') decisions for 2024, 2023, and 2022. We also draw on these insights in developing the thematic findings in Chapter 4.

The aim of this strand of the research was to investigate the role and impact of medico-legal evidence of torture in practice in appeals decisions, using the publicly available information contained in the IPAT's archive.

For context, the IPAT was established as an appellate body by the International Protection Act 2015. It is a "statutorily independent body and exercises a quasi-judicial function."[32] The Tribunal's mandate has subsequently been expanded and currently includes appeals from first instance decisions in respect of:

- International protection status – refugee status and subsidiary protection ("international protection decisions");
- Inadmissibility of an application for international protection ("inadmissibility" decisions");
- Consent to make a subsequent application for international protection;
- Transfer decisions under the European Union (Dublin System) Regulations 2018 ("Dublin III decisions"); and
- Reception conditions in the international protection process, including labour market access.[33]

This chapter first explains how we identified and categorised relevant decisions, whilst acknowledging the limitations of this exercise. It then (i) sets out the findings of this exercise, and (ii) uses 2023 as a 'snapshot' year to consider success rates in international protection appeals. Finally, it includes a set of general observations, based on our reading of over 400 appeals decisions.

How did we identify and categorise decisions?

Step 1 – Identifying Decisions

The research assistant searched the online archive of the IPAT for the years 2024, 2023, and 2022. They used the search terms 'Spirasi'; 'Medico-Legal'; 'MLR'; and 'Istanbul' to identify relevant decisions. Duplicates were removed from the lists (i.e. decisions with the same decision number which are on the system twice.) The lists generated by the search terms were consolidated. The research assistant manually created a 'master list' of relevant decisions for each year, as at 13 March 2025.

Most of the identified decisions were international protection decisions, however there were a small number of "Dublin III" transfer decisions and "inadmissibility" decisions identified in each year (<10 in each of these categories per year).

At this stage of the research, we noted that the archive's functionality from a research perspective is very limited. For example, searches do not produce on-screen full results lists or total numbers of decisions. In addition, users are frequently automatically logged out of the archive or 'locked out'.

32. See the IPAT website, at https://www.protectionappeals.ie/about-the-tribunal/what-we-do/
33. See generally, IPAT Annual Report, 2024, at p.10.

Step 2 – Categorising Decisions

The researchers manually reviewed and categorised the identified decisions.[34] The aim was **not to assess whether the decision is legally or procedurally 'correct'**. Similarly, we did not focus in this exercise on whether the appeals were successful per se. Rather, the aims were to (i) classify the decisions according to the apparent impact of the MLR on the decision, and (ii) glean insights from the decisions themselves on the treatment and interpretation of MLRs by decision-makers.

The categories - developed by the researchers through an iterative process involving consultation with Spirasi colleagues - are as follows:

1. Positive (P) - MLR had a clear positive impact on the decision, which is articulated by the decision-maker.
2. Considered but Outweighed (OW) - MLR was considered by the decision-maker but impact was outweighed by credibility or evidential issues, or other factors particular to the case.
3. Negative (N) - Decision-maker appears to regard the MLR negatively. This means:
    a. The MLR 'works against' the appellant; eg, is used to highlight some discrepancy in the appellant's testimony or evidence, or
    b. The decision-maker speaks negatively about the MLR; or
    c. The MLR appears to be disregarded without any consideration.
4. Unclear (U) – Impact of the MLR cannot be determined, usually because the MLR is not referred to in enough detail to determine the impact.
5. No report (NR) – No MLR drafted in accordance with the Istanbul Protocol was submitted to the Tribunal. This was for a variety of reasons.[35]

Limitations

There was necessarily a subjective element to the categorisation process, as it involved interpreting the decision in question and applying a qualitative assessment of the impact of the MLR. The categories were initially assigned by the research assistant and then each classification was reviewed by the lead researcher. Any differences of opinion were discussed. All classifications were re-checked against the relevant IPAT decision by the lead researcher in the final stages of the research.

We analysed relevant decisions for 2024, 2023, 2022 that we could find (using our search terms) on the IPAT archive, as at 13 March 2025. Our review was limited to three years due to resource constraints.

The analysed decisions are best understood as a selection of relevant decisions in each year rather than a full, or a representative, sample. Our searches will not have unearthed *all* relevant decisions issued during 2024, 2023, 2022, partly because all relevant decisions are not contained in the archive. Previous academic research has identified gaps within the IPAT's online archive as a limitation of the archive from a research

34. At this stage, we removed decisions in which there was no substantive reference at all to an MLR.
35. In some cases, it is unclear from the face of the decision whether there was an MLR or whether it was a more general medical report. We treated such reports as MLRs where this seemed likely from the context.

perspective. Brown notes that the archive is incomplete, i.e. does not contain all decisions counted in the official statistics contained in the IPAT Annual Report.[36] This is reflected, for example, in the apparent mismatch between the number of decisions issued (1588) and the number of decisions which appear in the archive for 2023 (1042, according to a VizLegal database search in March 2025). In particular, decisions that are quashed following a decision by the Superior Courts in judicial review proceedings are removed from the archive.[37] This means that particularly contentious decisions may not be available on the archive.

Key findings

Table 1 displays the overall findings of our review and classification of IPAT decisions, broken down by the number of cases that were reviewed for each year, and by category.

Year	Number of cases analysed	Positive	Outweighed	Negative	Unclear	No Report
2024	136	66	27	13	10	20
2023	141	67	32	9	8	25
2022	134	54	29	10	11	30

Table 1: *IPAT decisions analysed by outcome and year*

In Table 2, we have removed the cases in which there was apparently no report before the Tribunal, in order to provide a clearer picture of the impact of MLRs in cases in which a report was actually submitted.

Year	Number of cases analysed	Positive	Outweighed	Negative	Unclear
2024	116	66	27	13	10
2023	116	67	32	9	8
2022	104	54	29	10	11

Table 2: *IPAT decisions analysed by outcome and year, with 'No Report' cases removed*

Table 2 shows that MLRs had a positive impact in the majority of cases that we examined in which an MLR had been submitted. The next largest cohort of cases were those in which the MLR was considered by the Tribunal but its impact was outweighed by other factors. In the remainder of cases, the impact of the MLR was unclear, or we classified the treatment of the report as 'negative'.

36. S. Brown, "Bordering in the archives: An investigation into a digital archive of the Irish asylum and refugee determination" (2023) 42(6) *Environment and Planning C: Politics and Space* 925.
37. Decisions are removed and replaced with a notice of removal. Although please note that information on some of these decisions which were subject to judicial review should be available through a search of High Court decisions.

We discuss the 'positive', 'outweighed' and 'negative' categories in further detail below, using examples of relevant decisions to illustrate the categories.

> In some cases, the discussion of the MLR forms part of a holistic appraisal of the evidence and the MLR is not extensively considered.[38] In others, the decision-maker appears to view the MLR as 'tilting the balance' in favour of the appellant and the MLR is examined in detail.[39]

A. 'Positive'

We broadly observed two main types of 'positive' cases. In some cases, the discussion of the MLR forms part of a holistic appraisal of the evidence and the MLR is not extensively considered.[38] In others, the decision-maker appears to view the MLR as 'tilting the balance' in favour of the appellant and the MLR is examined in detail.[39] Thus, in one 2024 decision, the MLR played a substantial role in balancing the case in the appellant's favour, with the Tribunal noting that:

> "the Tribunal accepts that the Appellant is a gay man from Ghana. The Tribunal makes this finding on the balance of probabilities, but notes that this was a very finely balanced case and the medical report played a substantial part in balancing it, just about, in his favour."[40]

This sub-category can include cases in which the MLR helps the Tribunal to understand lapses in memory or inconsistent narratives. For example, in a decision issued in 2023:

> "The Tribunal recognises that the findings in the submitted Spirasi Report are not determinative of the Appellant's overall claim. In this respect, the Tribunal has also had regard to the Chairperson of the Tribunal's Guideline on Medico-Legal Reports. Nonetheless, the Tribunal gives positive weight to the Spirasi Report and based on its findings accepts that the Appellant has scars which are consistent with torture and that he suffers from PTSD, highly consistent with the trauma he described to Dr XX. ...
>
> Notably, the Appellant's claim was presented in the most detailed and compelling fashion in his Spirasi report. The Tribunal is mindful that in this setting the Appellant may have felt more comfortable to disclose and describe traumatic past experiences. Taking into consideration the Appellant's poor mental health, coupled with the more detailed account given by him during his Spirasi assessment, the Tribunal is prepared to extend the benefit of the doubt more liberally to him in respect of omissions in his claim at first instance."[41]

In some cases, the MLR reduced the need for the appellant to provide detailed testimony on difficult issues. For example, in Decision 2337229-IPAP-23, the Tribunal member indicated that, in light of the MLR the appellant did not need to give particulars of the violence she suffered at the hands of her abusive husband.[42]

38. 2347271-IPAP-23; 2354650-IPAP-23; 2289670-IPAP-23; 2291141-IPAP-23. Please note that we use the reference numbers assigned by IPAT to cite the relevant decision.
39. 2304893-IPAP-23; 2305381-IAAP-23; 2197683-IPAP-22.
40. 2036130-IPAP-21.
41. 2086109-IPAP-22. See also, for example, 2287206-IPAP-23; 2330101-IPAP-23.
42. See also, for example, 1991445-IPAP-20; 2255524-IPAP-23.

B. 'Outweighed'

The reasons why the medical evidence was outweighed by other factors varied between cases.

The MLR is often considered at some length in 'outweighed' cases. For example, in Decision 2074893-IPAP-22, almost 5 pages of the decision is given to the discussion of the MLR. This decision also illustrates a key issue arising in some 'outweighed' decisions, whereby the MLR is seen as relying on "self-reported" symptoms, or where the Istanbul Protocol finding is perceived as relying on the contextual information supplied by the appellant, in circumstances where they are not otherwise seen as credible. The Tribunal member notes:

> "While the Medico-Legal Report, as always, maintains impeccable integrity, its probative value in the context of the Tribunal's assessment of this aspect of the Appellant's appeal, is diminished by the fact that it had to rely on the Appellant's anecdotal testimony for background information. When put in the context of the negative credibility findings in the Appellant's appeal, the Medico-Legal Report is not sufficient to displace the negative impact of the credibility issues identified in this aspect of the Appellant's appeal."[43]

A further issue relates to the perception that while an MLR can help to prove the existence and cause of injuries, it cannot necessarily identify the perpetrator.[44]

C. 'Negative'

It was very rare that an MLR drafted in accordance with the Istanbul Protocol was explicitly disregarded or criticised. Most 'negative' classifications arose because the report worked against the applicant in a way that might not have been anticipated - for example, by highlighting some inconsistency in the evidence. Thus, in Decision 2270023-IPAP-23, for example:

> "The evidence under oath contradicts information in the MLR. Given the credibility issues arising therefrom, the benefit of the doubt cannot be afforded to the Appellant in how his physical/psychological condition was caused."

On rare occasions, a Tribunal member has made negative comments about specific MLRs, stating that they do not consider a particular doctor to be an objective witness and therefore they will not afford the MLR any weight.[45] These appear to be outlier cases.

43. For similar reasoning, see 2043804-IPAP-21; 2195757-IPAP-22; 2181071-IPAP-22; 2245506-IPAP-23; 2142666-IPAP-22. In contrast, while a similar formulation of words is used in 2297018-IPAP-23 in relation to anecdotal testimony, in that case the appellant's evidence before the Tribunal was perceived to be detailed and consistent and, viewing the report in the context of that evidence, the Tribunal found that it supported the Appellant's claim and granted the appeal (this decision was coded 'positive').
44. 1992798-IPAP-20; 2043804-IPAP-21; 2116560-IPAP-22.
45. 2084821-IPAP-22; 2267224-IPAP-23; and 2306963-IPAP-23.

International Protection Appeals in 2023

Above, we explained how we categorised decisions according to the treatment of the MLR in the IPAT's decision. Here, we examine the separate issue of success rates in substantive international protection appeals, using 2023 as a 'snapshot' year.

Table 3 shows the number of international protection appeals analysed in our sample for 2023, alongside the overall number of relevant appeals in 2023 for context.

Type of appeal	Total number analysed in our sample	Number analysed in our sample after 'no report' cases removed	Overall number in 2023 (IPAT Annual Report)
International Protection (Substantive and Accelerated)	131	109	1392

Table 3: *International Protection Appeals vs Overall Appeals in 2023*

Table 4 provides information on the percentages of appeals that were granted and the original decision set aside, in our sample and in 2023 overall.

Type of appeal	% of appeals granted in our sample after 'no report' cases removed	% of appeals granted in 2023 overall[46]
International Protection (Substantive and Accelerated)	67.8%	30%

Table 4: *Success rates in International Protection Appeals in 2023*

Within the group of decisions that we considered, appellants with a medico-legal report had a much higher rate of success (67.8%) than the general success rate at the IPAT (30% for international protection appeals). We have already discussed the limitations of our sampling and review exercise and do not suggest that the fact of having a medico-legal report alone results in an increased chance of success on appeal. For example, those who have been referred for an MLR have likely had access to effective legal representation (see Chapter 4 below). However, this data echoes research findings in the US, the Netherlands, and Italy.[47]

46. Source: IPAT Annual Report, 2023.
47. See Lustig; Atkinson; Aarts; Franceschetti as cited in footnote 22.

General observations

Below, we set out some general observations on MLRs in everyday practice in the IPAT, based on our reading of over 400 decisions. It was striking to observe across all the examined decisions that, irrespective of the outcome of the appeal, they concerned a cohort of people who had experienced significant trauma and who were subsequently suffering from varying degrees of mental distress, and often mental illness.

- Tribunal members often emphasise the importance of the MLR in supporting their decision, specifically commenting on the quality and rigour of MLRs in some cases. The Tribunal seems to give particular weight to where the medical practitioner is highly experienced in MLR work,[48] where the evidence is presented in a fair and impartial manner,[49] and sometimes where the report is thorough or detailed.[50] The Tribunal has recognised that the reports can be very labour intensive.[51]
- In 'positive' decisions, Tribunal members often note that the International Protection Office did not have the benefit of the MLR at first instance.[52] Indeed, it appears that reports are rarely available at first instance.[53]
- In some decisions in which there is 'no report', the Tribunal member notes that an MLR could have been helpful to the appellant.[54] In some cases, there were medical letters,[55] letters from the psychosocial team in Spirasi,[56] or psychological reports that the Tribunal expressly states do not carry the same probative weight as an MLR.[57]
- It appears that the time taken to obtain an MLR can contribute to delays in the system: hearings are sometimes postponed to facilitate a report,[58] while in some cases the appellant was afforded time to submit a report after the hearing.[59] In some instances, the Tribunal had exchanged correspondence with the appellant's representatives on the issue and stated that it had gone to significant lengths to facilitate the appellant in obtaining a report.[60]
- The appellant's history and narrative as recorded in the MLR are sometimes compared to the account provided by the applicant at other

48. 2296501-IPAP-23; 2353573-IPAP-23; 2249512-IPAP-23.
49. 2045339-IPAP-21; 2027762-IPAP-21.
50. 2045339-IPAP-21; 2027762-IPAP-21.
51. 2266519-IPAP-23.
52. See, among many other examples, 2282623-IPAP-23; 2297018-IPAP-23.
53. We did not keep track of this information across all cases, but to take 2024 as an example, there were only 4 cases in which it was clear that the IPO had considered an MLR (out of 136).
54. 2195840-IPAP-22; 2196008-IPAP-22; 2196008-IPAP-22.
55. 2154267-IPAP-22; 2158010-IPAP-22 (consultant's letter).
56. 2157799-IPAP-22.
57. 2332775-IPAP-23; 2155673-IPAP-22.
58. 2057157-IPAP-22; 2311605-IPAP-23; 2330319-IPAP-23.
59. 2333395-IPAP-23; 2351422-IPAP-23. However, note 2106516-IPAP-22, in which the Tribunal refused to postpone as the applicant applied for medical report at last moment and the Tribunal considered that he had had ample time to get one.
60. 1998740-IPAP-20 (no report ultimately produced); 2322939-IPAP-23; 2328249-IPAP-23; 2322544-IPAP-23, in which it was stated at the oral hearing that the appellant would not be producing an MLR but then after the hearing the Tribunal got a holding letter to say that one was on the way. In this case, it was really important and helped to swing the case in favour of the appellant. 1998740-IPAP-20.

stages of the application process (in the questionnaire, interview, and/or appeals hearing, for example). This can work 'for'[61] or 'against'[62] the applicant, either supporting the decision to grant the appeal or to reaffirm the first instance recommendation.

- The Istanbul Protocol is not usually referred to in any detail by Tribunal members in their consideration and interpretation of the medical evidence (although note that we do not suggest that discussing the Protocol is legally necessary). We did not track this across all the decisions. In 2024 for example, 53 of 136 decisions mentioned the Istanbul Protocol, but this was often just in quoting directly from the MLR.
- Sometimes a medico-legal report will not be needed for the Tribunal to make a decision in favour of the appellant.[63] For example, in Decision 2027741-IPAP-21, there was no MLR submitted due to delays. The Tribunal member noted that: "Taking into account the Appellant's psychological report on file ... wherein reference is made to a number of appointments in 2009 where the Appellant received sessions of psychotherapy, for stress and anxiety, and the fact that the appellant reached out to SPIRASI in Ireland coupled with the Appellant's evidence to the Tribunal where he stated, 'My memory is not the best. With the life I have had, I could even forget my name,' the Tribunal is not minded to give any weight, in a negative sense, to the Appellant's inconsistencies and forgetfulness."

Overall, the role and impact of an MLR in a decision of the IPAT depends on the individual case, with an MLR often forming part of a complex matrix of facts and evidence that are weighed by the Tribunal member.

- Conversely, in a small number of cases the Tribunal has refused to allow extra time for a report, indicating that notwithstanding the report's findings, it would not be enough to displace negative credibility indicators.[64]

Overall, the role and impact of an MLR in a decision of the IPAT depends on the individual case, with an MLR often forming part of a complex matrix of facts and evidence that are weighed by the Tribunal member. MLRs are generally recognised as an important piece of evidence by the Tribunal. However, it is clear that earlier access to MLRs could have resulted in more timely access to protection for some victims of torture.

61. 2171700-IPAP-22; 2287070-IPAP-23; 2197683-IPAP-22.
62. 2270023-IPAP-23; 2272763-IPAP-23; 2346686-IPAP-23.
63. This is clearly articulated in 2041876-IPAP-21.
64. 2044804-IPAP-21.

Chapter Four: Stakeholders' Perspectives

This chapter presents key thematic findings of the research, drawing primarily on the stakeholder interviews. The research team conducted semi-structured interviews with 13 key professionals, including legal practitioners, medico-legal report (MLR) physicians, a UNHCR employee, and public servants with current or former roles related to decision-making. Interviews were recorded and transcribed; a full list of the interviews can be found in Appendix 2. In this chapter, "T" denotes "Transcript."

Questions focused on stakeholders' perspectives on the role of medical evidence of torture in an international protection application, access to medico-legal reports (MLRs), the quality of MLRs in the Irish system, human rights of survivors in the international protection system, and ideas for reform.

Importance of MLRs

Chapter 3 highlighted the significant role of medical evidence of torture within the appeals process. We saw that Tribunal members frequently articulate the value of MLRs in supporting their decision-making, even in cases in which the appeal is unsuccessful. The research interviews similarly revealed the importance of MLRs, albeit that stakeholders acknowledged that the precise role and impact of a report depend on the circumstances of an individual case. The interviewees expressed varying perspectives on the importance of MLRs within the protection process, depending on their professional role and perspective.

From the legal practitioner's perspective, MLRs are "vital." [T2] They are seen as "incredibly important" pieces of evidence. [T2; T4] Whilst legal practitioners acknowledged that the role of the MLR varies from case-to-case and is not necessarily determinative of a claim for international protection, [T2; T12] overall they were considered to be very important given that they may tilt the balance in some cases:

> "I think ... an MLR report reinforcing what the client is saying has been the difference between ... them possibly making their claims successful or not or making their appeals successful or not." [T4; see also T13]

The value of timely access to MLRs was emphasised, in a context where timely access is not often possible and MLRs are usually only available at the appeal stage. As one legal practitioner interviewee noted: "medical evidence is crucial from the beginning. It's just that often we're limited by time, resources and I suppose now that we're not involved at pre-questionnaire stage". [T4] 1. A UNHCR employee similarly commented that MLRs play a particularly important role at appeal stage, rather than at first instance. [T3] They are often not available at first instance, with the possible consequence that first instance decision makers may not in turn "realise how important medical evidence is and don't attribute enough evidential weight to the medical report." [T2; T12] This need for first instance decision-makers to appreciate the importance of MLRs was reflected in the view of a solicitor that "with the backlog my sense is that certainly more recently when I've been in with individuals it wasn't apparent that the decision maker had actually reviewed the medico-legal report in advance of the interview." [T12]

Decision-makers, in contrast, stated that MLRs are "very good evidence" [T1] but placed more emphasis on MLRs as just one part of the overall

evidence. This perspective is clearly demonstrated in the 'outweighed' category of decisions discussed in Chapter 2, and in decisions of the High Court relating to MLRs.[65] For a decision-maker, the MLR's importance will depend on the other evidence and the strength of the findings of the report itself. (T1; T8; T9) In the words of one interviewee: "sometimes people view them as kind of like a silver bullet, but frequently they're not." (T1) Decision-makers highlighted that not all victims of torture will necessarily fulfil the criteria for international protection. (T1; T8; T9) For decision-makers, "any medical documentation [is] beyond reproach because we're not medical practitioners ourselves, but we do have to look at it in a holistic way. What does the rest of the application tell you?" (T9)

MLR physicians rely on feedback from legal professionals and clients in respect of the impact of their reports; they "hope that it is important", (T13) while being aware that it can vary from case-to case. (T7) In short, one participant noted that: "it's no guarantee that someone will have a positive decision, but we would, we would certainly consider them to be important and if it's to be a fair system, essential." (T7) Medical professionals also saw the importance of MLRs for the clients "in terms of just having their stories told." (T13)

Finally, the broader importance of the MLR, from the perspective of the client, was highlighted by one legal practitioner. For this interviewee:

> "I think it has a really important role. In terms of safeguarding and supporting someone in relation to their experiences … I think there's huge value in it. I think at the earliest stage possible. I think it can identify if somebody is in need of additional services. And I think that that intervention is really beneficial for the person. So, if I was thinking about the person … I think it can have a really important role for them."

This links into the purposes of MLRs to reduce the need for testimony and in shaping the conduct of interviews and hearings, which is discussed below.

Purpose of MLRs

Interviewees for this research identified three broad purposes of MLRs within the international protection process: to provide objective medical evidence in support of a person's application; to inform the decision-maker of the effects of trauma on the person's capacity to provide a detailed or consistent account (thus possibly explaining inconsistencies that damage credibility); and to inform the approach of decision-makers to the person during an interview or hearing (e.g. interviewing style, need to recount details during testimony).[66] Stakeholders' responses to this question also revealed the importance of specialist and individual legal advice and representation: an experienced solicitor who has an opportunity to consult with a protection applicant is best-placed to spot that an MLR would be beneficial and to make the appropriate referral.

At its simplest, medico-legal evidence of torture is "proof to support one's claim"; (T13) evidence in a legal process. It empowers the applicant to effectively present their claim by providing an objective, clear, impartial professional opinion: it is an "objective independent account" (T12; T4) providing an "expert lens" through which to assess the person's narrative. (T12) One legal practitioner noted that this is an important aspect of a fair system. (T12) For the doctors, it is "about documenting clinical findings and our

65. See, for example, *J.U.O. (Nigeria) v The International Protection Appeals Tribunal* [2018] IEHC 710; *A.S. v International Protection Appeals Tribunal* [2023] IEHC 53.
66. Each of these purposes also come through clearly in the case-law of the IPAT as discussed in Chapter 2.

interpretation of those findings" and "explaining those findings in an easy-to-understand way to our non-clinical legal colleagues and then to make a determination in according to the Istanbul Protocol in terms of the levels of hierarchy." [T6] This aligns with the purpose of MLRs, as stated in the Istanbul Protocol, to make complex medical information digestible to the layperson. [T11]

The purpose of explaining the reasons for possible inconsistencies was highlighted by several participants. One legal representative summed up this purpose in clear terms:

> "if they have significant psychological issues that might mean that their recounting of the evidence might be re-traumatising, which is the problem, or it might affect their recall and their memory, so it's important in that respect as well. So, like typically for example, like an appellant would have been maybe found not credible by the IPO because they didn't have a medico-legal report. And then on appeal, that would address both the issues that they say that they have and then also might address why they weren't able to adequately remember or address the issues at first instance." [T2]

One MLR physician noted that doctors are "providing a conducive environment for people to talk" by conducting a trauma-informed assessment in accordance with the Istanbul Protocol. [T6] MLR physicians also commented that their role partly relates to highlighting why someone may have difficulty presenting their case [T6] and/or outlining the reasons why inconsistencies may have arisen [T11]. One MLR physician noted: "

> "we really do need to highlight where somebody may ... have difficulty presenting their case and why there may be limitations that influence a person's ability to talk about past trauma leading to inconsistencies which may be affecting their credibility." [T6]

However, this purpose of MLRs may involve the writer in matters relating to credibility more generally, which we will see below can become contentious.

In addition to their role in providing evidence in relation to the core claim for international protection, MLRs have 'softer' implications and uses. In terms of the treatment of individuals within the process, the MLR may assist in having the interview or appeals hearing "conducted in a way that's dignified", with one participant commenting that "there are dignified modes of doing the same thing". [T2] Thus, having an MLR may reduce the need for the individual to provide detailed testimony on some points, or perhaps will support a request for other accommodations. [T12] One solicitor noted that when a client had an MLR at their first instance interview, the interview was conducted in a much more humane fashion." [T12] This tied in with MLR physicians' perspective that a vital purpose of the MLR is to "avoid the need for them to ... possibly be re-traumatised in, in retelling their story again and again." [T10]

In addition to the three main purposes of medical evidence of torture, a less-emphasised purpose was to provide evidence of the possible effect of removal and return to the country of origin or a third country upon a person's physical or mental well-being. [T5] This was also an important feature of the IPAT case-law. One MLR physician described this as a challenging aspect of the work because it involves an element of predicting what may happen in the future. [T11]

Relationship to the credibility assessment

One of the trickiest and most contentious aspects of the use of medical evidence of torture worldwide is the relationship of the MLR to the credibility assessment in asylum procedures.[67] In Ireland, the High Court case-law is clear on this point: the medico-legal evidence should form part of a holistic credibility assessment and should not be compartmentalised, or completely disregarded by the decision-maker without giving reasons.[68] However, the role of MLRs in respect of credibility appears to be a grey area in practice, given the inescapable link in some cases between the doctor's opinion on the veracity of the torture claim and the person's overall credibility.

In this regard, a UNHCR employee noted:

> In training on credibility assessments, we emphasise four key credibility indicators, including consistency. It can be challenging when inconsistencies are noted without fully considering psychological findings in an MLR, such as PTSD, which may explain these discrepancies. This highlights the importance of factoring in MLR findings when preparing for interviews or hearings. [T3]

Decision-makers emphasised that MLRs are limited in terms of their legal function: "They aren't there to assess credibility. … All they're being asked is this consistent with how it was said the injury occurred? That's the sole function of the reports." [T1] Similarly, a solicitor noted that "they're not being asked to assess someone's credibility. They're just being asked to kind of give their medical views on the presentations in front of them". [T12].

From the perspective of one medical professional:

> "we make our own judgements in on whether we think the person is telling the truth. I suppose at the end of the day. And while it's not our position to, you know, to talk about credibility, the Istanbul Protocol does say that the clinician has a duty to look for fabrication." [T5]

Obtaining an MLR in practice

In practice, an international protection applicant is generally referred by their legal representative for a medico-legal assessment. [T2; T4].

Spirasi's current referral criteria are based on the UN Convention Against Torture's definition of torture, containing four elements:

- Severe pain or suffering, whether physical or mental;
- Intentionally inflicted;
- For a particular purpose (for example, obtaining information or a confession, punishment, intimidation or coercion, or for any reason based on discrimination of any kind);
- Inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

67. See generally, A. Sadana et al, "Medical evidence in asylum applications: Medical versus legal approaches" [2023] 97 *Journal of Forensic and Legal Medicine*.
68. See, for example, R.S. [*Ukraine*] v *The International Protection Tribunal; I.H. [Ukraine] v The International Protection Tribunal* No.2 [2018] IEHC 743; *A.S. v International Protection Appeals Tribunal* [2023] IEHC 53; *BAC v The International Protection Appeals Tribunal [Botswana]* [2024] IEHC 297.

If the referral is accepted, a medico-legal assessment follows, after which a report is finalised and sent to the legal representative. The report is then reviewed by the legal representative and may be submitted as part of the application or appeal. This is usually at appeal stage. Due to limited capacity, at present Spirasi accepts referrals only at appeals stage.

The independent MLR physicians coordinate their work in response to referrals from solicitors. There is no referral form and they take referrals directly from legal representatives.[69] These cases include those who are due to have an imminent IPAT appeal hearing or where a decision is on hold until an MLR is obtained, those who are paper-based-only decisions without a date, and occasionally Dublin III and deportation cases. The independent MLR physicians often take on cases that consider the broader definition of torture and ill-treatment as outlined in paragraph 4 of the Istanbul Protocol:

> "State responsibility for torture and ill-treatment extends to individuals acting in an official capacity, as well as to non-State actors acting with the consent or acquiescence of the State. As stated under article 1[1], torture involves acts "by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity". The term acquiescence necessitates a rather broad interpretation, under which States are responsible for the actions of public officials and non-State actors who "have awareness of such activity and thereafter breach [their] legal responsibility to interfere to prevent such activity". The principle of official capacity therefore keeps States accountable for more than just State officials and creates a wider understanding of the definition of torture."

The independent MLR physicians aim to be as responsive as possible so that MLRs can be made available to decision-makers in a timely manner.

Non-availability of reports and cumbersome referral processes

Despite the importance and multi-faceted purpose of MLRs in law and practice, many stakeholders drew attention to the non-availability in practice of MLRs at all stages of the protection process, and the difficulties with obtaining reports. This issue was particularly emphasised by legal practitioner interviewees, one of whom identified the non-availability of reports as "the biggest problem throughout all of the processes, whether on first instance or appeals". [T2] Although "that's not to say that everybody needs an MLR". [T2] The difficulties in obtaining a report may in turn deter legal practitioners in practice from seeking a report. [T4]

For legal practitioners, the key necessary reform is: "being able to access them more easily and you know that the whole process wouldn't take as long that it wasn't as expensive, that it was ... more available and more attainable". [T4]

It appears that MLRs are rarely available at first instance and that there can be intense difficulty with obtaining them on appeal. [T2; T4] Civil servants involved in first instance decision-making also noted that they do not tend to see MLRs and that they would welcome receiving more of them. [T9] These first instance decision-makers acknowledged that they "would like to think that if had we got an MLR here we would have been able to make an absolute robust decision and therefore there'd be less need for appeals." [T9] Moreover, stakeholders pointed out that obtaining MLRs has become "increasingly difficult" in recent years.

69. Information in this section has been provided by the independent MLR physicians.

> Many stakeholders drew attention to the non-availability in practice of MLRs at all stages of the protection process, and the difficulties with obtaining reports.

[T4] The process of referral to Spirasi by way of an online form is perceived to be time-consuming and cumbersome, although efforts are ongoing at Spirasi to streamline the form and reduce its length.[70]

Legal practitioners emphasised that the Tribunal may not be aware of the difficulty in obtaining reports or that they are not generally available at first instance and may end up criticising the legal representative as a result. [T2]

Participants identified some reasons for the shortage of MLRs, including the dearth of MLR physicians, linked to the fact that "the Legal Aid Board won't pay them enough money, so it's really, really hard." [T2] An MLR physician agreed that the "Legal Aid Board payment is miserly", making it difficult to bring more doctors on board to do this work. [T7] Medics also highlighted that doctors would need to feel "respect for the ... practitioners doing the work and the difficulty of that work" [T7].

Some specific practical issues related to access included:

- The difficulty of securing quality interpreters.
- The labour-intensive nature of reports for MLR physicians and the time required to produce a report. [T13]
- The long online form that needs to be filled out to refer a person to Spirasi can be off-putting for legal representatives. [T2; T4][71]

More broadly, medical evidence outside of the strict remit of the Istanbul Protocol and/or Spirasi's remit was seen as important and difficult to obtain. This included: "domestic violence or other areas, and there are other also issues with minors and age disputed minors and relation to medico-legal reports." [T4] One legal practitioner pointed out that medical reports are "used ... to be readmitted into the asylum system. They're used in the leave to remain review on the humanitarian grounds. Medical issues ... they're used in so many other forums, not just the [refugee] appeal." [T13]

Access to MLR usually dependent on access to effective legal representation

International research on medical evidence within asylum processes suggests that unrepresented claimants will usually not seek to secure psychological reports, nor will they request accommodation in a refugee hearing.[72] The experiences discussed in the previous section suggest that in the present system in Ireland, access to MLRs is largely dictated by access to effective legal representation. This can be

70. Comment of Spirasi on reading an earlier draft of this report.
71. The online form has been re-designed in 2025 to reduce the amount of information required, based on feedback from referrers.
72. A. Purkey et al, "Accommodating Vulnerable Claimants in the Refugee Hearing: The Canadian Example," in *Between Protection and Harm* (Springer, 2024).

problematic in terms of timely requests for an MLR given that applicants will not always have access to early legal advice and may only see a solicitor at appeal stage. (T12) Moreover, referring a client for an MLR is very time-intensive in the context that the legal aid payment for private practitioners taking on protection claims is very low. (T13)

From the perspective of one medical professional:

> "It seems almost arbitrary. Sometimes who gets a medical report and who's referred for a medical report? You know, some solicitors seem to be aware of the importance seem to seek us out and seek Spirasi out and go to the trouble of doing that." (T7)

For one legal practitioner, "there has to be adequate training of practitioners" along with access to legal advice and representation at the earliest stage. (T13).

One participant noted that recent caselaw has clarified that a decision-maker's duty to cooperate may, in certain circumstances, require obtaining a medico-legal report; (T3) while another suggested that it should be possible to access an MLR on foot of an initial vulnerability assessment. (T12)

Time and effort associated with obtaining an MLR

One of the most striking themes to emerge across the stakeholder interviews was the time and work that goes into producing an MLR for professionals involved in the process. This stretches from the legal representative who organises the referral and provides extensive documentation, to the doctor who may examine and triage referrals before completing a time-intensive examination of background information and medico-legal evaluation prior to drafting a report, to a decision-maker who will review a report alongside lots of other documentary evidence after possibly postponing proceedings for the purposes of facilitating its drafting.

Risk of retraumatisation associated with obtaining an MLR

Stakeholders also drew attention to the extremely taxing nature of the process for survivors of torture, who may be retraumatised by reliving and retelling their story and reviewing a draft report, for example. One MLR physician brought together the impact on clinicians and victims of torture:

> "There's not enough consideration of ... the difficulty of this work. And how harmful it can be for the person and for us as practitioners doing this over and over again with, with, with people." (T7)

This issue is discussed in further detail in the section on "retraumatisation".

Sources of guidance for professional stakeholders

Irish law and practice does not contain highly formalised prescriptions for what should be seen as admissible medical evidence in the international protection process, unlike some countries such as Germany.[73] Moreover, Ireland appears to be doing well in terms of the provision of relevant guidance for stakeholders: participants broadly indicated that there is sufficient guidance available in their respective areas. Challenges mainly

73. See N. Gill et al, *Inside Asylum Appeals: Access, Participation and Procedure in Europe* (Routledge, 2025), at p.129.

related to ensuring that the guidance is correctly implemented and applied in individual cases. [T1]

For legal practitioners, the focus was mainly on the IPAT Guidelines, rather than the High Court case-law, although this case-law was seen as important for emphasising the key point that MLRs should not be ignored. [T4] A legal practitioner described the updated IPAT guidelines as "useful" and "very balanced". [T2] In their view, "most Tribunal members I feel would be familiar with those guidelines and I would hope that, well, I would hope all of them would be. But I'm sure that most practitioners would be as well." Interviewees indicated that the international Protection Office has its own internal guidance, [T8 and T9] although some legal representatives were unaware of this guidance. [T12] Only one legal practitioner mentioned Spirasi's "Guidance Note to Referrers." [T12]

From a medico-legal perspective, it is well-accepted that the Istanbul Protocol can help to improve the legal standing and probative value of MLRs.[74] In Ireland, the Istanbul Protocol is the "Bible" for physicians drafting MLRs. [T13] They may also refer to sources such as "Forrest guidelines" and, rarely, in specific cases, peer review journals such as *Torture*. [T11]

The issue of the various stakeholders understanding how others exercise their discretion and judgement in line with their professional guidelines was raised by several interviewees. One legal representative put it succinctly: "what is the value of guidelines, you know, I think if different stakeholders are not ... understanding and putting themselves in the position of others." [T12] Another participant noted that while decision-makers

From a medico-legal perspective, it is well-accepted that the Istanbul Protocol can help to improve the legal standing and probative value of MLRs.

are generally familiar with the Istanbul Protocol, additional training could further support its effective interpretation. [T3]

In respect of the Istanbul Protocol, it is clear that while decision-makers and legal representatives are aware of and respect the Protocol, this awareness mainly extends to the Protocol's levels of consistency. These stakeholders may not be aware of the extent to which MLR physicians rely on the Protocol to draft their reports, or that certain items may be contained within the report because this is required under the Protocol. It may also explain the length of reports, which "get longer because we're putting in quotes from the Istanbul Protocol to back up everything we're saying". [T5] Moreover, some MLR physicians drew attention to the need for decision-makers to comprehensively understand the grading system under the Istanbul Protocol in order to accurately interpret and apply the MLR in a particular case. [T6]

Some MLR physicians were concerned by a statement in the revised version of the IPAT Guidelines, whereby the weight to be accorded to medical reports depends on their quality and conclusiveness.[75] In their view, if decision-makers

74. Gill et al, *ibid*, at p.131.
75. Chairperson's Guidelines 2025/2, at paragraph 6.2

are to make this evaluation, they should be au fait with the Istanbul Protocol. (T7) This would include "knowledge of the Istanbul Protocol, the detail of that and what it says about how medical clinical symptoms, scenarios, narratives should be interpreted". (T7) A further more general issue related to how guidance is developed and the extent (or lack) of stakeholder consultation (T7; T12)

Finally, an important point in relation to the 'shared duty' of the applicant and the decision-maker in respect of international protection applications[76] was raised by a UNHCR employee. They raised the question of whether clearer guidance could help decision-makers respond proactively when an applicant may have limited capacity to participate in an interview, and how best to manage such situations. (T3)

What does a strong MLR look like?

We saw in Chapter 3 that IPAT members particularly valued reports that they considered to be high quality and impartial, for example where the medical practitioner is experienced in writing MLRs and well-trained in the Istanbul Protocol, where the report is written in an impartial and objective style, and sometimes where the report is very detailed or extensive. This reflects international experience that features of a strong medico-legal report include "clear, concise, and corroborative accounts that supported the applicant's story from a diagnostic perspective and forensic descriptions that reinforced the credibility of the applicant."[77] One legal practitioner noted that MLRs are generally of very high quality (T2).

One interviewee provided an interesting perspective on strong MLRs. In this person's view, accessible clear reports that avoid medical jargon where possible are vital in the context where decision-makers are under significant time pressure. These were "written clearly, concisely, not going into what we would regard as superfluous narrative", and "the final section of the report is crystal clear in terms of what are the medical findings." In addition, MLRs in which the writer has have clearly considered other alternatives explanations for injuries, and "are still kind of been able to kind of make their findings and hang it on a particular rating within the Istanbul Protocol" are very persuasive, as are those that acknowledge co-stressors and that there may be various contributing factors to psychological symptoms. (T12) Particular challenges experienced by this legal representative included:

> "where physicians have strayed away from the Istanbul Protocol and have kind of drawn conclusions around what their views are around kind of credibility in particular. So that or where they've gone into very detailed narrative around someone's history. Again, it can lead to inconsistencies with what's in a questionnaire."

This account tallies with the discussion in Chapter 3 of some decisions in the 'negative' category.

Psychological injuries

International research on the use of expert psychological evidence within refugee status determination procedures shows that such evidence is (i) difficult to obtain, and (ii) inconsistently handled by decision-makers.[78] One US study assessing the impact rate of forensic

76. The UNHCR Handbook (2019) states that while the burden of proof "in principle rests on the applicant, the duty to ascertain and evaluate all the relevant facts is shared between the applicant and the examiner. Indeed, in some cases it may be for the examiner to use all the means at his disposal to produce the necessary evidence in support of the application.
77. E. Scruggs et al, '"An absolutely necessary piece": A qualitative study of legal perspectives on medical affidavits in the asylum process' (2016) 44 *Journal of Forensic and Legal Medicine* 72, 76.
78. See for example, A. Purkey et al, "Accommodating Vulnerable Claimants in the Refugee Hearing: The Canadian Example," in *Between Protection and Harm* (Springer, 2024).

medical evaluations on immigration relief grants found that having physical evidence of torture was associated with a positive outcome, in comparison to psychological evidence of torture which was only marginally associated with a positive outcome.[79] Similarly, in the Netherlands it was found that positive asylum decisions were positively associated with the physical evidence of torture and that evidence's consistency with the asylum seeker's story, however this was not the case for psychological evidence.[80] In the Netherlands, applicants had a better chance of obtaining asylum if they had physical evidence of torture,[81] possibly because psychological symptoms are perceived as more subjective than physical symptoms.[82]

Legal practitioners and doctors interviewed for this research raised issues related to the perception of psychological injuries. One interviewee noted that they had witnessed scepticism among Tribunal members in relation to psychological findings. (T2)

> "It's kind of almost, I don't know if that's like a stigma against mental health ... So, if you have an MLR that only really touches on psychological issues a Tribunal member, certainly anecdotally in my experience, Tribunal tends to be more sceptical of that than if it was physical issues." (T2)

A UNHCR employee's experience was that "interpreting psychological assessments and understanding their relevance to credibility can be complex. Trauma may lead to inconsistencies or difficulty providing detail, so continued training and awareness in this area can be very helpful to ensure decision-makers fully appreciate these dynamics when assessing credibility." (T3)

This should be seen in the context of MLR physicians' expertise and experience showing that:

> "in general in the literature around torture and international protection, it's clear that psychological injuries are the main injuries that people, suffer. And so, the idea that decision makers have the opposite assumption that, you know, medical reports are about scars, gunshot wounds, burns, etcetera. That's completely false to the reality of what we deal with. In fact, most asylum seekers their suffering is psychological suffering and that's what we are grappling with in our reports...

> Psychological medicine if you like, is a subjective territory. We don't have objective ... tools to make diagnosis with, as in much of the rest of medicine. So, all psychiatric diagnosis are based on what the patient says to us, our own observation of that patient. ... collateral histories from other people. And that's our experiences, ... that's how we work. That's just the nature of the work...

> So, for someone to say, oh, I won't accept ... that account from a doctor because it's based on subjective is to misinterpret or to misunderstand the whole area of psychological medicine".

79. H. G. Atkinson et al, "Impact of Forensic Medical Evaluations on Immigration Relief Grant Rates and Correlates of Outcomes in the United States" (2021) 84 *Journal of Forensic and Legal Medicine*.
80. R. Aarts et al, "Expert medico-legal reports: The relationship between levels of consistency and judicial outcomes in asylum seekers in the Netherlands" (2019) 29 *Torture Journal: Journal on Rehabilitation of Torture Victims and Prevention of Torture* 36, at p. 43.
81. Ibid 43.
82. Ibid 44.

Rights

Interviewees highlighted undignified practices within the international protection process; poor living conditions within reception centres; difficulties with accessing healthcare, education and employment in isolated locations; and limited access to early legal advice as rights protection gaps experienced by survivors of torture.

Survivors of torture experience a range of issues within the reception system. (T3) One MLR physician noted that that from the time that "an MLR has been requested to the time that they're actually done. I mean interviewed and then written up. I mean, you know, there's usually months involved. And of course, in that timeline, then the client is usually living in Direct Provision and mental health is suffering". (T11) People can be sharing a room with lots of others, and the wait for mental health services and other healthcare can be very long. (T3, T11, T6) Access to proper food and nutrition can be an issue. (T11) Another interviewee noted that they may be living in isolated locations,

> "it is a very tough environment in terms of you know just looking at their social aspect in terms of accommodation, the types of accommodation, sharing accommodation, accommodation that may be quite isolated from kind of services, employment, education." (T11; see also T6)

Overall, the sense was that the wellbeing of survivors is not adequately protected within the reception system. (T12) This reflects conditions in other jurisdictions, with one recent study published by the UK-based NGO, Freedom from Torture, finding:

"It can be profoundly retraumatising, leading to a deterioration in wellbeing, increased anxiety and depression and thoughts of self-harm or suicide. Survivors placed in hotels, former military sites or forced to share a bedroom experience a worsening of trauma symptoms, disruption to essential therapy and delayed rehabilitation."[83]

Freedom from Torture calls for an end to the use of hotels and large sites and for survivors to be housed in communities.

In addition, challenges in the availability, timing and scope of vulnerability assessments can mean that some applicants with support needs are not identified. (T3) In this regard, a solicitor noted that

> "the most vulnerable are the ones that I think are being lost between the cracks because they don't just go into the IPO doors ... talking about their trauma". (T13)

Rights and retraumatisation

Retraumatisation refers to "traumatic stress reactions (emotional and/or physical) triggered by exposure to memories or reminders of past traumatic events".[84] The Istanbul Protocol reminds clinicians that "clinical interviews and evaluations, including recounting past experiences of torture and severe trauma, as well as physical and psychological examination and common procedures and ancillary diagnostic testing, such as blood tests, can be profoundly retraumatizing for victims, both during the examination and afterwards."[85] Medical professionals are acutely aware of these risks, (T11) trying to "avoid ... within the interviews re-traumatisation while at the same time gaining, you know, sufficient information to make the process worthwhile". (T11)

83. Freedom from Torture, "A Place to Heal: Solutions to ensure safe and dignified housing for survivors of torture" (2025), at p.3.
84. Istanbul Protocol, para 277; M.P. Duckworth and V.M. Follette, eds, *Re-traumatization: Assessment, Treatment, and Prevention* (Routledge, 2012.
85. Istanbul Protocol, para. 277. See also M. McDonnell and others, "The experiences of undergoing medico-legal assessments when seeking asylum in the UK: an interpretive phenomenological analysis" (2025) *Psychiatry, Psychology and Law* 1.

For some interviewees, the international protection process "lends itself to re-traumatising applicants as well." (T4) One participant noted that the interview room had been designed to be as pleasant as possible (T9). One solicitor's experience was that the physical environment of the IPO is generally harsh, and that the lack of separate spaces for childcare, for example is difficult, as is the need to go through airport-style screening. (T12) This participant had witnessed a person being called to their interview in Irish, and a woman being told off for leaving a baby on a chair.

> "I do think it comes down to kind of that we can have great policies like we must treat people with dignity and respect but I think that only happens when poor behaviour is called out and there's consistent and continuous training." (T12)

Similarly, an MLR physician noted that some applicants "don't feel what they're saying is being given enough confidentiality and privacy." (T7) "We've had some very serious concerns about how interviews were conducted in the IPO, where clients have informed us that they were taken aside to fill in questionnaires in a room with other people or do their initial interview in a room where they knew they could be overheard." (T6) The mode of questioning of applicants in their initial interview, especially around sexual orientation, was also problematic in the view of some participants. (T5; T7; T12)

Reform

When asked how the current system could be improved, interviewees had a range of suggestions related to the accessibility and availability of reports; consistent and continuous training for all stakeholders; the conduct of interviews and hearings; and other issues such as outreach and access to legal representation for vulnerable applicants.

Most participants emphasised that the most important reform is to try and ensure greater availability of reports. One participant stated this in clear terms: "improving the system is figuring out how to get more doctors involved." (T1) This is consistent with international experience, which indicates that there is still a lack of trained physicians able to meet the need of medical/psychological evaluations for asylum applicants.[86]

One participant noted that a state-provided MLR referral service could help to address some of the problems and potentially make reports more widely accessible. (T4) Similarly, there was a suggestion that this could be done at the early stages as part of a vulnerability assessment. (T12) From the perspective of one legal practitioner, "a more straightforward procedure and maybe clear guidelines as to when one is and isn't required" would be useful. (T4) This question of understanding when a report would be beneficial was raised by several interviewees. (T1; T12)

Several participants emphasised the need for more training for all involved: doctors, legal professionals, decision-makers and interpreters. (T3; T2) Such training should:

- be "consistent and continuous." (T12)
- possibly take place within medical degrees. (T1)
- include cultural sensitivity training . (T12)
- be mandatory and address dealing with people and applicants or appellants in the process who have been traumatised. (T4; T5)

Independent MLR physicians recommended "a state initiative to set up an organisation that will be responsible for recruitment, training, governance, support, payment, and CPD in relation to MLR work."

86. E. Scruggs et al, '"An absolutely necessary piece": A qualitative study of legal perspectives on medical affidavits in the asylum process' (2016) 44 *Journal of Forensic and Legal Medicine* 72.

Some participants noted that the possibility of the MLR writer being able to refer the person to aftercare or for treatment for issues that may be disclosed during the medico-legal assessment is "invaluable to the infrastructure of how we are supporting survivors as a country." (T12)

Other recommendations for reform centred on collaboration between the various stakeholders involved. This echoes international research, which has emphasised the need for strong collaboration between medical and legal professionals throughout the evaluation process.[87] For example, one participant noted that decision-makers at the appeals stage could encourage legal representatives to make submissions on whether a remote hearing is appropriate for a vulnerable applicant, or what accommodations might be required. In this interviewee's view, "stronger connections between medical experts, legal representatives, and decision-makers would help ensure the process is as supportive as possible for survivors of torture." (T3) From the medical perspective, it is very useful if solicitors can provide the MLR physician with all available documentation, (T13) including their questionnaire, interview, and legal and medical documentation. One medical professional noted:

> ""I have had to submit reports because IPAT are looking for them, or the person is about to be deported, but I still don't have the original international protection documentation. And we're always told by the solicitors that to get it from the IPO takes a minimum of a month." (T6)

This is consistent with the Istanbul Protocol, which notes that best practice is that clinicians should familiarise themselves with the case by reviewing appropriate documents/affidavits that the subject's legal counsel may have prepared. The Protocol states: "Such documents may help the clinician to anticipate the content of the individual's narrative. Also, knowledge of prior testimonies may aid in identifying elements in the history that need clarifying".[88]

Reforming an inherently adversarial system?

Interviewees differed on the question of how to make the system less adversarial for survivors of torture, especially at the appeals stage. One interviewee expressed the view that this would be very difficult to do because "there is a claim that must be assessed" and "the nature of our legal system is adversarial". (T1) Some doctors remarked that the process "just feels very adversarial." (T7)

A decision-maker expressed the view that the first instance interviews are not intended to be adversarial; "[t]hat's not what we want."(T8) At first instance, it is an inquisitorial interview, guided by EU Asylum Agency training, and UNHCR reviews. (T8) Indeed, a UNHCR employee noted that their interview training seeks to address these issues, for example by encouraging interviewers to think about accommodations that need to be put in place for interviews or hearings. (T3)

One medical professional highlighted that affording the applicant themselves more time in initial interview or afterwards to address any inconsistencies arising could be useful. (T11)

Stakeholder roles and expectations

Medico-legal reports sit at the intersection of law and forensic medicine, with actors from various professions involved. Interviewees generally expressed respect for the other actors in the process. (see for eg T1, T11, T5)

87. *Ibid.*
88. Istanbul Protocol, para. 79.

As noted above, access to MLRs is currently linked to the provision of effective legal representation. Another issue raised by several interviewees related to the role of doctors. Some interviewees emphasised that MLR physicians should be careful to avoid overstepping the boundaries of their role as providers of expert opinion evidence. (T1; T12) In particular, they should not effectively act as advocates for their clients. (T1; T6) For their part, medical professionals rejected the idea that they acted as 'advocates', drawing attention to the fact that MLR physicians do not treat clients as clients are not their patients. (T6) One MLR physician noted that: "experienced doctors like ourselves know the duality of our role". (T6) In this regard, MLR physicians are guided by the Istanbul Protocol, which emphasises that "The evaluation should be based on the clinician's expertise and professional experience. The ethical obligations of beneficence, non-maleficence, confidentiality and respect for autonomy demand uncompromising accuracy and impartiality in order to establish and maintain professional credibility."[89] This said, one MLR physician noted that they do have an ethical duty towards people that we see who are in acute distress and do not have immediate healthcare supports to point them in the right direction. (T6) For this interviewee,

> "there is a lot of safety netting and risk mitigation going on that I don't think the Department of Justice or IPO or IPAT have any idea of when we see clients who have no designated GP". (T6)

Some MLR physicians commented that they had seen cases in which the decision-maker had rejected an MLR and purported to evaluate injuries themselves, which was seen as highly problematic. (T5; T7) Independent MLR physicians expressed the view that MLR physicians should have access to IPAT decisions for MLR physicians where an MLR has been contested or criticised, to respond to any misunderstandings of clinical findings and identify any learnings for future MLRs. (T4; T5; T6)

Overall, stakeholders had perspectives on other professionals' roles, which can be broadly summarised as follows:

a. Solicitors could provide as much information and relevant documentation as possible to the MLR physician; and make the referral as early as possible where one is necessary.
b. MLR physicians could be aware that being seen to stray into general credibility findings could be counter-productive in terms of the impact of the MLR; and bear in mind the features of a strong report identified above.
c. Spirasi could consider the length of its referral form and its referral processes.[90]
d. Decision-makers could take into consideration that the length of MLRs and some of the relevant analysis contained therein may be related to the requirements of the Istanbul Protocol; be mindful of the nature of psychological injuries and medicine; be aware of the time and work that has gone into producing an MLR; and understand that MLRs are not always available and that there can be significant delays.

89. Istanbul Protocol, para. 69.
90. The online form has been re-designed in 2025 to reduce the amount of information required, based on feedback from referrers.

Chapter Five: Key Recommendations

The aim of this exploratory study has been to gain initial insights into the role and impact of medical evidence of torture in the international protection process in Ireland. Based on the findings set out in Chapters 3 and 4, we make the following recommendations:

1. Further research to understand the lived experiences of survivors of torture within the Irish protection system is urgently needed; these perspectives were not captured within this study.
2. The timely availability of medico-legal assessment - at first instance - should be ensured. Important factors include:
    a. Early identification of victims of torture through comprehensive vulnerability assessments at the earliest possible stage.
    b. Access to specialist, independent early legal advice in the international protection process.
    c. Recognition that individuals may disclose torture very late in the protection process: there must be a mechanism to ensure that a referral for an MLR can be facilitated at all stages if necessary.
    d. A functional mechanism for decision makers (at first instance or on appeal) to directly request an MLR.
    e. A strategy to train and retain more doctors to conduct medico-legal assessments and provide MLRs is necessary. This could include not just specialist training, but also peer mentoring and the establishment of a professional network to share best practice and new developments. In practice, attracting more doctors to this work will require (among other things):
        i. Adequate funding.
        ii. Sufficient time for doctors to conduct the evaluation.
        iii. General respect for MLRs within the system.
3. The quality and consistency of MLRs must be maintained if they are to continue to perform a meaningful function within the system. Relevant factors include: ensuring that the Istanbul Protocol remains the basis of MLRs; ensuring that MLRs are based on full information passed on by legal representatives; ensuring adequate funding, time, and respect (as already noted in Recommendation 2).
4. Section 73 of the International Protection Act 2015 grants to the Minister for Justice, Home Affairs and Migration the power to "accord priority to any application" or request the International Protection Appeals Tribunal Chairperson to prioritise any appeal. We understand that this is used by the International Protection Office at first instance as the basis to prioritise likely well-founded cases, including those who produce an MLR.[91] It should be considered whether prioritisation should be extended (i) beyond the scheduling of interviews, to potentially eliminate the need for an interview in some cases, (ii) to those who may not have an MLR but who have been assessed as a possible survivor of torture, and (iii) to the appeal stage.

91. See "Prioritisation of International Protection Appplications under the International Protection Act 2015 (as amended", available at https://www.ipo.gov.ie/en/IPO/IPO%20Prioritisation%20Statement%20Final%2014.06.21%20Website.pdf/Files/IPO%20Prioritisation%20Statement%20Final%2014.06.21%20Website.pdf. It appears that a similar power of prioritisation will be available under the new international protection legislation: see Head 61(2)(m) likely well-founded applications and (n) applicants with special reception needs or in need of special procedural guarantees.

5. Continuous training for all stakeholders is needed, in particular in relation to:
    a. Mutual understanding of stakeholder roles and processes in respect of medical evidence of torture.
    b. The role of MLRs in the context of the credibility assessment.
    c. Medical evidence in respect of psychological injuries.
    d. Trauma-informed practice, specifically in respect of survivors of torture, and understanding the impact of trauma on memory.
6. Establish a stakeholders' working group that could develop 'ways of working' between professional stakeholders, consolidate mutual understanding and respect, and share good practice/concerns. Annual meetings could be scheduled as a starting-point.
7. Consider ways to reduce the need to obtain/provide MLRs, particularly in cases that may be supported by other strong evidence. This recommendation takes into account (i) our findings on the time and work that go into producing MLRs, and (ii) the fact that whilst MLRs can empower survivors to 'tell their story' in a supportive environment; the process may still be retraumatising for a person.
8. Consider clarifying the precise role and weight of MLRs in decisions other than standard international protection appeals (e.g. transfer to another EU Member State, or inadmissibility decisions). This recommendation will be particularly important in the context of the implementation of the EU Pact on Migration and Asylum and consequent overhaul of the international protection system. For example: what is the role of MLRs in respect of challenging detention or restrictions on movement for victims of torture (or others with special reception needs); what is the role of MLRs in respect of medical exceptions to the asylum border procedure?[92]
9. Upgrade the capabilities of the appeals archive to enhance transparency and enable in-depth/systematic research.
10. Further research is needed into how an awareness of issues relating to retraumatisation could be more fully inform the design and implementation of the international protection process, as well as the wider reception system.

92. See General Scheme of the International Protection Bill 2025, including at Head 122 and 110. See also "Joint Committee on Justice, Home Affairs and Migration Report on Pre-Legislative Scrutiny of the General Scheme of the International Protection Bill 2025", available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/34/joint_committee_on_justice_home_affairs_and_migration/reports/2025/2025-12-01_report-on-pre-legislative-scrutiny-of-the-general-scheme-of-the-international-protection-bill-2025_en.pdf

Appendix 1 – MLR Providers

Spirasi[93]

Spirasi is the national centre for the rehabilitation of torture survivors and their families and a provider of MLRs for the purpose of the international protection system in Ireland. It is a national member of the International Rehabilitation Council for Torture Victims (IRCT). Its rehabilitation services include multidisciplinary assessments, therapeutic interventions, psychosocial support, outreach, language training and befriending. Spirasi's team of examining physicians conduct medico legal assessments and produce medico legal reports written in line with the Istanbul Protocol (the United Nations Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment). Spirasi is committed to sharing knowledge about torture and its effects to professionals in healthcare and other relevant fields who may come into contact with torture survivors, delivering training to the International Protection Office and Legal Aid Board on the effects of torture, trauma informed care and MLRs with specific reference to documentation according to the Istanbul Protocol.

Spirasi's doctors receive in house training peer support and training from UK partners Helen Bamber Foundation, Forrest Medico-Legal Service and Freedom from Torture. Its medico-legal team is a pro bono partner with A&L Goodbody Law Firm who conduct legal reviews.

Independent MLR physicians[94]

A group of three independent doctors, who previously worked with Spirasi until 2023, currently provide many MLRs in Ireland. They have collective expertise of obstetrics/gynaecology, anthropology, psychotherapy, public health medicine, general practice, and psychiatry with many years' experience of clinical, research and medico-legal work with refugees and asylum seekers.

The doctors meet regularly for supervision and CPD activities, including meetings with the medico-legal writers network of the UK affiliate organizations.

These doctors left Spirasi (the Spiritan Asylum Services Initiative) when Spiritan abuse in schools became public.[95]

93. This information has been provided by Spirasi.
94. This information has been provided by the independent MLR physicians.
95. See generally, https://www.gov.ie/en/education-scoping-inquiry/publications/scoping-inquiry-into-historical-sexual-abuse-in-schools-run-by-religious-orders/; Commission of Investigation into the Handling of Historical Child Sexual Abuse in Schools.

Appendix 2 – Interviews

Interviewee No.	Professional Role/ Organisation	Status/Location of Interview	Type of Interview	Date of Interview
1	Public servant with current or former role related to decision-making	MS Teams	Individual	24.09.2025
2	Legal practitioner (Barrister)	MS Teams	Individual	24.09.2025
3	UNHCR employee	MS Teams	Individual	26.09.2025
4	Legal practitioner (Solicitor)	MS Teams	Individual	30.09.2025
5	MLR physician	MS Teams	Group	1.10.2025
6	MLR physician	MS Teams	Group	1.10.2025
7	MLR physician	MS Teams	Group	1.10.2025
8	Civil servant with current or former role related to decision-making	MS Teams	Group	1.10.2025
9	Civil servant with current or former role related to decision-making	MS Teams	Group	1.10.2025
10	MLR physician	MS Teams	Individual	1.10.2025
11	MLR physician	MS Teams	Individual	6.10.2025
12	Legal practitioner (Solicitor)	MS Teams	Individual	8.10.2025
13	Legal practitioner (Solicitor)	MS Teams	Individual	17.10.2025

Appendix 3 – Glossary

Clinical expert - a health professional who provides health-care services and/or conducts clinical evaluations of alleged torture and ill treatment. In Ireland, MLRs are provided by a physician. In this report, 'clinical expert' is used interchangeably with 'MLR physician', and 'doctors'.

Ill-treatment - encompasses any form of cruel, inhuman or degrading treatment or punishment, as prohibited by the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and Article 3 of the European Convention on Human Rights.

International protection – as defined in section 2 of the International Protection Act 2015, status in Ireland either (a) as a refugee, on the basis of a refugee declaration, or (b) as a person eligible for subsidiary protection, on the basis of a subsidiary protection declaration.

International protection applicant - a person who has applied for international protection in Ireland. In this report, this term is used interchangeably with 'asylum seeker' and 'asylum applicant'.

Serious harm – as defined in Article 15 of the EU's Qualification Directive,[96] consists of: (a) the death penalty or execution; (b) torture or inhuman or degrading treatment or punishment of an applicant in the country of origin; or (c) serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict.

Torture – as defined in Article 1 of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."

Victims of torture – includes applicants for international protection who may have experienced torture, while it may yet to be ascertained whether their past experiences legally qualify as 'torture'. In this report, used interchangeably with 'survivors of torture'.

Spirasi Report – sometimes used to describe an MLR obtained through Spirasi.

96. See Directives 2004/83/EC and 2011/95/EU. See also Article 15 of EU Regulation (EU) 2024/1347 of the European Parliament and of the Council of 14 May 2024 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection and for the content of the protection granted, amending Council Directive 2003/109/EC and repealing Directive 2011/95/EU of the European Parliament and of the Council (the Qualification Regulation).


Spirasi


Taighde Éireann
Research Ireland


Maynooth
University
National University
of Ireland Maynooth