

Medical services policy in respect of detainees: evolution and outstanding issues

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Received 7 January 2019

Revised 23 March 2019

Accepted 28 March 2019

Published Online First

20 April 2019

ABSTRACT

Alleged and confirmed abuse of civilians arrested or detained by the UK Armed Forces has been the subject of four formal enquiries, and all have used medical evidence and/or addressed medical issues. After the first three, robust policies were put in place to ensure that all those arrested had appropriate medical examinations and that healthcare personnel acted appropriately. However, by the time of the Second Gulf War, the training and medical processes had lapsed and were found to be a contributory factor in not preventing abuse. The fourth enquiry has endorsed most of the lapsed policies but is ambiguous in two areas—on medical certification of fitness for interrogation and the timing to the first medical examination. This article summarises the medical aspects of the four enquiries and discusses the two ambiguous areas, arguing that to diverge from the policies eventually put in place in Northern Ireland is a retrograde step. It also discusses how training put in place to avoid the very events which occurred in the Second Gulf was discontinued.

BACKGROUND

The conflicts accompanying UK's withdrawal from the Empire involved the detention of civilians, as did the campaign in Northern Ireland. The medical services inevitably became involved in allegations of maltreatment and, after three formal enquiries, training on the medical care of detainees was formalised. Despite this, the medical services came under scrutiny again in a fourth formal enquiry. The approach to those detained continues to exercise government and parliament, with two recent parliamentary reports^{1 2} and ongoing work by the International Committee of the Red Cross.³

This article summarises the medical aspects of the four major enquiries and addresses outstanding issues.

BOWEN ENQUIRY

The 1966 report⁴ addressed events in Aden. After arrest, suspects were processed at an interrogation centre before being released or transferred to a detention centre. While management in the detention centre was appropriate, there was evidence of abuse at the interrogation centre, including memoranda from the Director of Health Services referring to initial medical records stating no injuries but subsequent records documenting their existence. The enquiry's recommendations included that the medical care of persons in the interrogation centre should be in the hands of the Army's Director of Medical Services; that the work should be carried out by civilians; that persons detained

Key messages

- ▶ Since World War 2 the British Army has regularly, although infrequently, been the subject of criticism of how it has treated detainees.
- ▶ Formal enquiries have used and sometimes relied upon medical evidence.
- ▶ High-quality medical examinations contribute both to protecting the detainee from abuse and the Army from false allegations of mistreatment.
- ▶ Failure to examine, document and treat and, when identified, failure to report abuse are likely to lead to charges of professional misconduct.
- ▶ Although medical examination of detainees is essential, it needs to be conducted in a manner that separates the doctor from involvement in interrogation.
- ▶ While appearing counterintuitive, medical personnel must not either certify fitness or unfitness for interrogation as this constitutes involvement in the process.

in the interrogation centre should be seen daily by the medical officer and asked if they had any complaints; that any allegations of cruelty or torture should be reported immediately by him to the Director of Health Services; and on transfer between facilities there should be a medical board for the purpose of recording any allegations made by the detainee. Bowen also referred to extant regulations that detainees should be medically examined as soon as possible after admission and before transfer between facilities. Other than the recommendation for a civilian doctor, considered impractical, all were accepted.

COMPTON ENQUIRY

The 1971 Compton report⁵ addressed the implementation of the decision to 'arrest, detain or intern persons suspected of having acted ... in a manner prejudicial to the preservation of the peace or the maintenance of order' and was in response to the perceived inability to rely on 'normal' legal procedures. Three hundred and forty-two individuals were arrested on 9 August and brought to three regional holding centres for up to 48 hours for interrogation and for a decision to be made on their release or transport to a place of detention. The enquiry considered, where they existed, the entry medical record made on admission of the



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To cite: Lillywhite L. *BMJ Mil Health* 2021;**167**:23–26.

individuals to, and discharge from, the regional holding centres and the medical record of those on admission at the place of detention. Doctors certified whether or not detainees were fit for interrogation.

Chapter VII addressed the medical arrangements. It criticised the late involvement of the senior medical officer (Assistant Director of Medical Services [ADMS]) in the preliminary and planning stages, leading to individual medical officers making their own ad hoc arrangements with medical arrangements being varied and uncoordinated and a failure to undertake a medical examination ‘on discharge from the Regional Holding Centre as well as on entry to it’, especially at one centre where no medical examination was made, depriving the enquiry of appropriate evidence. The enquiry acknowledged the difficulty for the medical officers at this centre to both care for their troops and undertake medical examinations on civilians, but considered that the ADMS, had he been aware, would have made appropriate arrangements.

PARKER/GARDINER

The 1972 report⁶ by Lord Parker, relying heavily on available medical evidence, addressed interrogation techniques. The majority report recommended acceptance of the techniques in use. It included a recommendation for the involvement of a ‘doctor with some psychiatric training’ in order to ‘warn the controller if he felt that the interrogation was being pressed too far having regard to the demeanour of the detainee’. However, a minority report by Lord Gardner, which held that the procedures used were illegal, was instead accepted by the government. Lord Gardiner’s only medical recommendation was to include the study of the Geneva Conventions relating to civilians in military training.

The role of medical officers following these enquiries appears to have been implemented via an internal government document,⁷ but was silent on whether a doctor should certify fitness for interrogation. It did require a doctor to be ‘on call in the medical inspection room while interrogation is in progress’. This was clearly an issue as an internal draft minute in 1974 from the Deputy Under Secretary of State⁸ states:

‘...a medical officer must be readily available ... There is no requirement that he shall be present during interrogation’ has had the last sentence changed in ink to ‘He will not be present during the interrogation’.

BAHA MOUSA ENQUIRY

The fourth enquiry, by Sir William Gage, reported in September 2011,⁹ and addresses the death of Baha Mousa.

Gage finds that detainees were not all seen by a regimental medical officer (RMO); medical inspections were not documented unless specific positive findings were made; that medical staff saw but did not report physical abuse, even after the death of Baha Mousa; and that the RMO did not check the medical status of other prisoners. He noted the gap in training in medical arrangements for detainees following the end of military involvement in handling civilian detainees in the 1980s. His recommendations include recognition that the doctor might be included among those as suitable officers to whom concerns over detainee handling is made (para 16.143) and endorsed the updated policy letter which:

‘required ... that each detainee be medically examined as soon as reasonably practicable after admission to a detention facility; that he be examined again prior to transfer to another facility and upon

release; that written records be kept of such examinations, in accordance with normal medical standards; that the normal rules of consent to medical care should apply; that medical personnel inspect detention facilities to ensure that they are hygienic and healthy; and that medics avoid involvement in interrogation. (16.233/4)

He held that suggestions that medical examinations need not be undertaken prior to arrival at a formal detention centre (eg, such as a front-line unit’s holding area) would be a retrograde step, although noting that such initial examinations might have to be carried out by a non-doctor such as a ‘medic’. He stressed that the main reason for such an examination was to ensure appropriate medical treatment, while acknowledging the role in helping to prevent abuse of detainees, and recommended that a medical examination should be undertaken within four hours of capture by the most medically qualified individual available and by a qualified doctor as early as possible and that interrogation does not take place until after such medical examination. Crucially, the report addresses issues of certifying an individual fit, or not fit, for detention (see below).

GENERAL MEDICAL COUNCIL (GMC) HEARING

On 21 December 2012, the Medical Practitioners Tribunal Service published their report in respect of the doctor responsible for the care of detainees who included Baha Mousa. Of 51 allegations, 30 were admitted while an additional 17 were found proven. He was struck off the medical register for at least five years. The allegations included a failure to keep medical records, a failure to examine detainees, authorisation of medication without an appropriate assessment and a failure to take appropriate action following the death of Baha Mousa.

GENEVA CONVENTIONS

The UK is a party to all four Geneva Conventions, giving effect to its obligations through legal and administrative instruments, including the Geneva Conventions Act 1957.¹ The treatment of enemy prisoners of war arising from international armed conflict is addressed within the Third Geneva Convention of 1949, and like the others includes an obligation to disseminate its text in peace and war; to include the study thereof in military programmes; and that any military or other authorities who in time of war assume responsibilities in respect of prisoners of war must possess the text of the Convention and be especially instructed as to its provisions.^{10 11} The Baha Mousa enquiry heard evidence of compliance.

The Fourth Geneva Convention addresses civilians and stipulates various obligations in respect of those civilians who are classified as ‘detainees’. It similarly includes a requirement (Article 144) for its inclusion in the study of military instruction. However, it does not specifically address questioning or interrogation of civilians involved or suspected of involvement in hostilities. The enquiry heard that for non-international armed conflicts, there was little training or rules governing the interrogation or detention of civilian detainees.¹²

DISCUSSION

Significantly, all the enquiries relied on medical records, which when absent led to criticism. Maintaining such records is a basic duty of a doctor¹³ reinforced at the GMC hearing and must include documenting the absence of positive findings. This duty must also apply to non-professionally qualified personnel (such as regimental medical assistants) with the record subsequently reviewed by the responsible registered practitioner.

Three enquiries expected examinations to occur at each handover from one organisation to another and on discharge, and expected or recommended that abuse would be reported by medical personnel to the appropriate authorities, a view confirmed by the subsequent GMC case. The teaching in the 1970s was that the appropriate authorities were the unit commanding officer and, if concerns remained, the senior medical officer (the equivalent of the Commander Medical). An implicit expectation is that medical personnel will be vigilant to the potential of abuse.

The Baha Mousa enquiry explicitly addressed medical ethical issues, which previous enquiries did not, although there is evidence that within the UK Ministry of Defence (MOD), medical ethical issues were considered, and for example a Loose Minute signed by the Deputy Under Secretary of State (Army) in November 1974¹⁴ stated in respect of detainees that *'the approved line must, of course, take into account both professional ethics and the legitimate requirements of the General Staff and that doctors cannot 'directly or indirectly' support interrogation. Debate occurred on whether a detainee would benefit by a doctor being present during interrogation, with textual amendments to the draft stating that the doctor should be prohibited from being present.*

The enquiry explored what advice a doctor should give in respect of fitness for detention or interrogation but is ambiguous. The detailed recommendation 29 states:

'Armed Forces medical personnel can and should be involved in providing advice that a CPERS (CPERS=captured personnel) is not fit for detention or questioning. Alternatively, the medic may validly advise that no specific intervention different from the normal process is required in respect of that CPERS. Medics should not advise that a CPERS is fit for detention or fit for questioning'.

The effect of the recommendation that doctors explicitly advise on unfitness for detention or questioning is that in the absence of such specific advice (that the detainee is unfit) the doctor is in practice certifying fitness, contrary to intention of the first sentence. A detainee certified as not being unfit (so interrogation can proceed) and who is then subjected to *'harsh questioning'* (see below) which potentially causes harm, and subsequently a doctor reaffirms that the detainee is not unfit, then the doctor is in practice endorsing and regulating the ongoing harsh questioning and is arguably directly involved in the interrogation process.

The evidence of myself (a former Surgeon General),¹⁵ and that of the British Medical Association Expert Witness and the MOD official,¹⁶ submitted that a doctor could not offer an opinion on fitness or otherwise for detention and/or interrogation. However, a forensic physician¹⁷ expert witness argued that such advice was both necessary and ethical. He stated that in civilian practice they provide an opinion to the police on fitness for detention and for fitness to be interviewed, noting that these are *'two of'* the key roles of forensic physicians and other healthcare professionals. He also noted that forensic physicians are in many respects in the same position as military doctors—for example they may provide medical care for those police who are detaining and interviewing the prisoner and will not necessarily be seen by the prisoner as independent and so on.

He also addressed the UN Office of the High Commissioner for Human Rights¹⁸ policy which prohibits a doctor to:

certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment ... which is not in accordance with the relevant international instruments...

but argued that if processes on operations complied with *'international instruments'*, military doctors should be able to certify fitness or unfitness for detention and questioning.

I believe his view is flawed. First, operations necessarily lack the policies that regulate police interviews, specifically the Police and Criminal Evidence Act 1984,² which contains provisions such as the right to independent legal representation during questioning and the right to be examined by an independent medical examiner of their own choice,¹⁹ as well as strict provision on the timings when rest is required. Questioning must also end once enough evidence is obtained that the individual has committed an offence. These safeguards do not exist on operations, while *'interrogation'* even when it complies with *'international instruments'* is not the same as the police *'interview'*.

The second reason arises from his acknowledgement that to certify fitness for questioning requires an understanding of the questioning process, which on operations includes a *'harsh approach'*. What this constitutes is outwith the scope of this article²⁰ but exceeds what is acceptable within a civilian setting. As even the enquiry did not appear to itself fully understand the meaning of the *'harsh approach'*, and it appears to be in evolution, I would argue that it is unreasonable to expect military medical professional to fully understand the process.

Thus, I believe that doctors should neither certify a person fit for detention or interrogation, nor as unfit. They must however continue to provide (and document) the detainee's health condition (within the bounds of medical confidentiality) and identify any need for further medical care and any vulnerabilities which might prejudice his health.

There is debate on the timing of the first medical examination. The unanimous view was *'as soon as possible'* but disagreement on what this meant! Gage elected for *'within 4 hours'* but accepted that this should be by the most medically qualified person available and not necessarily a doctor, and as soon as possible thereafter by a doctor. The four hours was chosen as this what was in the current Surgeon General's policy letter, which was based on the practice at the time of the Northern Ireland emergency. MOD was concerned that four hours (to an examination by a doctor) was impractical within the context of Afghanistan. A discussion on the validity of the claim is outwith the scope of the article other than to note that, as was the case in the Northern Ireland Campaign, meeting whatever timeframe is decided may require special arrangements while there may be scope for the initial examination to be by a non-doctor such as a paramedic.

The final issue was not explored, which is how the training required by the Fourth Geneva Convention and was provided during the Northern Ireland Campaign lapsed. One reason may be that the syllabi for training undergo constant revision with pressure to omit subjects that appear to have no current relevance. This was probably exacerbated by the integration of the three single services training (the other medical services having little responsibility for detainees), the retirement of doctors with experience of the medical issues, the lack of any formal medical publications on the subject and, perhaps, an inadequate review process for changing syllabi. There is also a parallel requirement to ensure that the chain of command and those responsible for capturing and questioning detainees are also appropriately trained.

CONCLUSIONS

The ordered environment of peace is different from that of conflict. The methods used by insurgents inevitably risk an

emotional response by the opposing uniformed forces, raising the risk of maltreatment. Although mitigated by doctrine, rules, regulations and so on, there remains a residual risk of maltreatment. Within this environment, medical personnel must remain impartial in their medical practice and take the same care, and apply the same standards, such as documentation, to detainees as they do to their own personnel. As all the enquiries have demonstrated, the doctor is also an essential safeguard against maltreatment. Importantly, he is also a safeguard against false accusations of abuse.

This impartiality can only be sustained by avoiding any involvement, direct or indirect, with interrogation. The Baha Mousa enquiry confirmed that doctors cannot certify fitness for detention or interrogation. Regrettably, by also recommending that they should specifically certify unfitness for detention or interrogation, the enquiry is also doing that which the same recommendation states that they should not do. Hopefully, MOD realises the inherent contradiction and will regulate appropriately as indeed I understand is the case.

Finally, one might conjecture that with the appropriate training the RMO responsible for Baha Mousa would not have erred. However, the case re-emphasises that doctors have a duty to uphold their professional ethics and standards wherever in the world they are practising and in whatever environment. Hopefully, we will in future take greater care not to omit teaching or instruction which is necessary to facilitate appropriate behaviour.

Contributors LL is the sole author.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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