# 6th international EFJCA Conference – Milan Italy

**4, 5 and 6 September 2024**

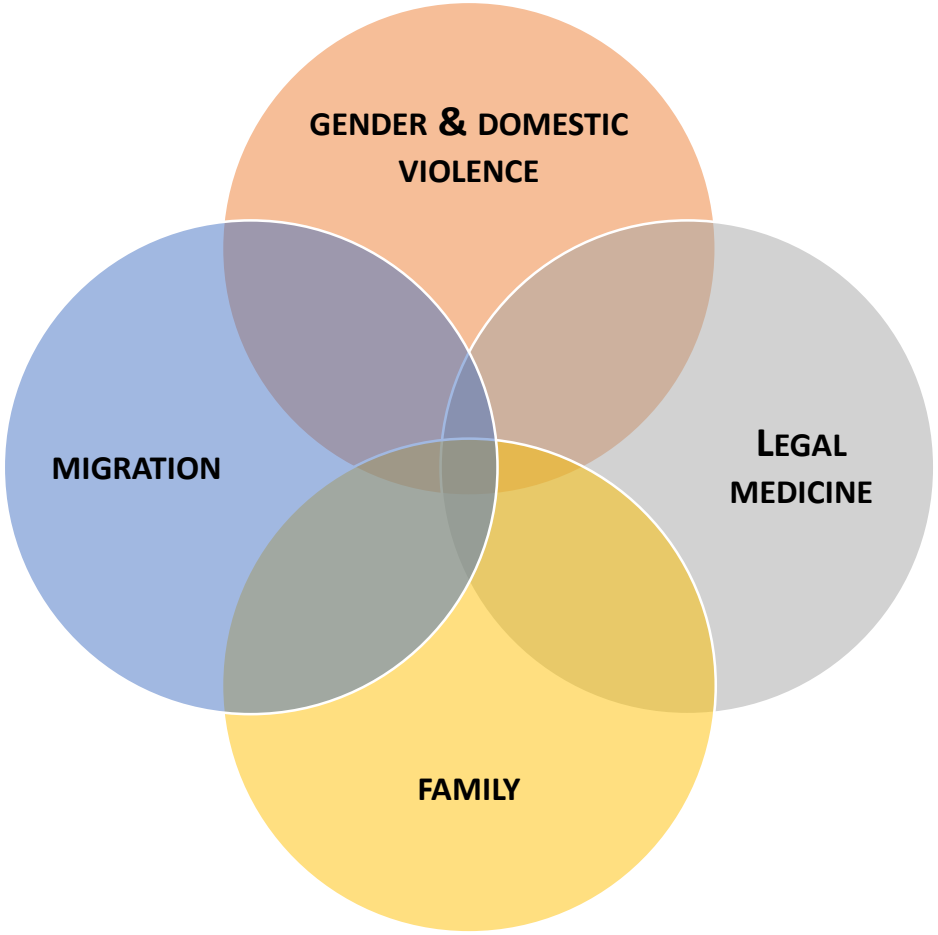
Collaborative Solutions: uniting health sector and Family Justice Centers to address gender-based and domestic violence

## Program Day 3

**Friday 06.09.24** – University of Milan, MUSA
Aula Magna, Via L. Mangiagalli 37 Milano MI

Organized by prof. Danilo De Angelis and the Institute of Legal medicine of the University of Milano and Labanof

**Extreme consequences in gender-based violence**
**From femicide to forced migration: challenges for the health sector**

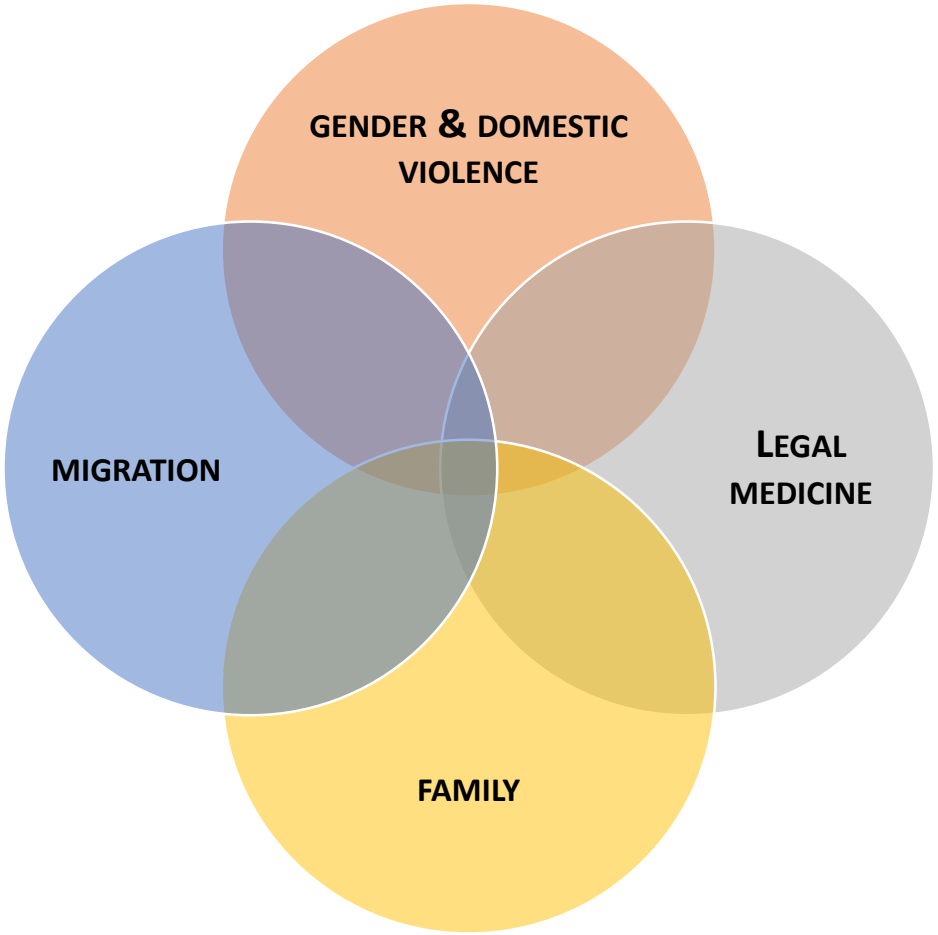



FEMICIDE – UNACCOMPANIED MINORS – TORTURE&ILL TREATMENT

Funded by the European Union

# Victims of torture and gender violence: new challenges for physicians in the era of migration

*Cristina Cattaneo*



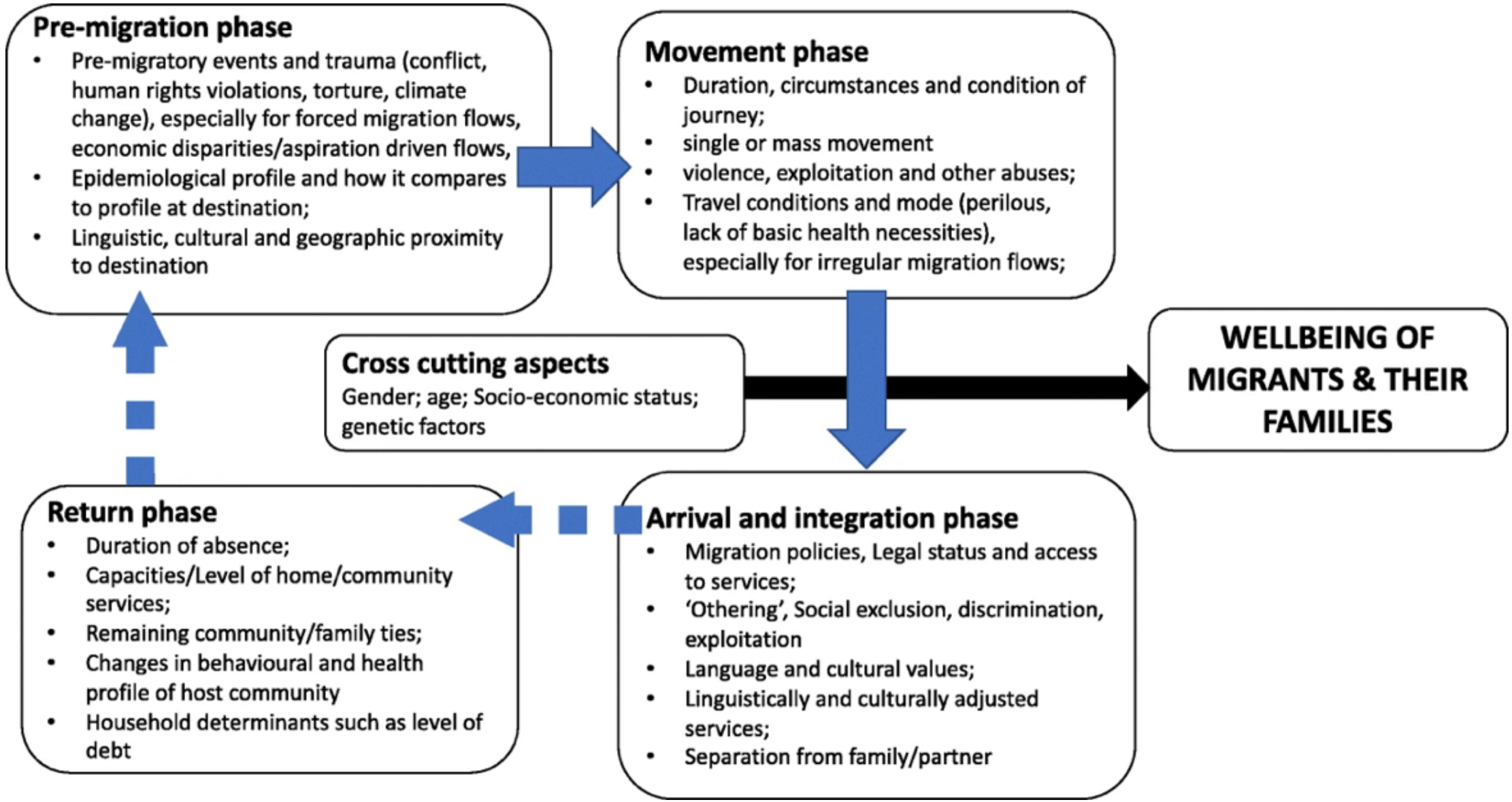

LABANOF
LABORATORIO DI ANTROPOLOGIA E ODONTOLOGIA FORENSE
Museo Universitario delle Scienze Antropologiche, mediche e forensi per i diritti umani
UNIVERSITÀ DEGLI STUDI DI MILANO
UNIVERSITÀ DEGLI STUDI DI MILANO
DIPARTIMENTO DI SCIENZE BIOMEDICHE PER LA SALUTE

# TORTURE, ILL TREATMENT, MIGRATION & FAMILY: THE MEDICO LEGAL (AND SOCIAL) CHALLENGE OF DIAGNOSING VIOLENCE

DOMESTIC AND GENDER VIOLENCE ONCE IN ITALY (MILANO)

VIOLENCE AND TORTURE IN ASYLUM SEEKERS

VIOLATION OF THE RIGHT TO KNOW


Pre-migration phase
Pre-migratory events and trauma (conflict, human rights violations, torture, climate change), especially for forced migration flows, economic disparities/aspiration driven flows,
Epidemiological profile and how it compares to profile at destination;
Linguistic, cultural and geographic proximity to destination
Movement phase
Duration, circumstances and condition of journey;
single or mass movement
violence, exploitation and other abuses;
Travel conditions and mode (perilous, lack of basic health necessities), especially for irregular migration flows;
Cross cutting aspects
Gender; age; Socio-economic status; genetic factors
WELLBEING OF MIGRANTS & THEIR FAMILIES
Return phase
Duration of absence;
Capacities/Level of home/community services;
Remaining community/family ties;
Changes in behavioural and health profile of host community
Household determinants such as level of debt
Arrival and integration phase
Migration policies, Legal status and access to services;
'Othering', Social exclusion, discrimination, exploitation
Language and cultural values;
Linguistically and culturally adjusted services;
Separation from family/partner

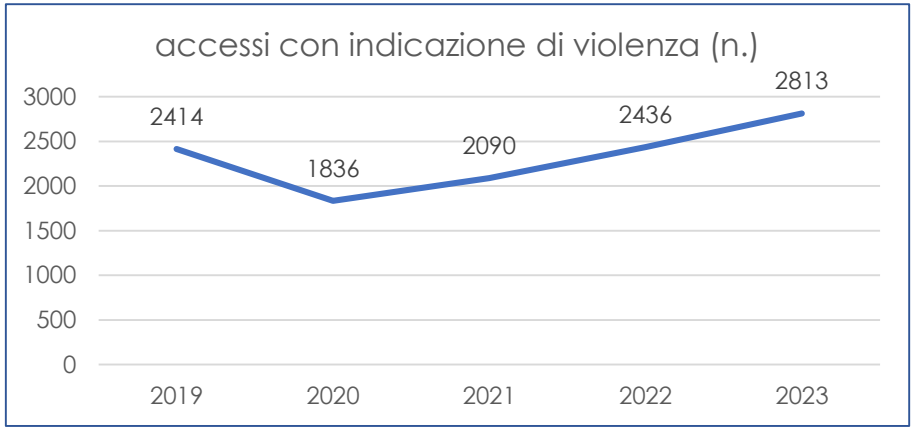
# DOMESTIC AND GENDER VIOLENCE ONCE IN ITALY (MILANO)

## METROPOLITAN CITY OF MILANO – THE VULNERABLE ATS

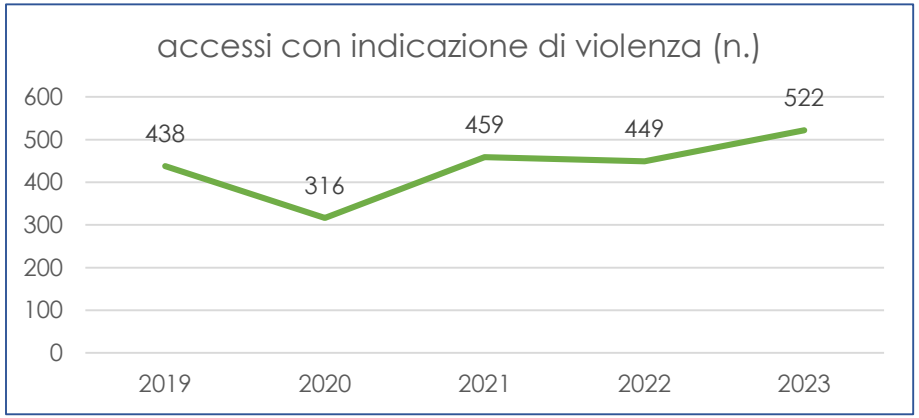
In Italy, just under 12.5 million (50.9 per cent) women between 18 and 84 years of age have reported having been victims of psychological and/or physical violence at least once in their lifetime.

The WHO estimates that 1 in 2 children worldwide are victims of violence and in Italy there is still a lack of accurate epidemiological data. (Working Group for the Convention on the Rights of the Child, 2023)

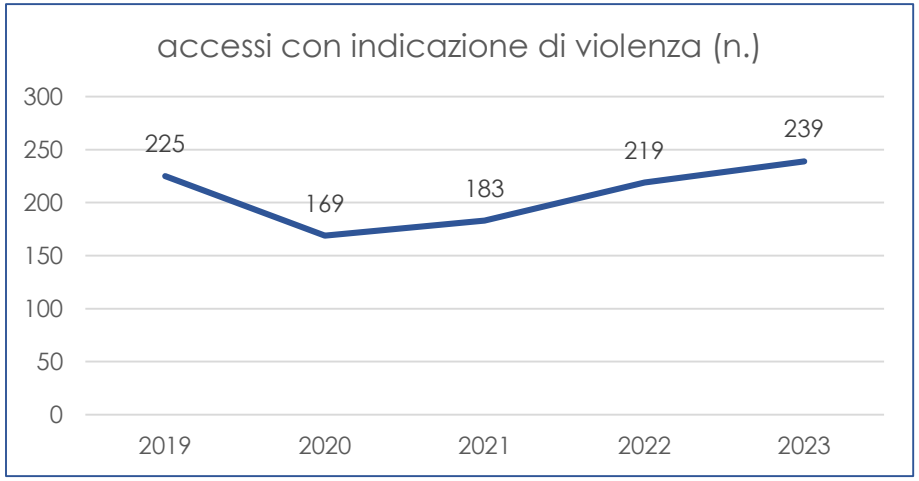
**Elder abuse is also a significant public health problem: an estimated 1 in 6 people over 60 have experienced some form of abuse.**



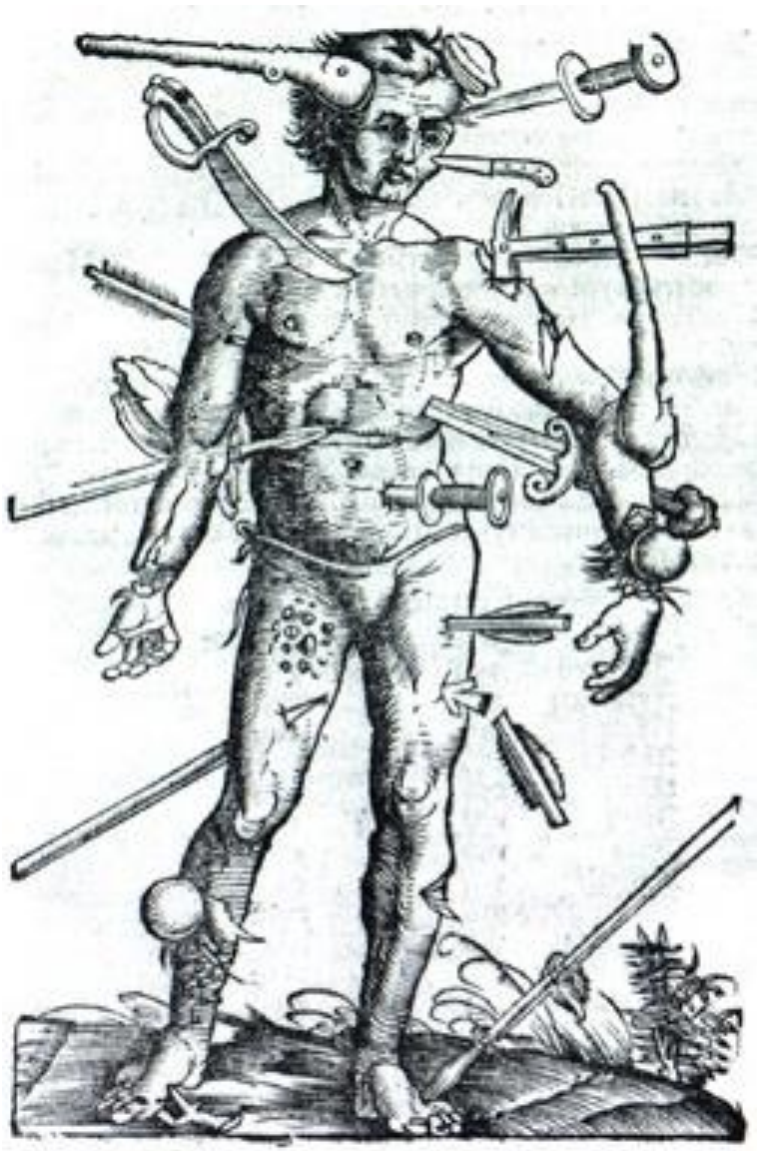

55% MIGRANT/FOREIGN WOMEN




40% MIGRANT/FOREIGN CHILDREN




3,5% MIGRANT/FOREIGN ELDERLY



MANNER
Accidental,
Non accidental

CAUSE/NATURE

WHO AND WHERE

WHEN

HISTORY-NO HISTORY

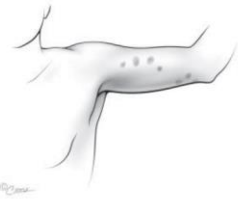
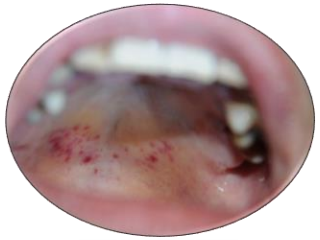
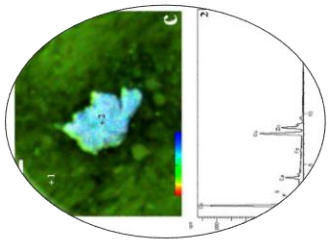
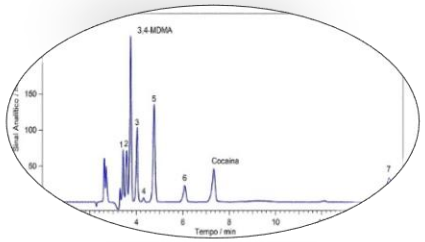
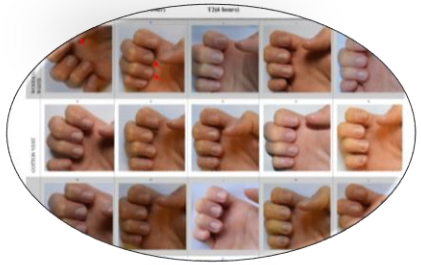


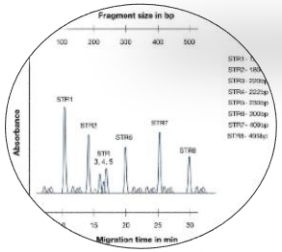
Figure 6 Fingertip bruising on the upper arm

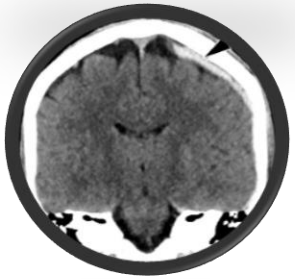


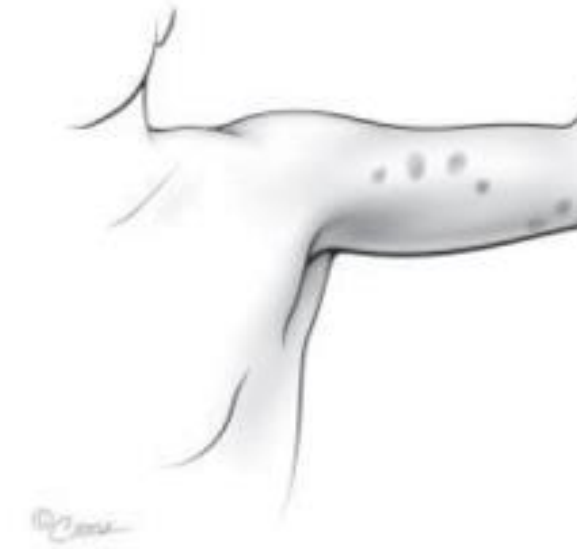








gure 6 **Fingertip bruising on the upper arm**

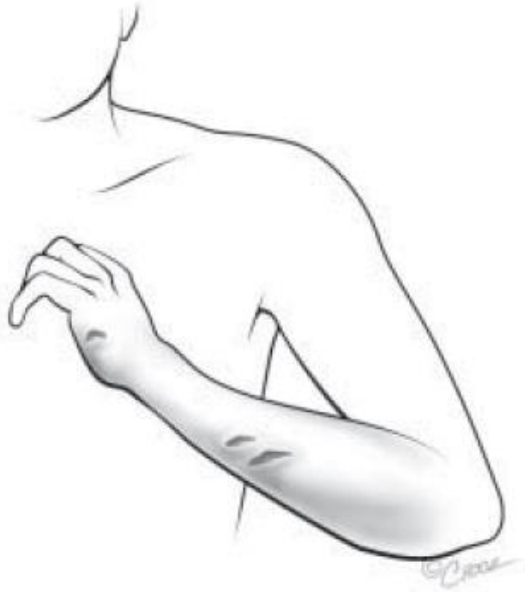
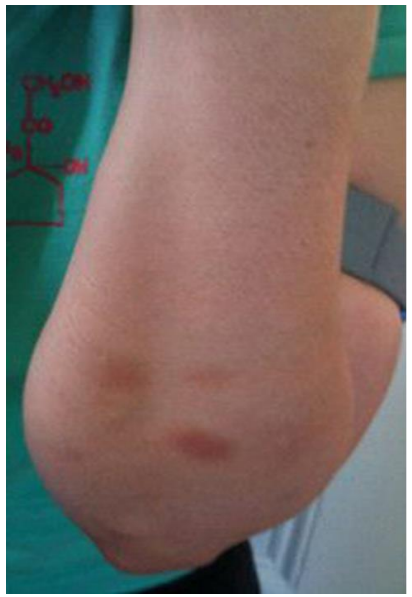
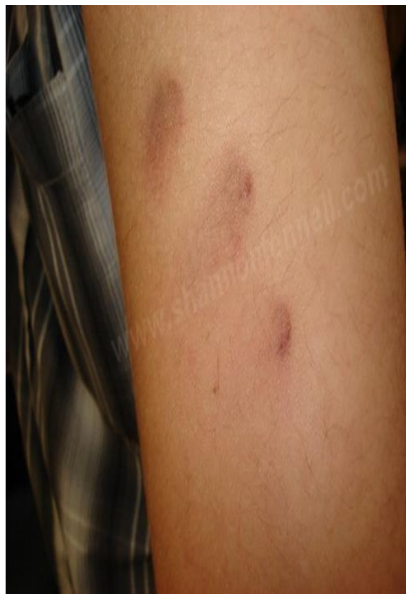
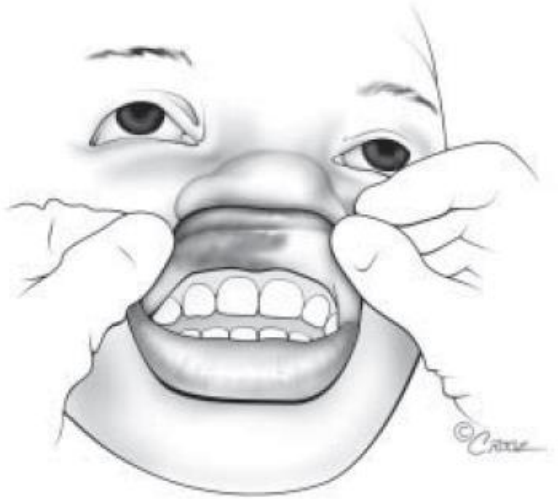


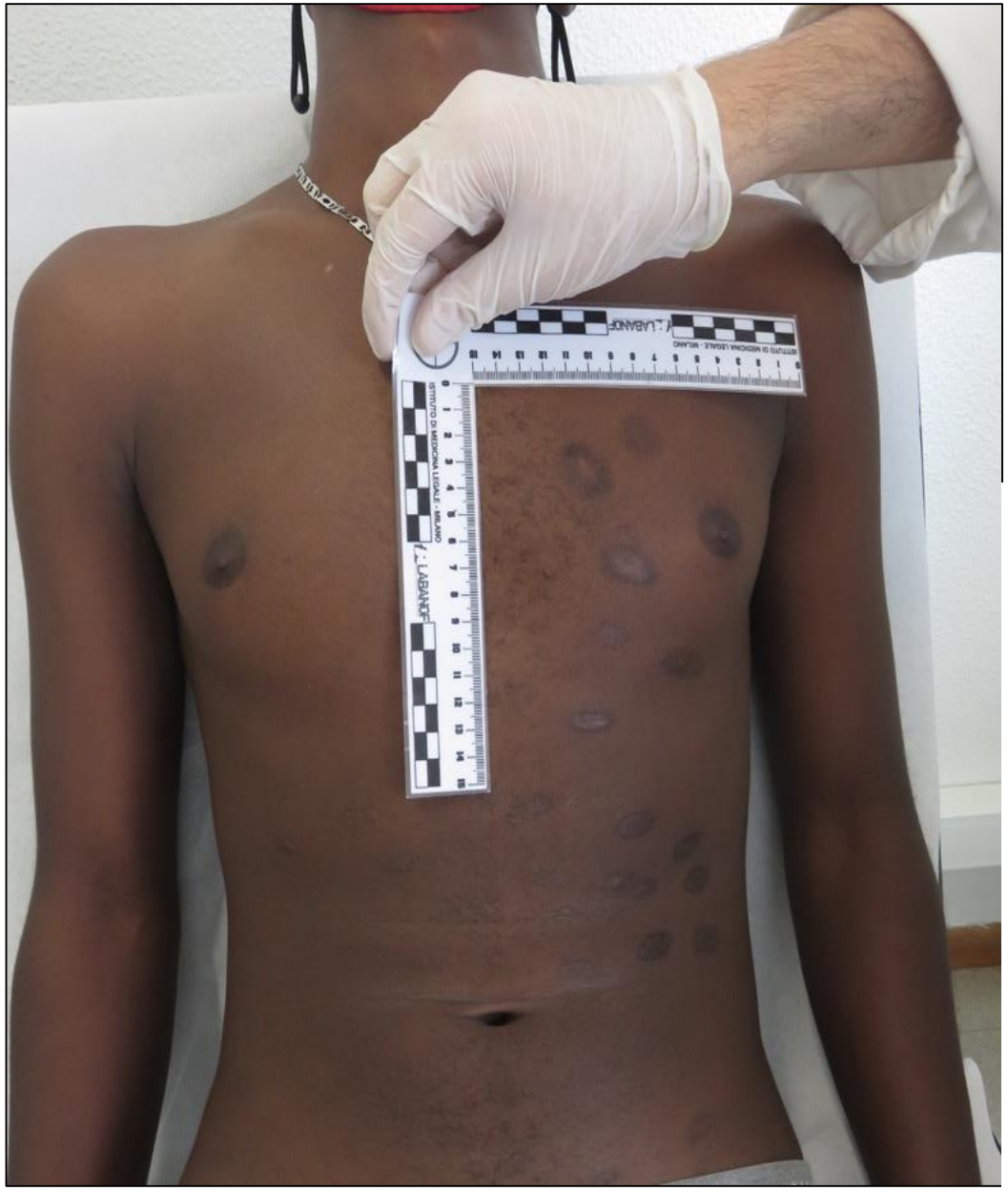
Figure 10 **Defensive lacerations and bruising on forearm and hand**

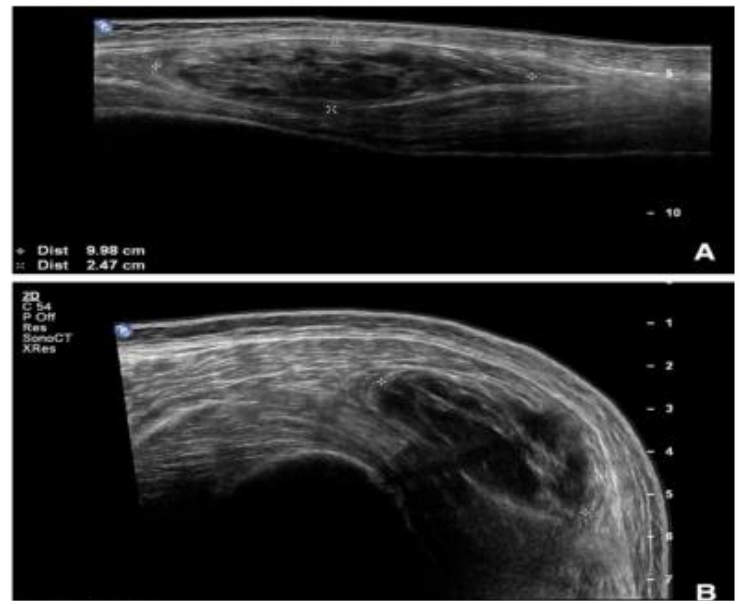






3 **Bruising on the inner upper lip of a dark-skinned woman**


LABANOF
ISTITUTO DI MEDICINA LEGALE - MILANO


Dist 9.98 cm
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A
2D
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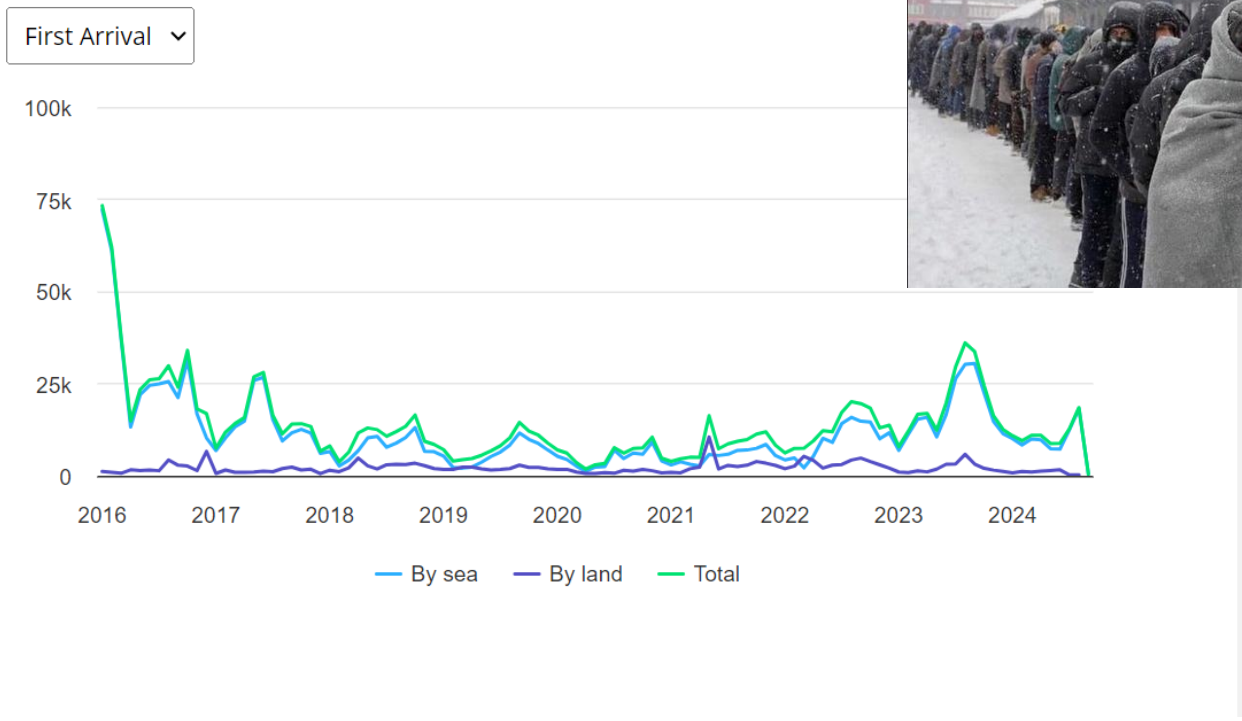
# VIOLENCE AND TORTURE IN ASYLUM SEEKERS

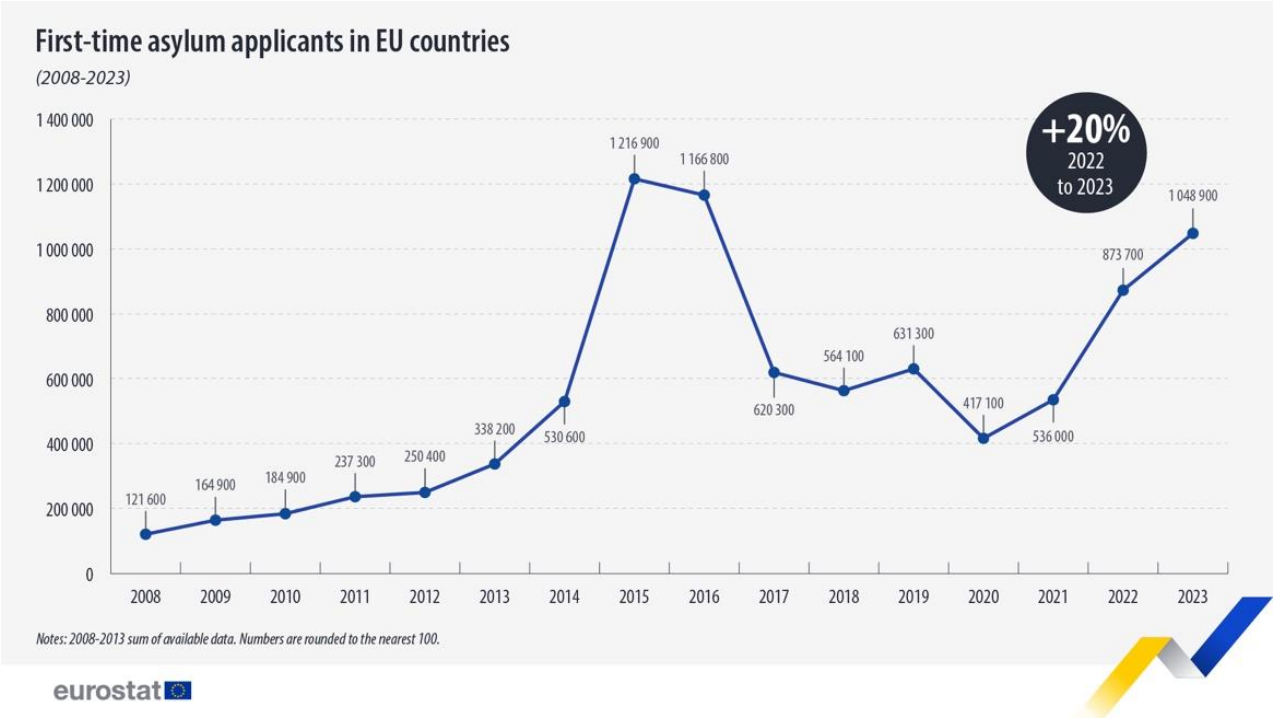
### Trends over time: arrivals, death and missing migrants to Europe

| Year | Arrivals | Dead and Missing |
|---|---|---|
| 2024 | 114,988 | 2,075 |
| 2023 | 292,985 | 4,114 |
| 2022 | 189,620 | 2,970 |
| 2021 | 151,417 | 3,188 |
| 2020 | 99,907 | 2,325 |
| 2019 | 128,663 | 2,087 |
| 2018 | 146,949 | 2,380 |
| 2017 | 187,499 | 3,140 |
| 2016 | 389,976 | 5,305 |

### Monthly arrival by land and sea



- The number of **forcibly displaced people** worldwide at the end of 2022 amounted to **108.4 million**.
- In 2023, there were **1,048,880 first-time asylum applicants** for international protection in countries of the EU.
- The migration route that primarily involves Italy is the **Central Mediterranean** one.
- The **dead and missing at sea** were 1,510 in 2019 and have become **4,110 in 2023**.

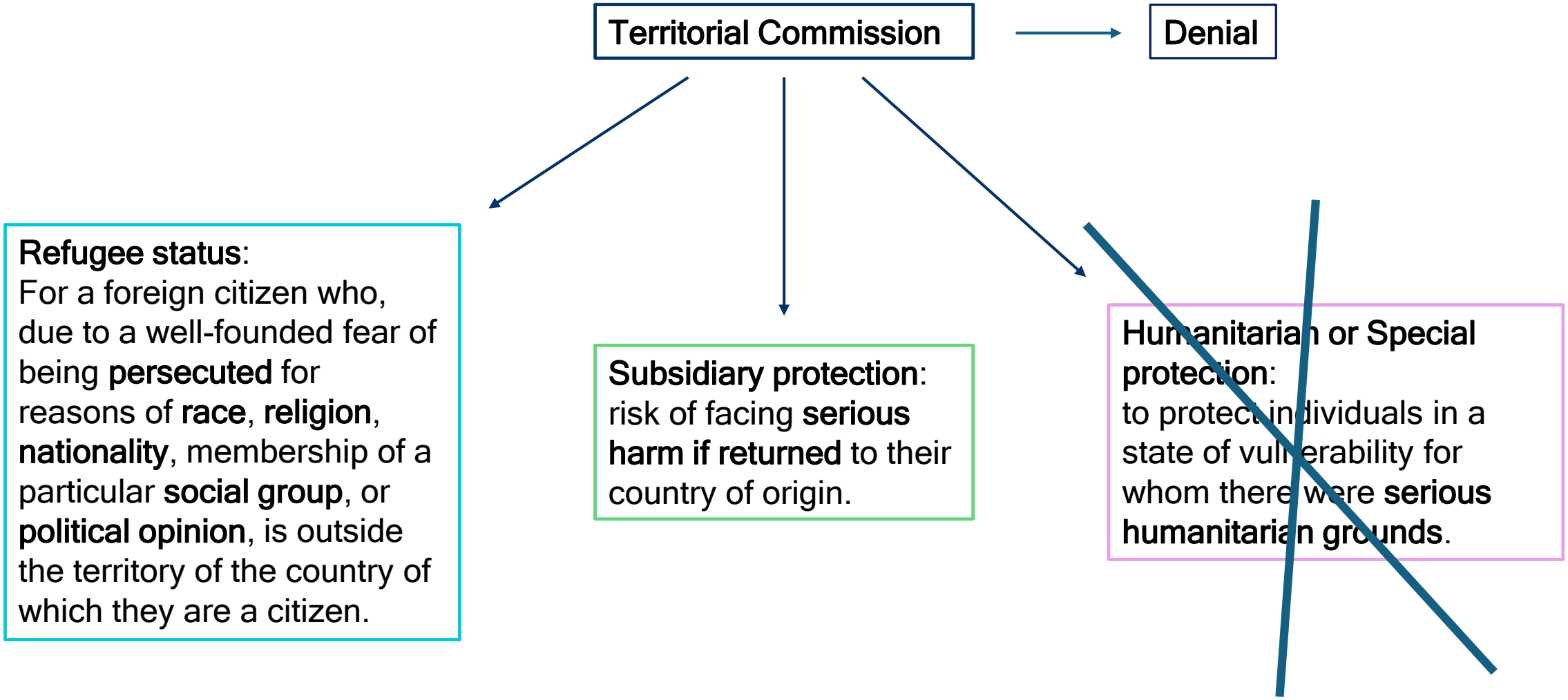



Italy, in 2022, **45.2%** of asylum seekers had their applications **denied**.

Source: Eurostat

INCREASING REASONS FOR REQUESTS:

**discrimination based on sexual orientation and/or gender identity**, **forced marriage**
**gender-based violence, Female genital mutilation (FGM)**
**ill treatment related to family issues**



## The Role of Physicians in Asylum Evaluation: Documenting Torture and Trauma

To the Editor The last several years have seen record-breaking numbers of displaced persons. An average of 42 500 people each day were forced from their homes as a result of conflict and persecution in 2014, a number 4 times higher than in 2010. Notable driving forces include Syria's civil war, the Taliban in Afghanistan, and forced labor in Eritrea.[1] The United Nations' *Convention Against Torture*[2] obligates nations to not expel individuals to a country where there is significant reason to believe those persons would be tortured or persecuted. The United States grants asylum to individuals that prove a well-founded fear of persecution in court.[3]

Physicians are uniquely poised to help victims of torture and trauma secure asylum status. Forensic medical evaluations are used in appropriate cases to corroborate a history of trauma. Asylum seekers who receive medical evaluation in concert with legal services have success rates of 79% to 89% compared with the national average of 37.5%, suggesting that medical evaluations have considerable effect on the application process.[3-5] In some cases, a forensic medical evaluation may mean the difference between an individual securing legal status and being forcibly returned to a country in which they face persecution and torture.

When evaluating asylum seekers, physicians should directly and empathetically elicit a detailed history of any trauma and ask about the origin of all examination findings.[4] Examples of relevant findings include lesions consistent with whipping and brachial plexus palsies caused by suspension, as well as evidence of bone fractures. In one cohort of asylum seekers, 69% had scars on their head and neck, 10% had scars on their genitals, 7% had fractured bones, and 6% had burn marks.[5] Official asylum evaluations involve a history, physical examination, and review of records. In contrast to a typical clinical encounter, treatment and counseling are not provided. Physicians document any findings in a medical affidavit in the form of detailed descriptions, photographs, and/or drawings. The affidavit is subsequently submitted as corroborating evidence in court. On occasion, the physician may also testify as an expert witness.

Physicians can be formally trained in performing forensic evaluations in short courses and provide this service on a volunteer, part-time basis. Given that the United States receives the third highest number of asylum applications per year,[1] physicians should consider this unique opportunity to defend human rights. Furthermore, we encourage all physi-

Jules B. Lipoff, MD

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**Additional Contributions:** The authors would like to thank Meredith Fortin, JD, at Physicians for Human Rights for her comments on the manuscript.

**Conflict of Interest Disclosures:** None reported.

1. United Nations High Commissioner for Refugees. 2014 Global Trends: Forced Displacement in 2014. Geneva, Switzerland: United Nations, June 2015. http://unhcr.org/556725e69.html. Accessed November 14, 2015.

2. *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, New York (United Nations, *Treaty Series*, vol. 1465, p. 85). https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9&chapter=4&lang=en. Accessed November 14, 2015.

3. Lustig SL, Kureshi S, Delucchi KL, Iacopino V, Morse SC. Asylum grant rates following medical evaluations of maltreatment among political asylum applicants in the United States. *J Immigr Minor Health*. 2008;10(1):7-15.

4. United Nations. The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment: Istanbul Protocol. Geneva, Switzerland: United Nations, November 1999. http://physiciansforhumanrights.org/issues/torture/international-torture.html#sthash.fWkkUifl.dpuf?. Accessed November 14, 2015.

5. Asgary R, Charpentier B, Burnett DC. Socio-medical challenges of asylum seekers prior and after coming to the US. *J Immigr Minor Health*. 2013;15(5):961-968.

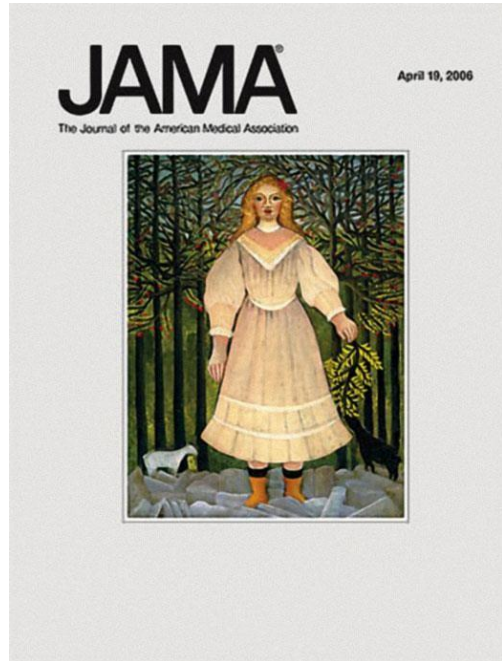
## CORRECTION

**Error in Text:** In the Original Investigation "Trends in Medicaid Reimbursements for Insulin From 1991 Through 2014,"[1] published online August 24, 2015, and also in the October 2015 print issue of *JAMA Internal Medicine*, text in the Discussion section of the article has been reworded. The sentence "It is unlikely, however, that rebates would offset the increases in payments that we identified because Medicaid rebates for innovator drugs are statutorily capped at 23.1% of the average manufacturer price," now reads, "It is unlikely, however, that rebates would offset the increases in payments that we identified because base Medicaid rebates for innovator drugs are the greater of 23.1% of the average manufacturer price (AMP) or the difference between AMP and the best price (the lowest price offered to any purchaser of that product, with a few exceptions, such as for drugs purchased by the Department of Veterans Affairs)."

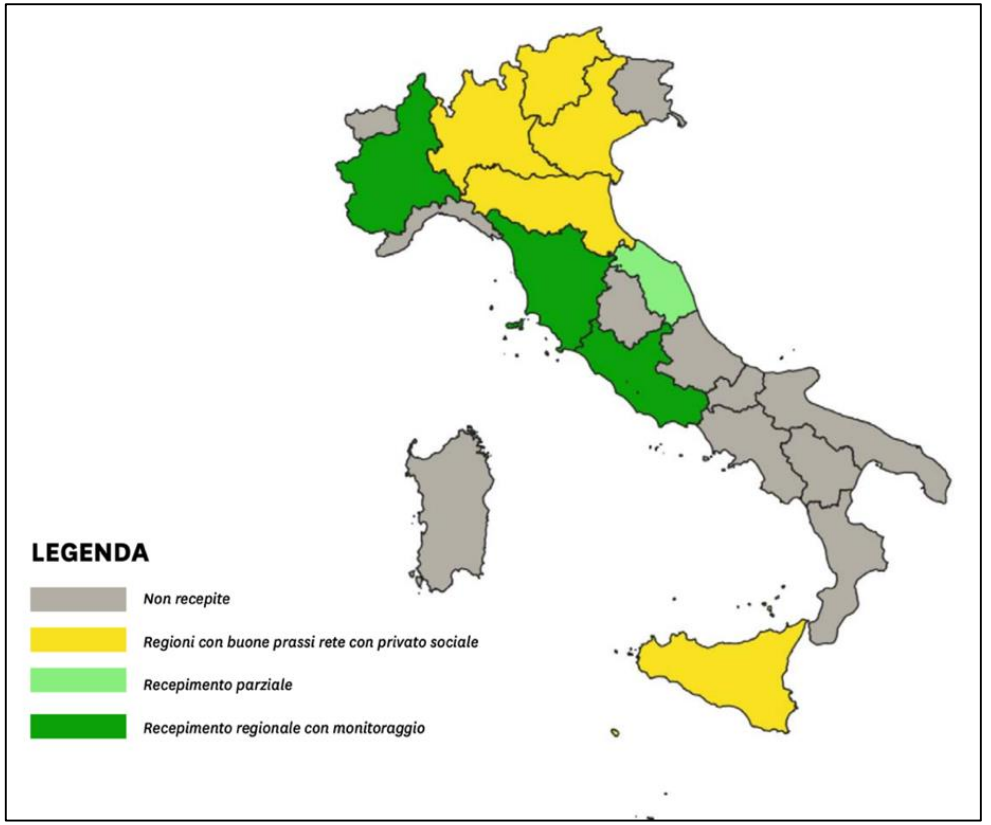
1. Luo J, Avorn J, Kesselheim AS. Trends in Medicaid reimbursements for insulin from 1991 through 2014. *JAMA Intern Med*. 2015;175(10):1681-1686.

**Error in Reference List:** In the reference list for the editorial by Cummings et al[1] titled "Vitamin D Supplementation and Increased Risk of Falling: A Cautionary Tale of Vitamin Supplements Retold," published online in *JAMA Internal Medicine* on January 4, 2016, reference 4 was incorrect. The reference should have read: Sanders KM, Stuart AL, Williamson EJ, et al. Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial. *JAMA*. 2010;303(18):1815-1822.

1. Cummings SR, Kiel DP, Black DM. Vitamin D supplementation and increased risk of falling: a cautionary tale of vitamin supplements retold [published online January 4, 2016]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2015.7568.



- In 2017, there was a first effort by the Italian Ministry of the Interior to guide the public health system in its reorganization to promote the early identification of the emerging needs of asylum seekers and refugees in order to ensure effective care.
- A Doctors Without Borders (MSF) report published in 2022 highlighted that “their implementation at the regional level continues to be **extremely limited**”.






ALLEGATO

***Linee guida per la programmazione degli interventi di assistenza e riabilitazione nonché per il trattamento dei disturbi psichici dei titolari dello status di rifugiato e dello status di protezione sussidiaria che hanno subito torture, stupri o altre forme gravi di violenza psicologica, fisica o sessuale***

Source: Doctors Without Borders

## The ethnopsychiatric report

Psychiatric **diagnosis** with a focus on a **transcultural approach**.

**Multidisciplinary strategy** to tackle the **biopsychosocial nature** of psychopathology.

Psychotherapeutic methods are tailored to the ethnic and cultural background of the patient in an attempt to foster the mental well-being of the patient **independently on the modality**.

## The medicolegal report

Comprehensive **interview**.

Detailed accounts of any experiences of violence, particularly those involving **physical trauma**.

**Physical examination** with specific attention to any **lesions or scars**.

Assessment based on the five different **degrees of consistency** within the **Istanbul Protocol** categories.

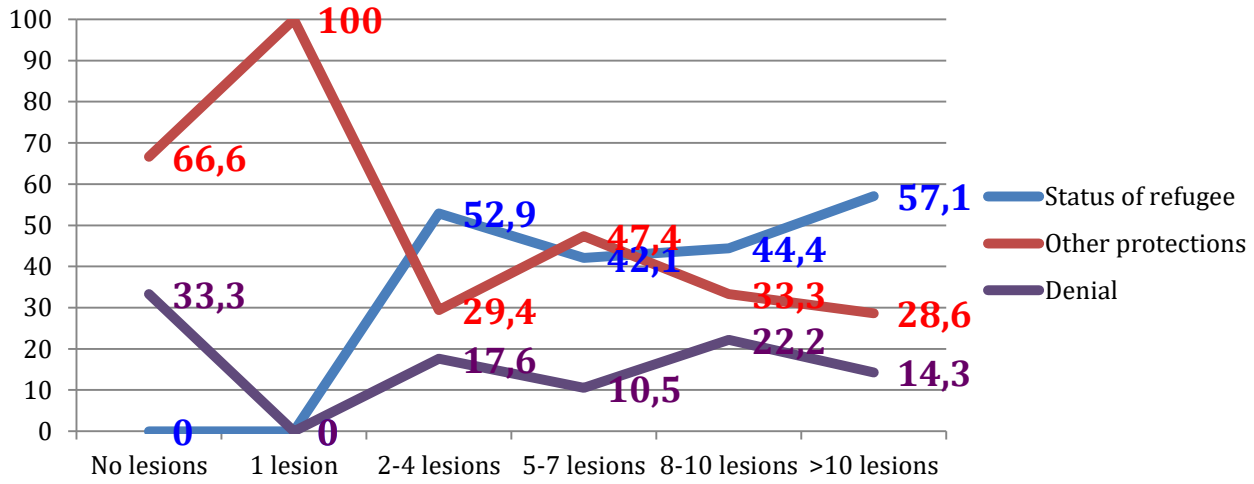
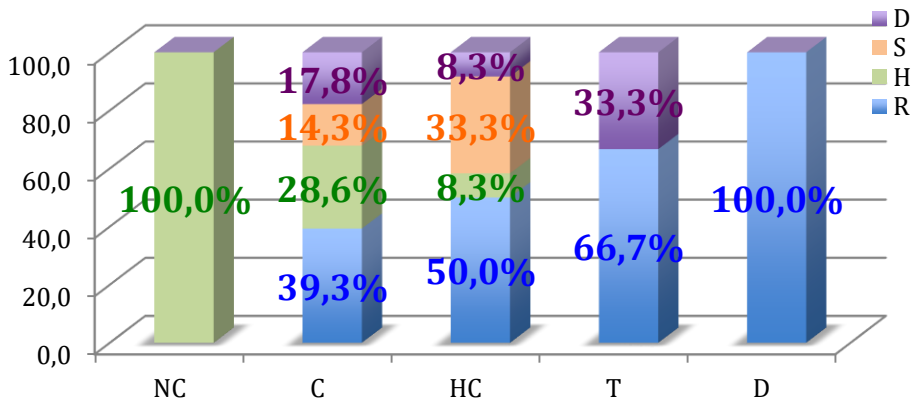


**TABLE 1** ] Five Classes of Opinion Describing Consistency Between a Lesion or Pattern of Lesions and the Attribution Given by the Patient According to the Istanbul Protocol

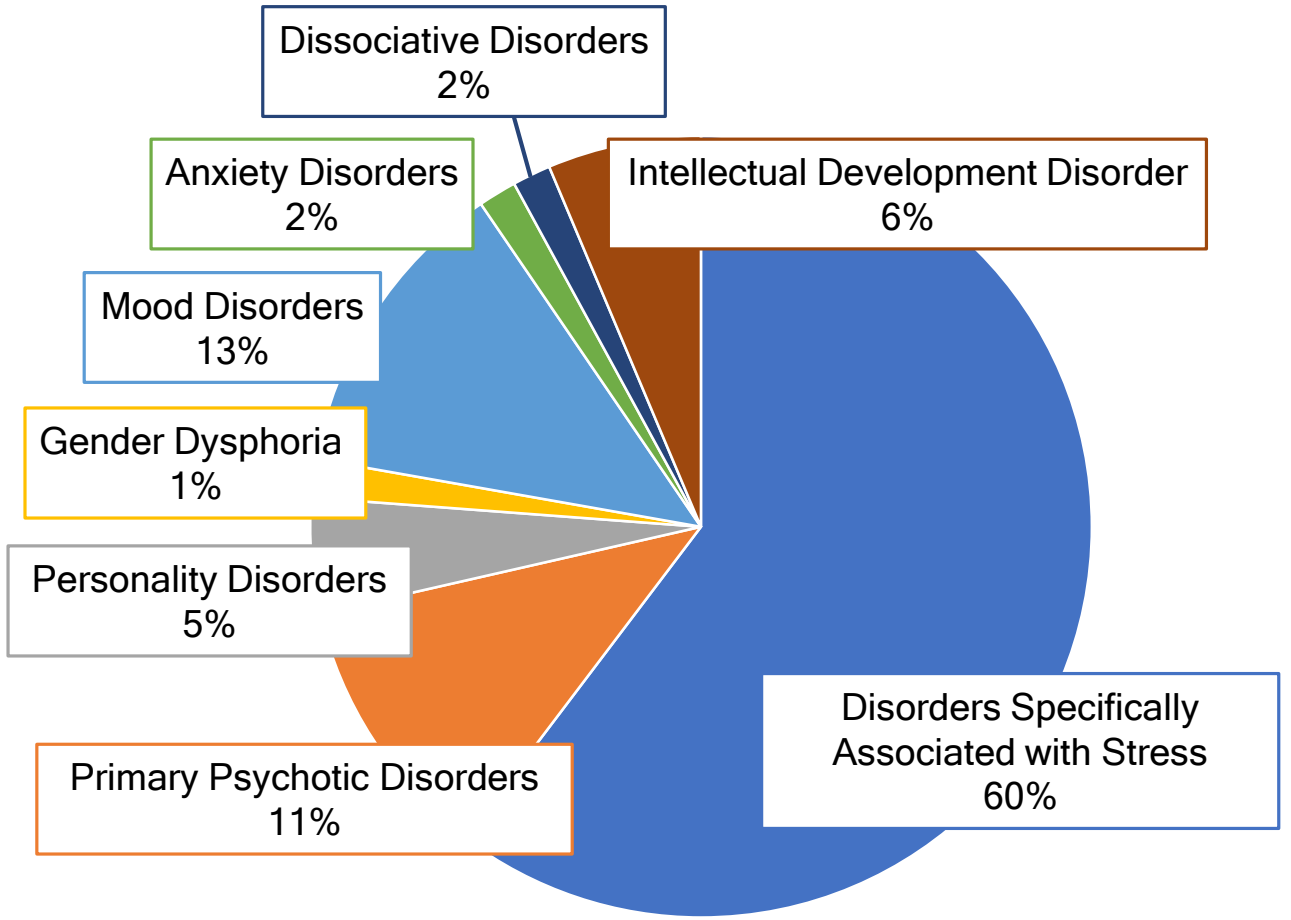
| Class | Description |
|---|---|
| I | Not consistent; the lesion could not have been caused by the trauma described. |
| II | Consistent with; the lesion could have been caused by the trauma described, but it is nonspecific and there are many other possible causes. |
| III | Highly consistent; the lesion could have been caused by the trauma described, and there are a few other possible causes. |
| IV | Typical of; this is an appearance that is usually found with this type of trauma, but there are other possible causes |
| V | Diagnostic of; this appearance could not have been caused in any way other than that described. |

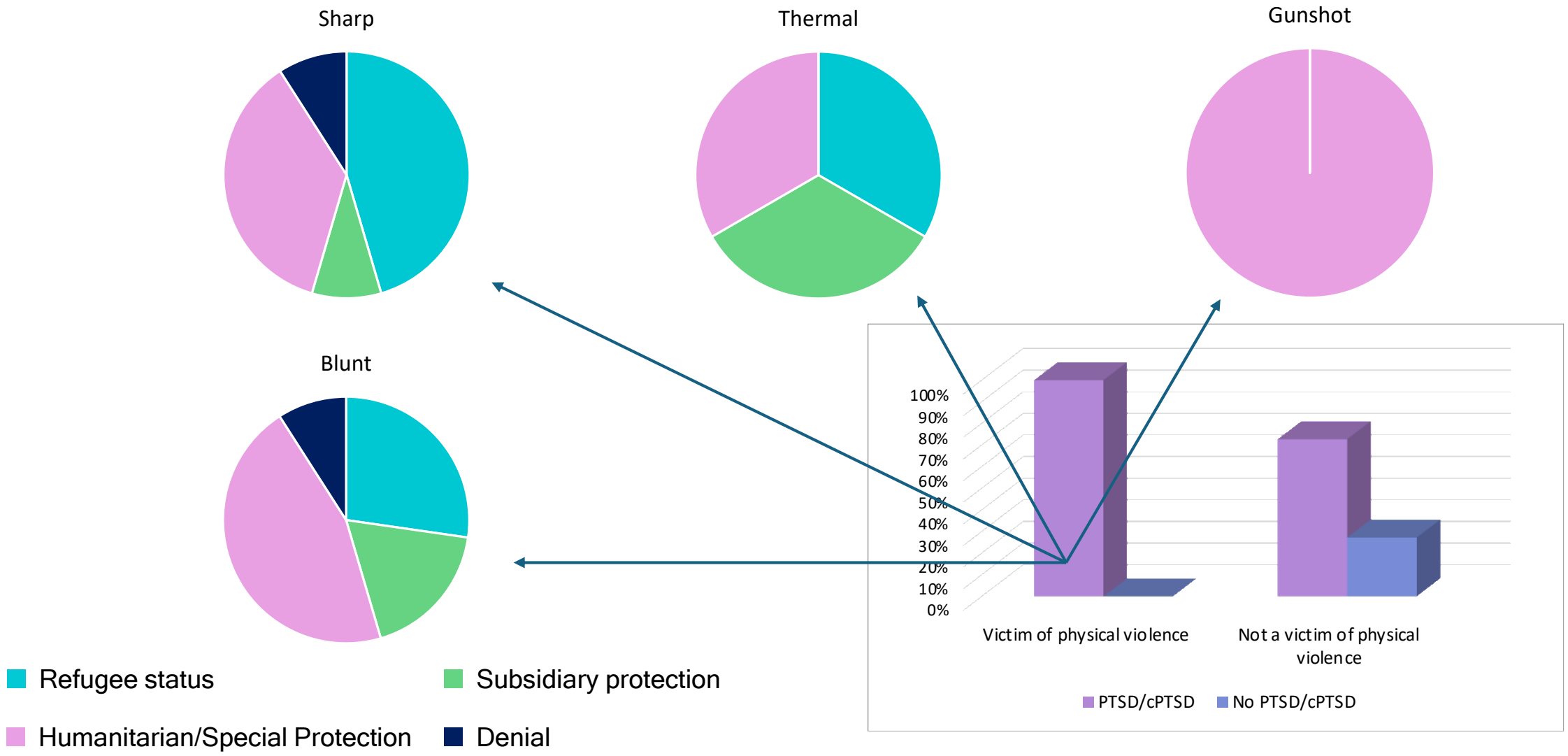


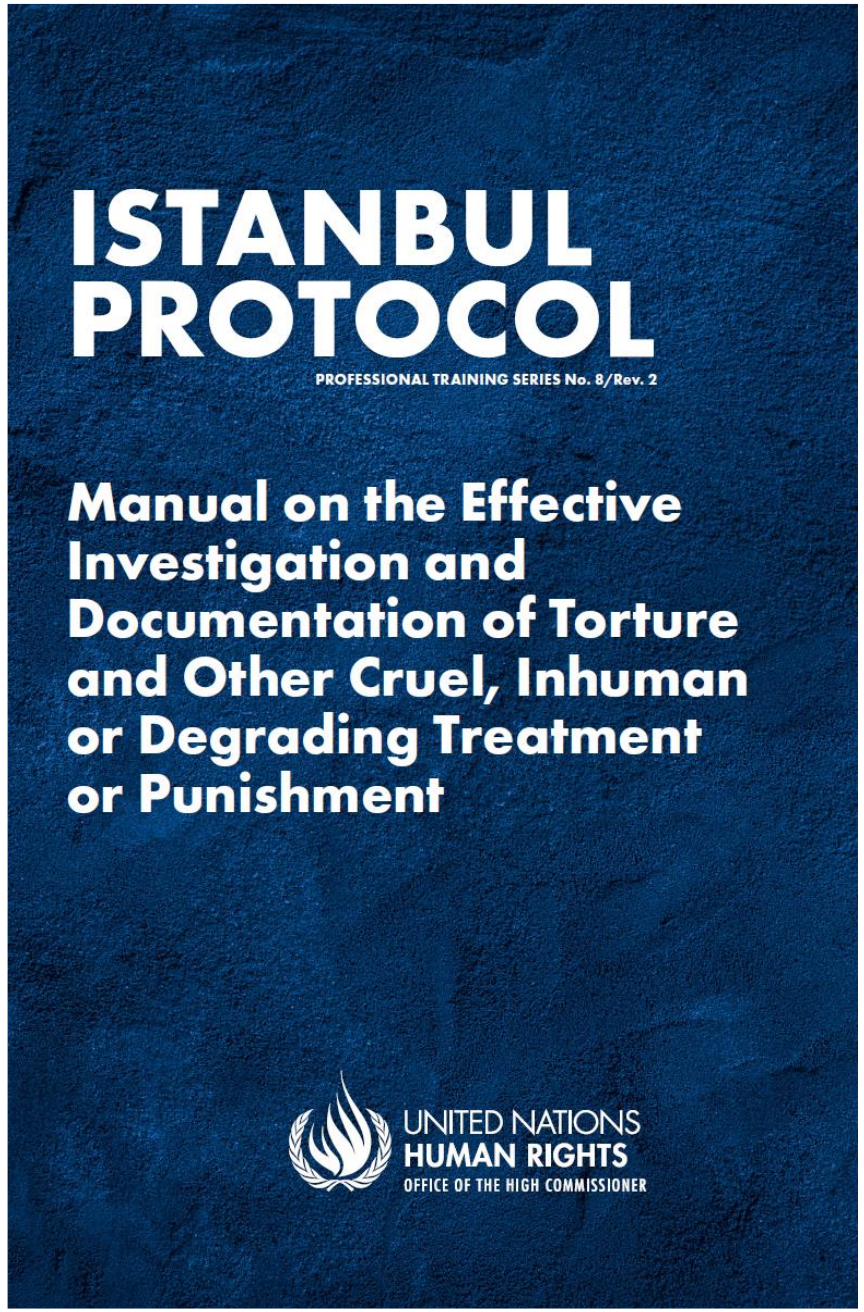

R: status of refugee;
H: humanitarian protection;
S: subsidiary protection;
D: denial.

NC: non concordant judgment;
C: concordant;
HC: highly concordant;
T: typical;
D diagnostic

- **Disorders Specifically Associated with Stress** were the most represented among the diagnostic categories
- **Complex Post-Traumatic Disorder**, a diagnosis found in the International Classification of Diseases 11th Revision (ICD-11) but not in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), was the most frequently diagnosed pathology.
- **Major Depressive Disorder** was at times found in co-occurrence with PTSD.
- **Primary Psychotic Disorders**, instead, was less frequently found in co-occurrence with PTSD.




Sharp
Thermal
Gunshot
Blunt
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Victim of physical violence
Not a victim of physical violence
PTSD/cPTSD
No PTSD/cPTSD
Refugee status
Subsidiary protection
Humanitarian/Special Protection
Denial




CHAPTER V

# Physical evidence of torture and ill-treatment

## 3. Suspension

**444.** Suspension is a common form of torture that can produce extreme pain, but which leaves little, if any, visible evidence of injury. Oedema of the dependent or constricted limbs may be found with the risk of deep vein thrombosis with prolonged restraint in a single position, including forced standing. The finding of peripheral neurological deficits, diagnostic of brachial plexopathy, virtually proves the diagnosis of suspension torture. Suspension can be applied in various forms:

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Review

# Suspension torture and its physical sequelae

Sara Woldu *, Marie Brasholt

*DIGNITY – the Danish Institute Against Torture, Bryggervangen 55, 2100, Copenhagen, Denmark*

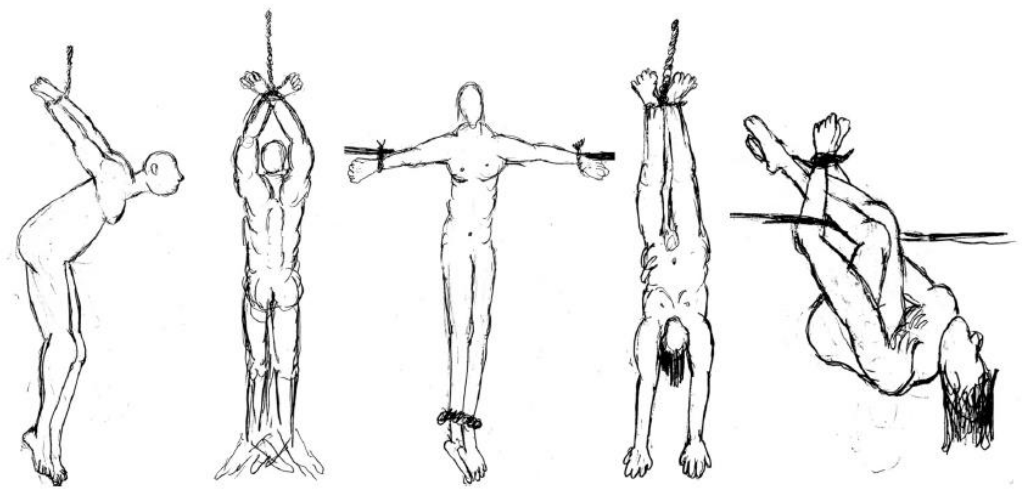
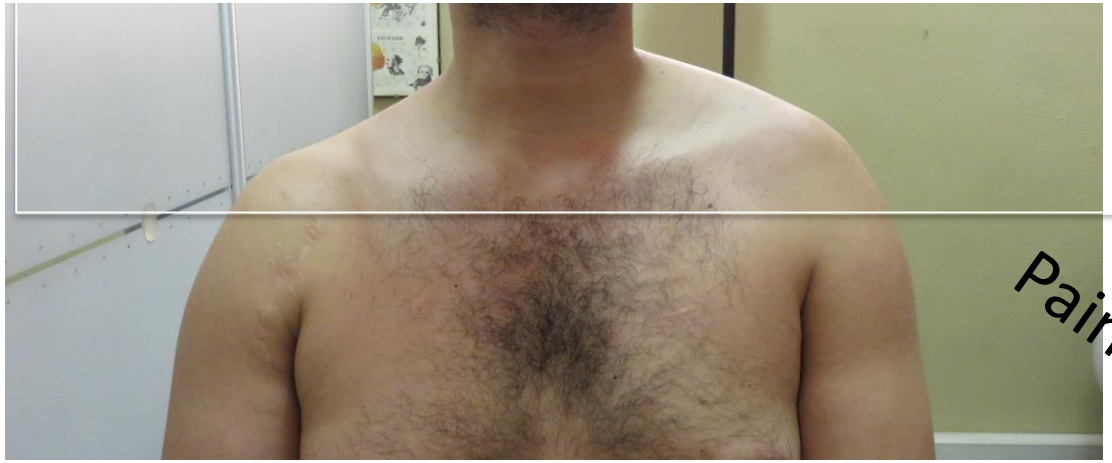


**Fig. 1.** A: Reverse suspension, B: Butchery suspension, C: Cross suspension, D: Reverse butchery suspension, E: Parrot perch.

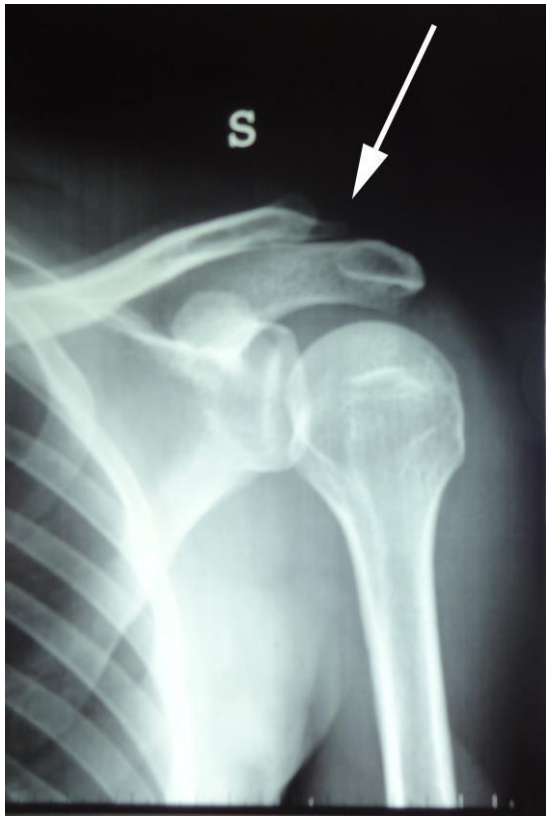
The neuropathic pain is a constant, superficial, burning or stinging pain. The victims of suspension by the arms localize the pain primarily to their shoulders and arms in the dermatomes C4-T1-2, with an intermittent spontaneous shooting feeling or electric shock, described as a combination of pain and reflex muscle cramps.[28,29] In some cases the symptoms progress to complex regional pain syndrome.[8,38]

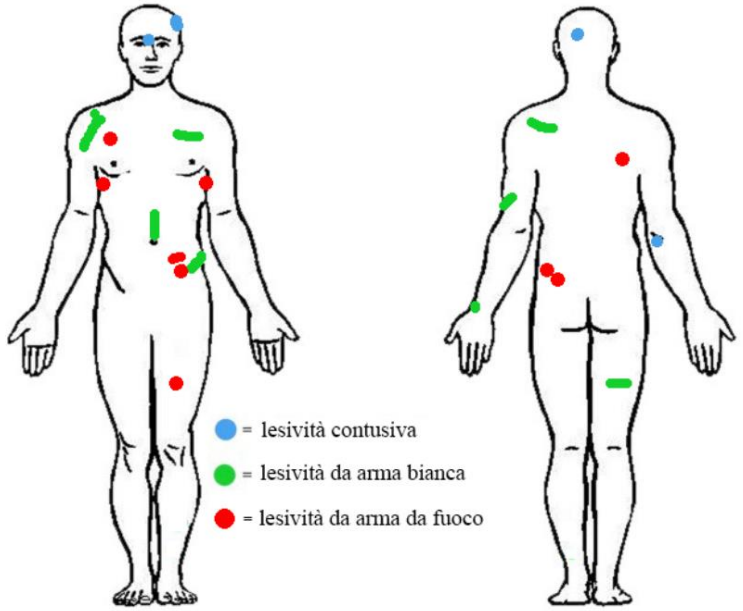


Injury to brachial plexus, axillary, long thoracic nerves

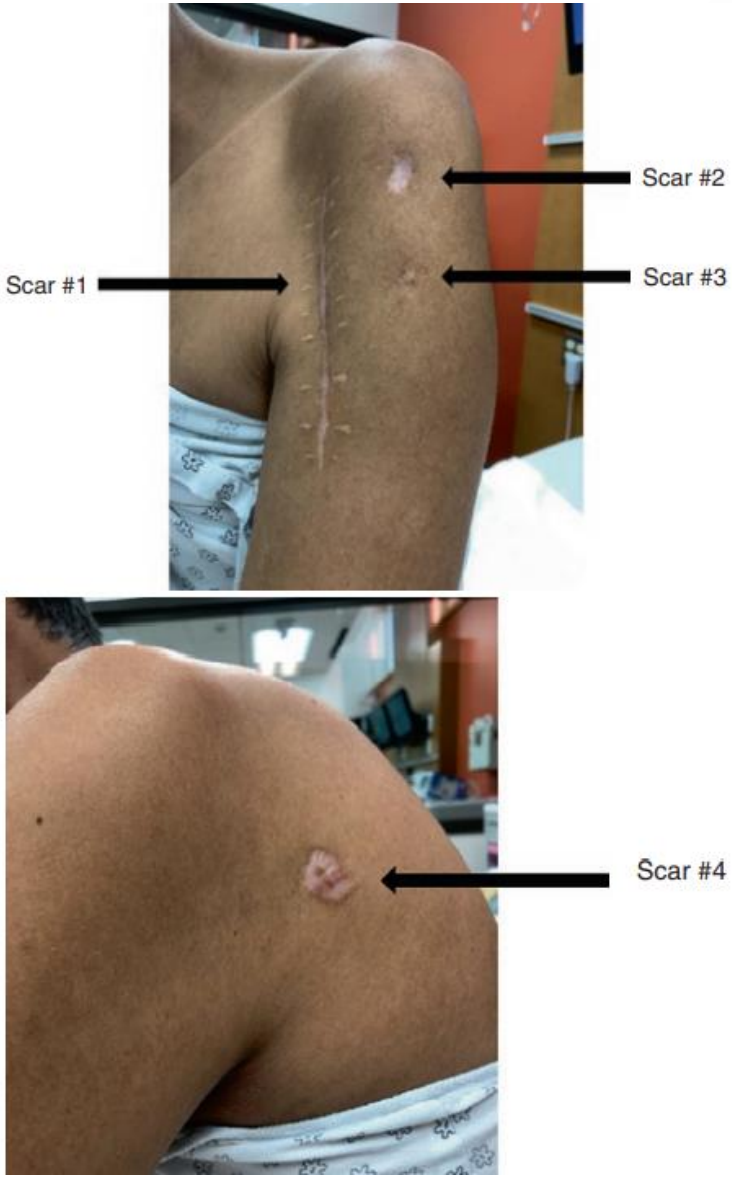
Pain and specific paralysis, scapular winging

- GUNSHOT
- SHARP FORCE
- BLUNT FORCE




Schema relativo alla localizzazione degli esiti cicatriziali




# Neuromuscular ultrasound findings in gunshot wounds

trick Fagan MD / Christopher D. Geiger DO / Gaurav Chenji MD /
d C. Preston MD

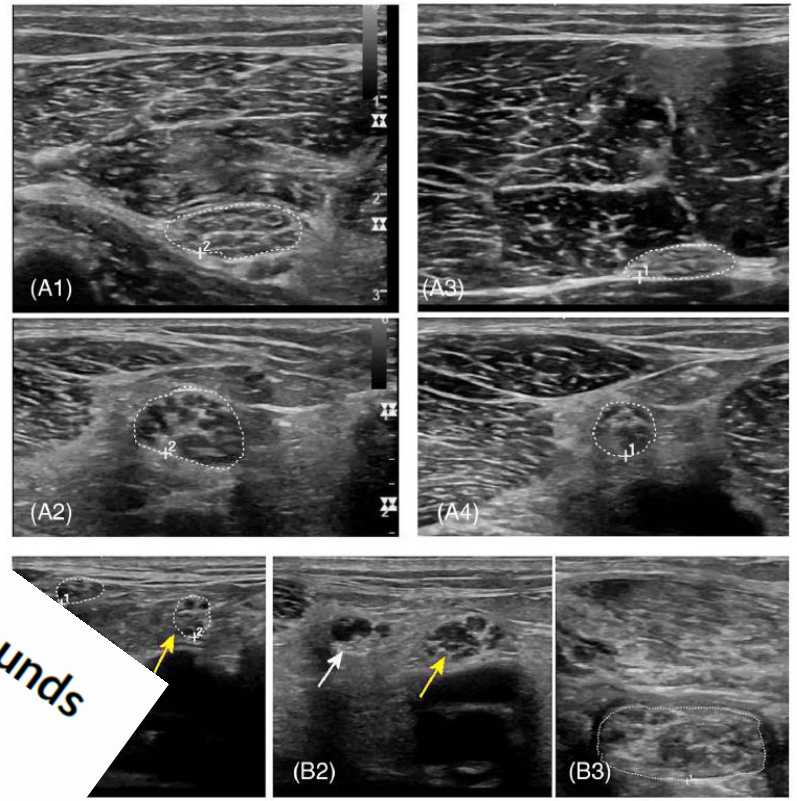
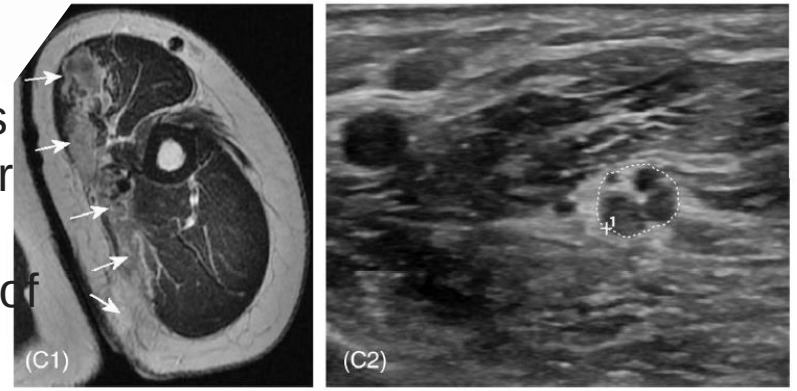


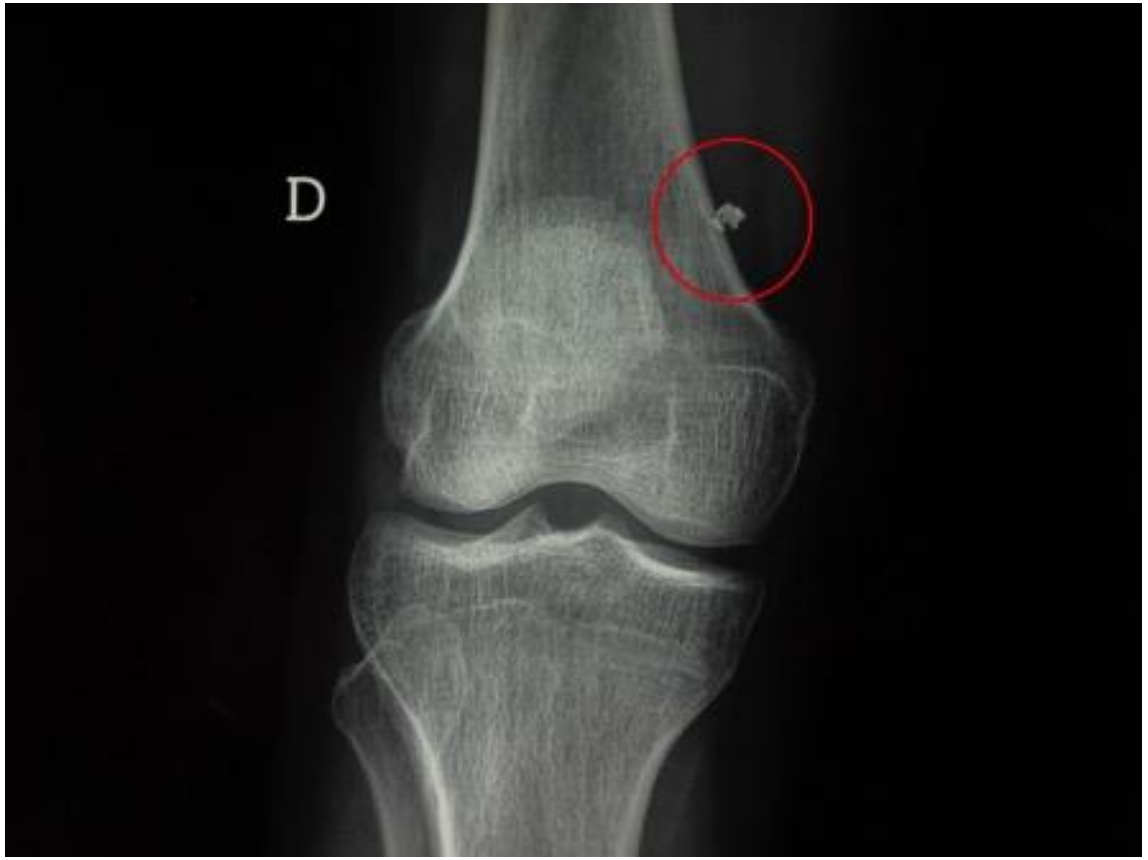

**FIGURE 1** Patient A. 21-year-old patient with a gunshot wound (GSW) to right sciatic nerve in the upper thigh/buttock three months earlier. (A1) Sciatic nerve in the mid-thigh distal to the injury (cross sectional area [CSA] = 57 $mm^2$); (A2) sciatic nerve proximal to the popliteal fossa (CSA = 69 $mm^2$); as compared to the uninjured left sciatic nerve (A3) in the mid-thigh (CSA = 30 $mm^2$) and (A4) proximal to the popliteal fossa (CSA = 28 $mm^2$). Patient B. 50-year-old ient with GSW to right mid-thigh earlier. (B1) Normal contralateral l (white arrow) and tibial erves in the popliteal 2) the GSW injury largement and ciatic nerve

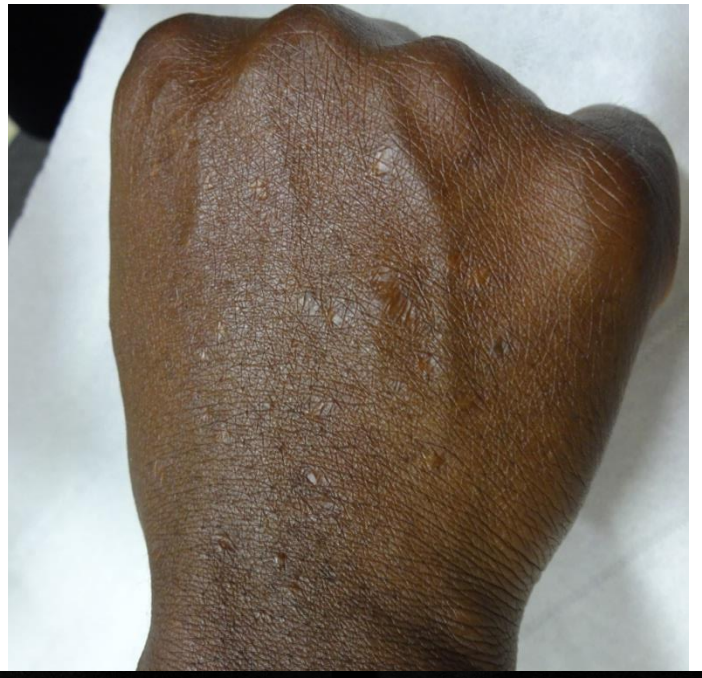
on
(C2) le
and fascicu
forearm (CSA =
were present throu
the median nerve.

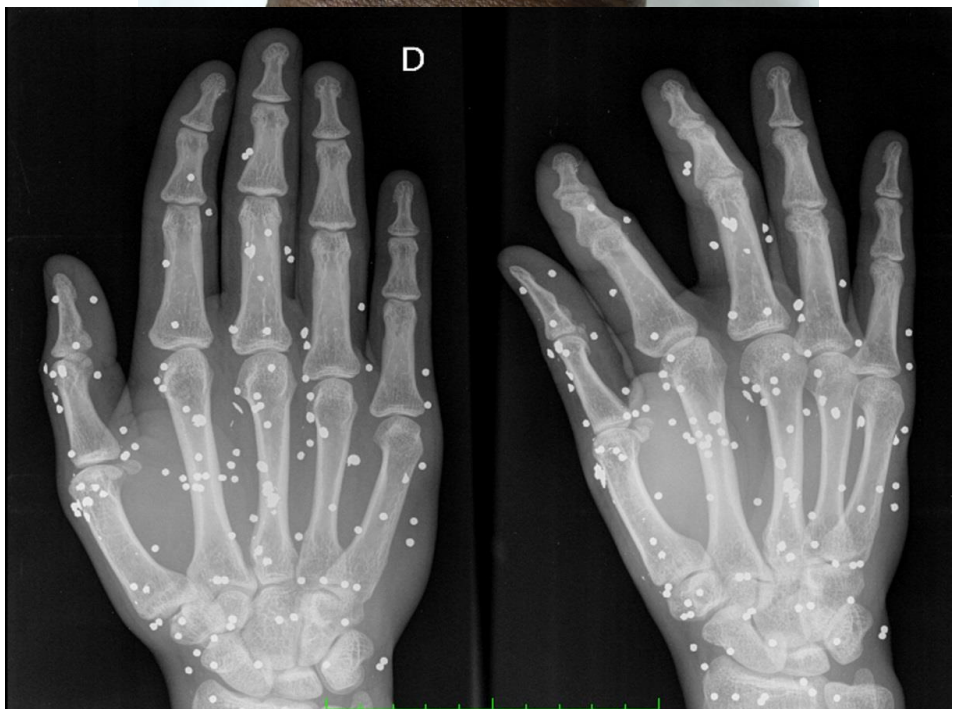



morphological changes at the site of t GSW but also in distal nerve segments including nerve enlargement, fascicular enlargement, and changes in nerve echogenicity. The complementary use of HRUS with EDX was highlighted in evaluation of GSW victims to assess the extent of peripheral nerve injury.

GUNSHOT OR EXPLOSION RESIDUES



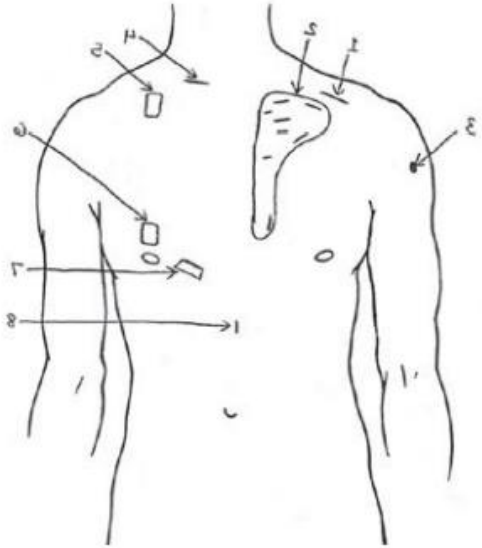



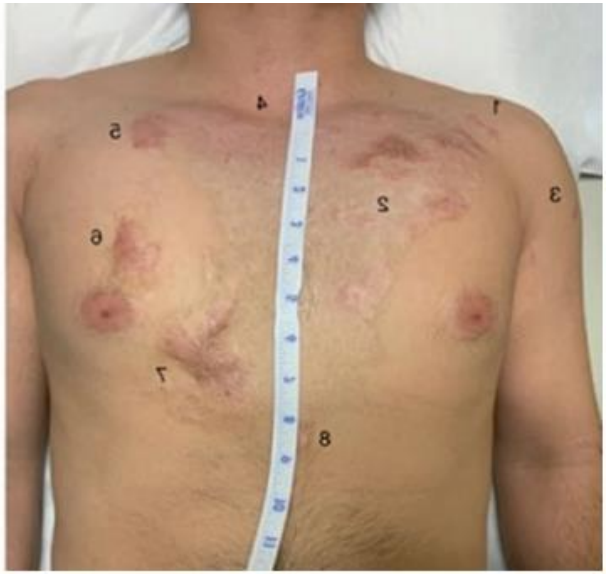


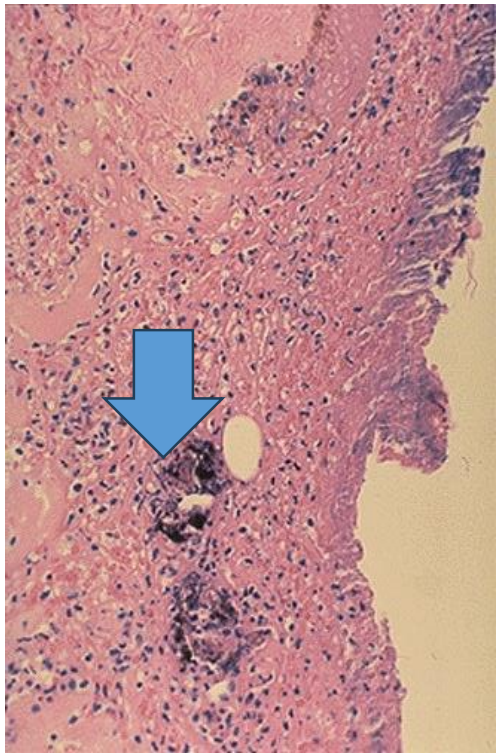
## 5. Electric shock torture

**450.** In electric shock torture, electric current is transmitt through electrodes placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips and genital area. The power source may be a hand-cranked or combustior generator, wall source, stun gun, cattle prod or othe conducted energy device. Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applie are characteristic. For example, if electrodes are placed on a toe of the right foot and on the genital region, there will be pain, muscle contraction and cramps in the right thigh and calf muscles. Excruciating pain will be felt in the genital region. Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder, and lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used cannot be determined with certainty upon physical examination of the victim. Torturers often use water or gels in order to increase the efficiency of the torture, expand the entrance point of the electric current on the body and prevent detectable electric burns. Trace electrical burns can be a reddish-brown circular lesion a few millimetres in diameter, usually without inflammation, which may result in a hyperpigmented scar. Skin surfaces must be carefully examined because the lesions are not often easily discernible. Hypersalivation may be reported, but often history is limited due to loss of consciousness during the torture.

Deposits of calcium salts distinctly located to collagen fibers were observed below the regenerated epidermis at the periphery of two skin lesions of the chest wall, in the lower part of dermis at the periphery of a skin lesion of the left arm, and within connective tissue adjacent to elastic arteries and peripheral nerves from the thoracic cavity. The pattern of calcification localized to collagen fibers and situated both superficially and deeply in the skin in a zone of viable tissue close to necrotic tissue is characteristic of electrically induced lesions.







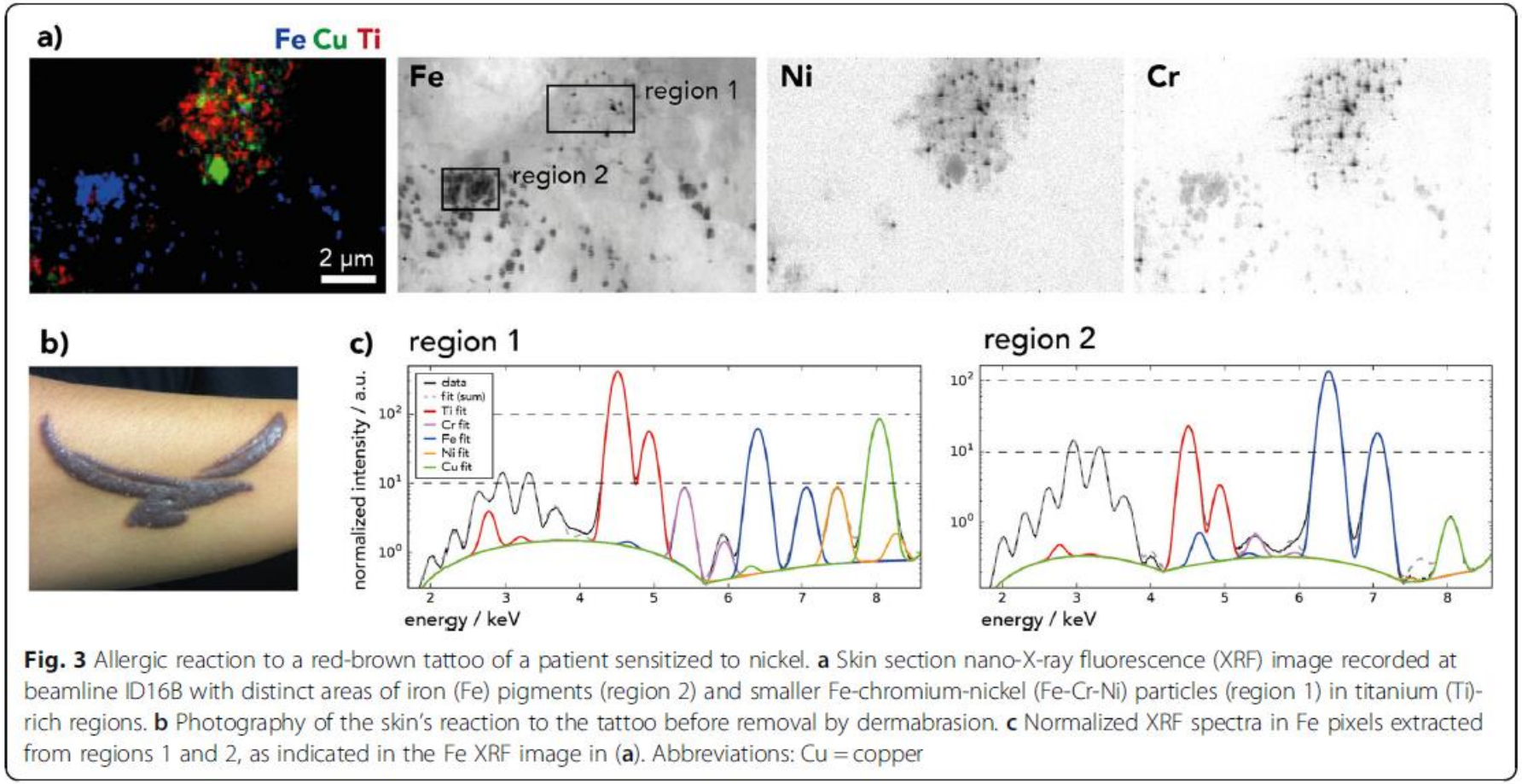
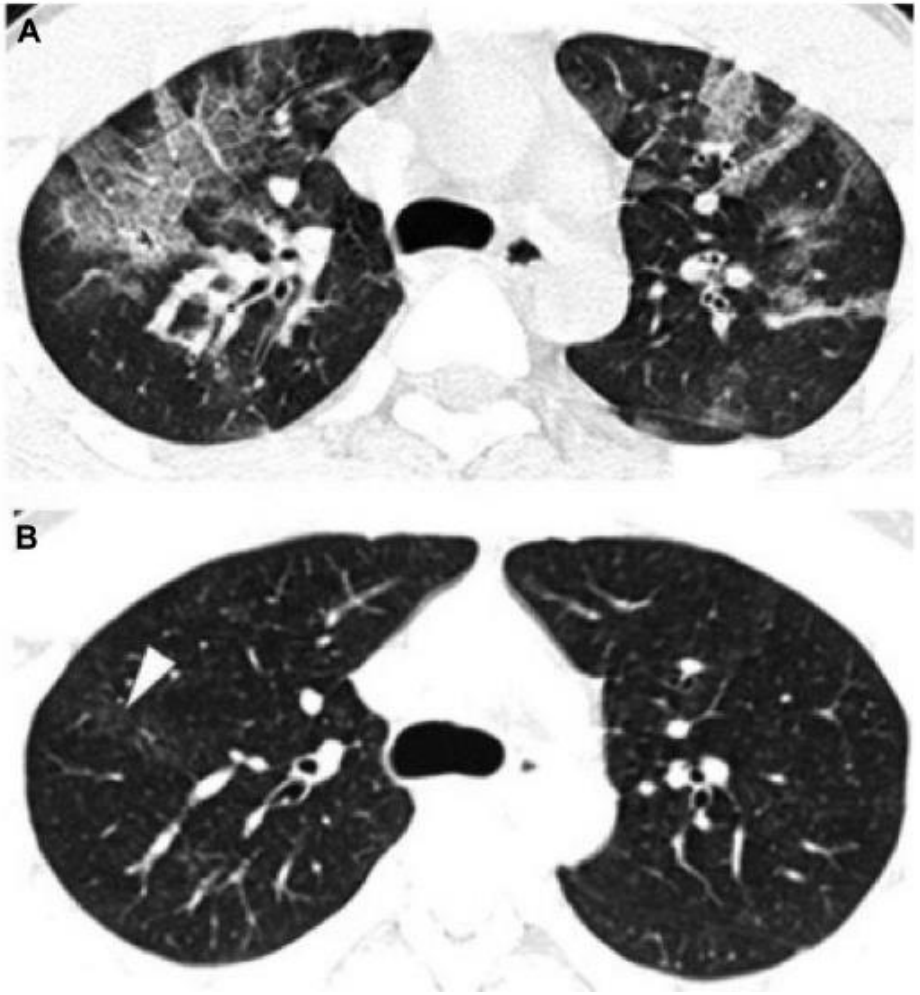



**Fig. 3** Allergic reaction to a red-brown tattoo of a patient sensitized to nickel. **a** Skin section nano-X-ray fluorescence (XRF) image recorded at beamline ID16B with distinct areas of iron (Fe) pigments (region 2) and smaller Fe-chromium-nickel (Fe-Cr-Ni) particles (region 1) in titanium (Ti)-rich regions. **b** Photography of the skin's reaction to the tattoo before removal by dermabrasion. **c** Normalized XRF spectra in Fe pixels extracted from regions 1 and 2, as indicated in the Fe XRF image in (**a**). Abbreviations: Cu = copper

FT-IR
SEM-EDX
XRF

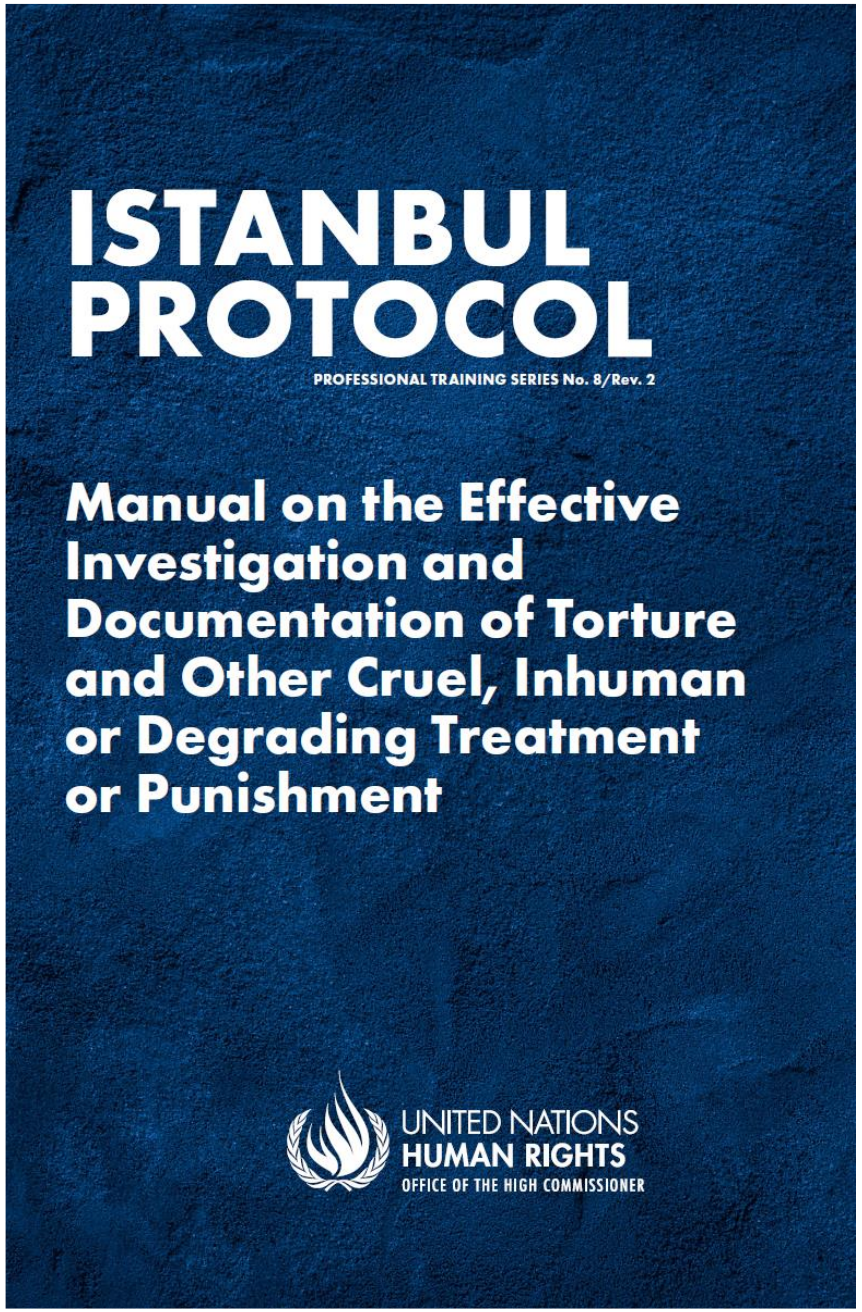
## 7. Asphyxiation

**452.** Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no mark and recuperation is rapid. This method of torture was so widely used in Latin America that its name in Spanish, *submarino*, has become part of human rights vocabulary. Normal respiration might be prevented through such methods as covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, pet[illegible] hot peppers etc.



## 8. Sexual torture, including rape[435]

**455.** Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. An individual is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the threat of potential sexual torture or ill-treatment, including rape. Furthermore, verbal sexual threats, verbal abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects. Sexual torture includes forced nudity, sexual assault by touching intimate parts of the body, digital penetration, forced masturbation, forced insertion of an object into the vagina or anus, oral rape, anal rape and vaginal rape, ejaculation or urination onto the victim, sexual slavery, forced pregnancy and enforced sterilization. A sexual torture experience is often a prolonged ordeal for the victim, in which many different traumatic events




# Psychological evidence of torture and ill-treatment

# PSYCHIC TRAUMA

- Psychic **trauma** is an emotional injury that manifests later in life as mental distress or disorder. Many different kinds of events can cause trauma of this sort, including public humiliation, physical abuse, and abandonment. The theory of psychic trauma holds that human beings sometimes find themselves incapable of fully overcoming certain emotionally damaging experiences. An inability to resolve this mental anguish leads to problems later in life, such as increased stress, nervous habits, or interpersonal difficulties.

## 2. Common psychological responses

**499.** This section describes some of the frequent psychological responses to torture. It is not meant to be an exhaustive list, as other reactions may occur as well.

### (a) Re-experiencing the trauma

**500.** A person who has experienced torture may have unwanted intrusive memories or flashbacks, in which the traumatic event is experienced as occurring again, even while the person is awake and conscious, or recurrent nightmares, which include elements of the traumatic event in their original or symbolic form. Such episodes of reliving the traumatic event cause significant emotional distress and/or physiological reactions and the person may feel or act as if the event is recurring. The person may also experience emotional distress and physiological reactions on exposure to cues that symbolize or resemble the trauma. This may include a lack of trust and fear of persons in authority, including health professionals, as they might evoke memories of the experienced torture and its perpetrators.

### (b) Avoidance

**501.** As the memories of torture are generally accompanied by severe emotional distress, often experienced as overwhelming and uncontrollable, survivors might avoid circumstances or cues that are likely to trigger these memories. Avoidance can include places, persons, activities, conversations, thoughts, feelings or any other cue that arouses a recollection of torture. Avoidance can seriously limit the survivors' capacity to participate in daily activities and social interactions and pursue plans and projects. It may even lead survivors to avoid seeking help for their symptoms and thus inhibit treatment or therapy.

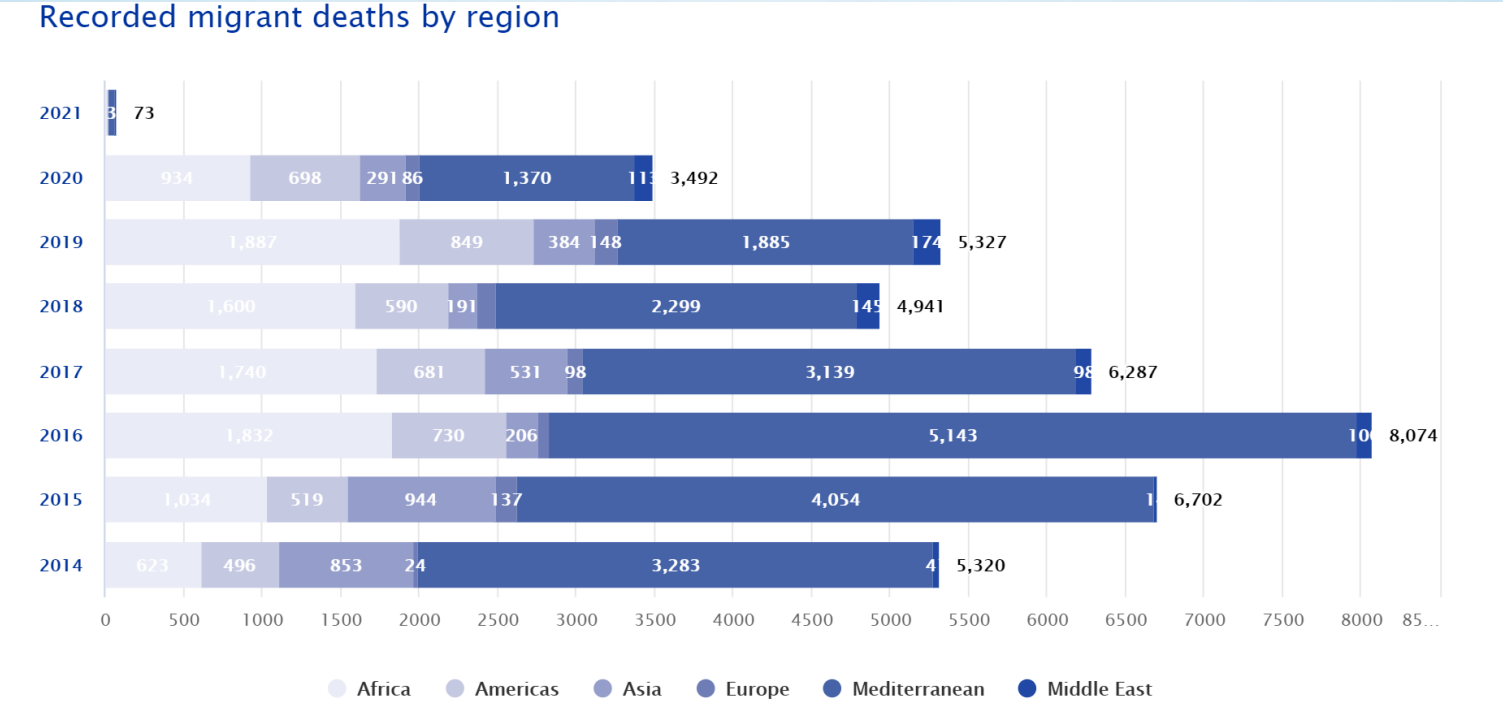
The ultimate connection between torture, the vulnerable and families

VIOLATION OF THE RIGHT TO KNOW

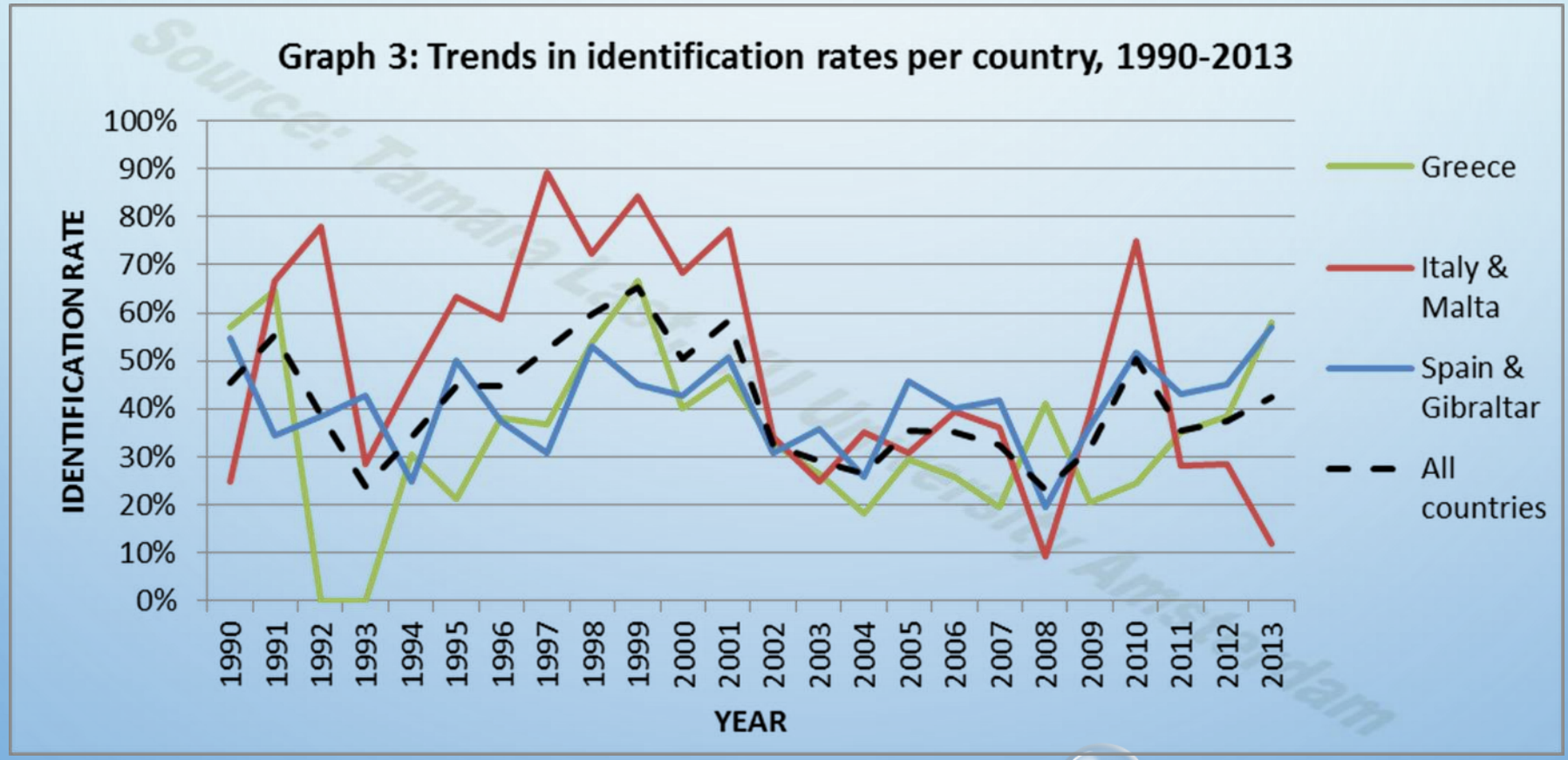
The right to identification of the dead

# WE ARE IN FRONT OF ONE OF THE LARGEST HUMANITARIAN DISASTERS OF OUR TIMES

> 30,000 KNOWN deaths only in the Mediterranean since the year 2013 (tip of the iceberg)



# AND OVER 60% ARE NOT IDENTIFIED, WITH WELL KNOWN CONSEQUENCES



# Key phrase: identification of the dead

Identification of the dead is a frequently misunderstood  ethical, cultural, administrative and legal obligation

Reasons MORAL (eg. dignity of the dead, religion, ritual, ethics)

CRIMINAL (eg. law enforcement)

CIVIL AND ADMINISTRATIVE (eg. certificates, compensation, familial issues especially widows and orphans)

cfr. Geneva convention, International Humanitarian Law, International Human Rights Law, Domestic law (?)

MENTAL HEALTH. Ambiguous loss is defined as a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present (Boss, 1999, 2004). It leads to psychological disorders, depression, alcoholism, PTSD, family conflict, depression as well as more “organic” diseases such as gastrointestinal disorders, cancer and immunological disease (Quirk and Casco 1994, Boss, 2006, ICRC 2013). Hence it is clear that the identification of the dead becomes a question of public health and of the rights to such health.

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https://doi.org/10.1007/s00414-024-03163-w

ORIGINAL ARTICLE

# Why identification matters: an explorative study on six cases of family reunification

Lorenzo Franceschetti[1] · Debora Mazzarelli[1] · Chiara Ragni[2] · Francesca Paltenghi[3] · Andrea Pecoraro[3] ·

Given the unfortunate and frequent occurrence of migrant fatalities, the demand for comprehensive legal measures to ensure proper identification and subsequent family reunification has amplified. The complexity and difficulty of these cases are enhanced by the inherent issues of jurisdiction, the differing legal codes across countries, and the practical challenges of identifying deceased migrants. If there is no corpse, there can be no crime from a legal point of view. This means that family members lose the right to be civil parties in criminal proceedings against those allegedly responsible for the shipwrecks. From an administrative point of view, in the absence of death certificates for parents or spouses, the administration of life involves serious delays and obstacles. Moreover, the lack of a death certificate for orphans of the migration phenomenon often means that they cannot reunite with relatives in Europe and may remain abandoned in countries of war. Meanwhile, their mothers, in the absence of marital or widow status, remain marginalized and deprived of their right to social life.

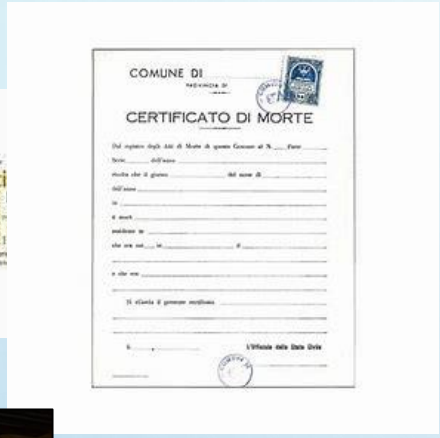
## Case 1

The first case involves a 13-year-old Eritrean boy who, following his parents' separation, relocated with his mother to Sudan in a refugee camp. His mother attempted to reach Europe via a fishing boat, perishing in the process during the shipwreck of October 3, 2013. In 2016, the boy's maternal relatives in Canada and Sweden managed to contact LABANOF staff. The ante-mortem material and the boy's genetic sample were collected and compared with profiles extracted from the 366 recovered victims housed at LABANOF. The juxtaposition of the living mother's photos with post-mortem material and subsequent genetic investigations proved crucial in establishing the familial link between the boy and the deceased woman. The resultant death certificate enabled the initiation of family reunification paperwork between the boy and his aunt in Sweden.

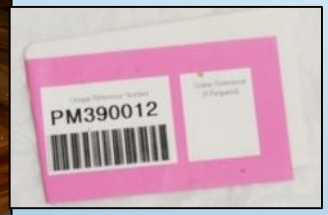

## Case 4

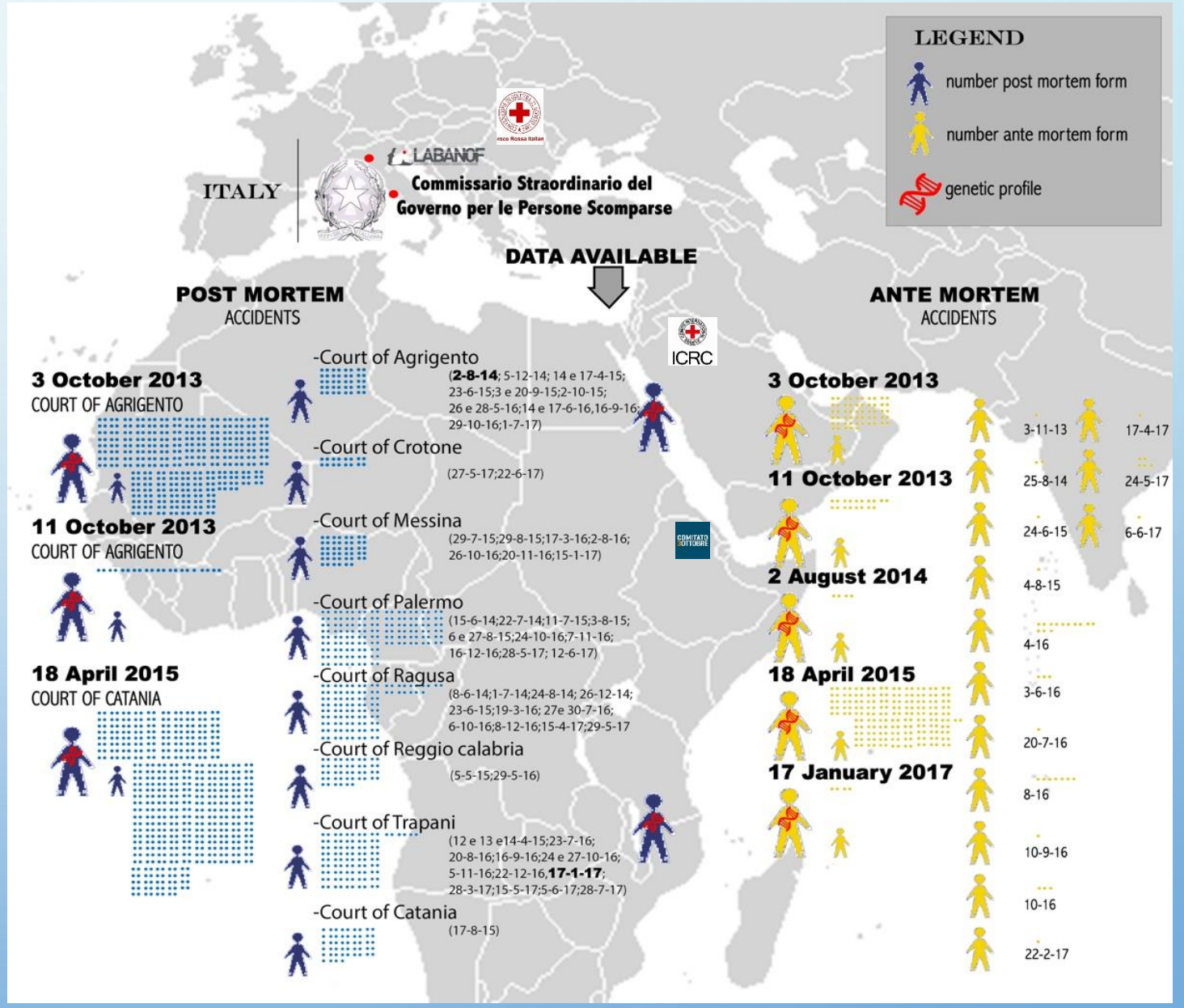
An Eritrean mother and her two children lived as refugees in Sudan following the father's departure and subsequent disappearance in the shipwreck of October 2013. The woman found herself neither being officially recognized as a widow nor having the legal freedom to work. In 2017, she reached out to the UCPS. Upon the arrival of the children's toothbrushes and salivary swabs in Italy, a successful match with the man's genetic profile was accomplished. This allowed the recognition of her status as a widow and the children as orphans.

# IL BARCONE, 18/04/2015, 1000 DEAD

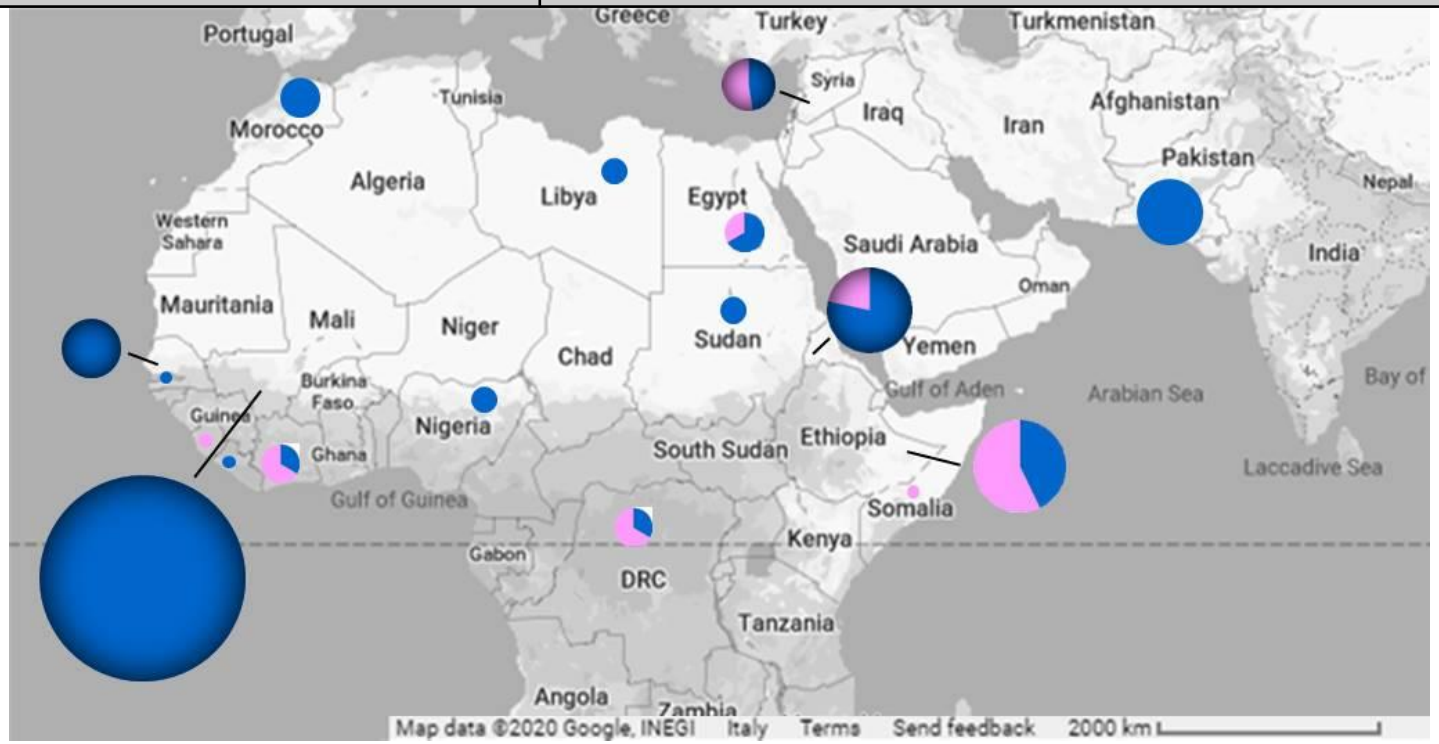




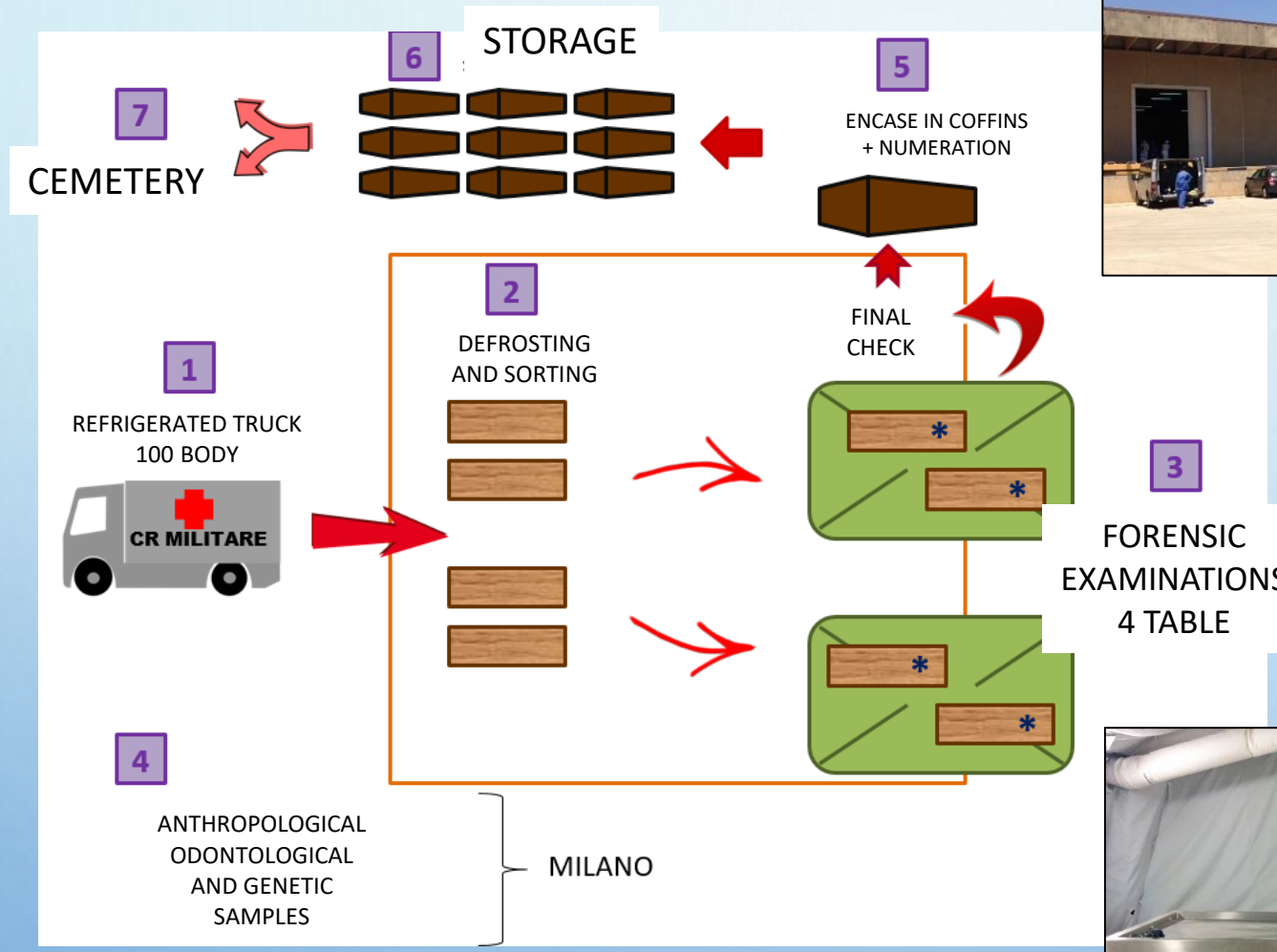
# Who is looking for them?

| | |
|---|---|
| **Number of interviewees** | 350 males +92 females (tot. 450) |
| **Degree of relationship** | 75% close relative |
| **Interview site** | 61% country of origin of the missing person |
| **Delta between disappearance and interview** | Minimum- a few months<br>Maximum- 6 years |



# IL BARCONE, 18/04/2015, 1000 DEAD

THE RECOVERY OF THE BOAT WITH THE BODIES INSIDE BY THE ITALIAN GOVERNMENT (PM MATTEO RENZI) AND LED BY MARINA MILITARE (ITALIAN NAVY- MINISTRY OF DEFENSE)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CEMETERY
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ENCASE IN COFFINS
+ NUMERATION
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DEFROSTING
AND SORTING
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CHECK
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REFRIGERATED TRUCK
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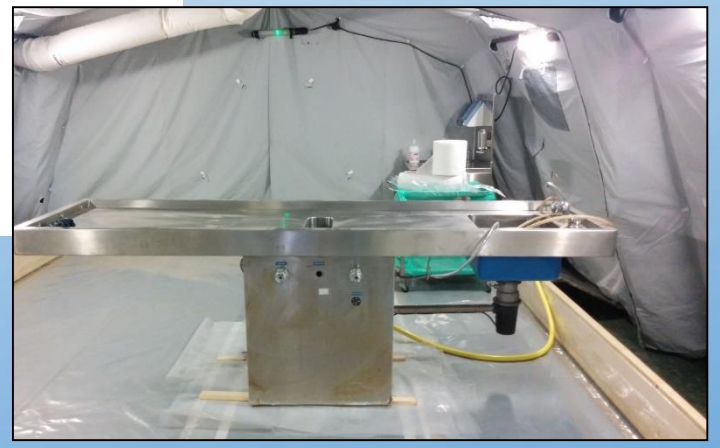
ODONTOLOGICAL
AND GENETIC
SAMPLES
MILANO

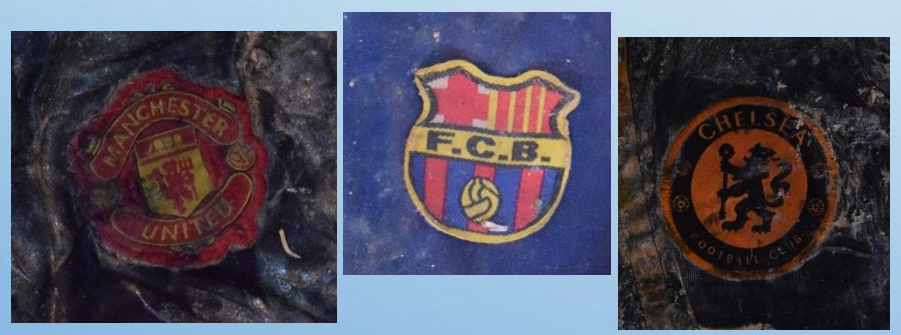


# «THEY ARE US»


PANTALONI TUTA

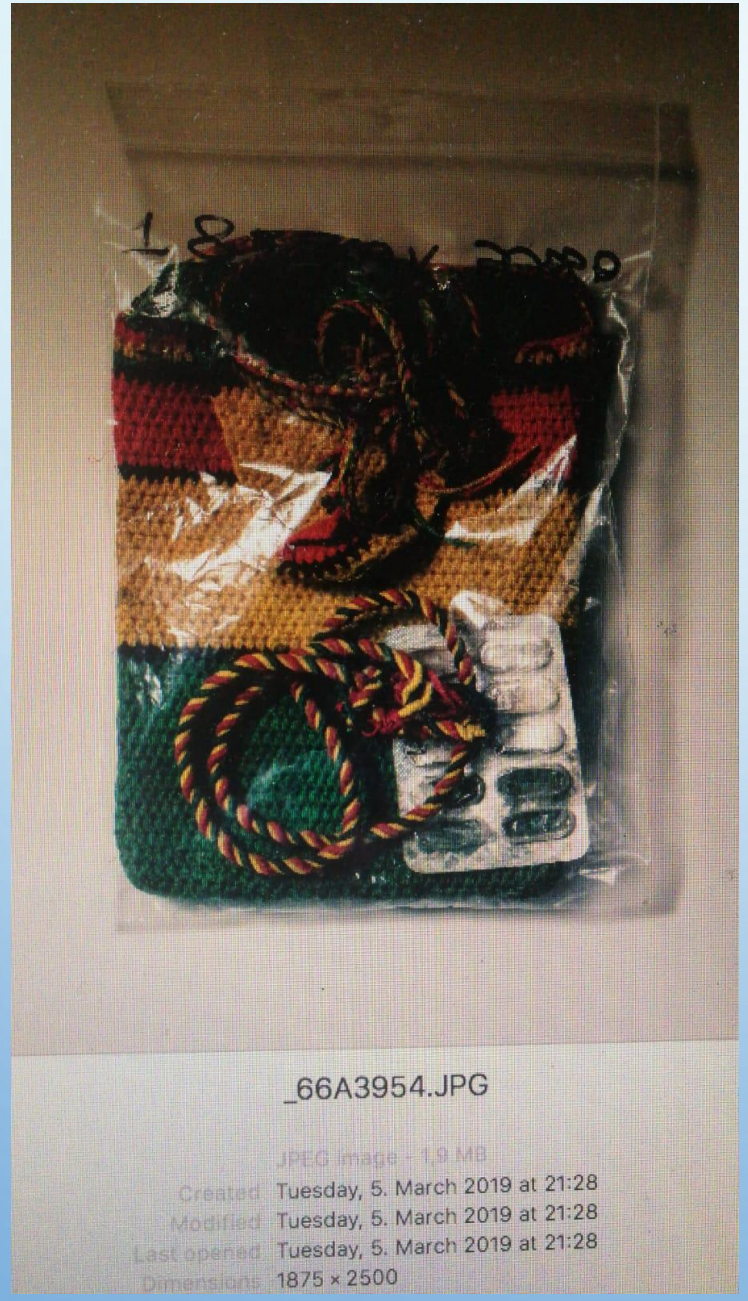
GUANTI DI SPIDERMAN

CALZINO CON FIOCCHETTO




PANTALONI/PANTALONCINI CON STEMMI SQUADRE CALCIO.


MERENDINA E LATTINA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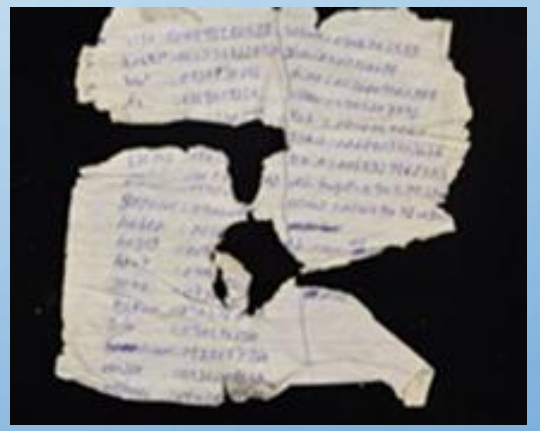

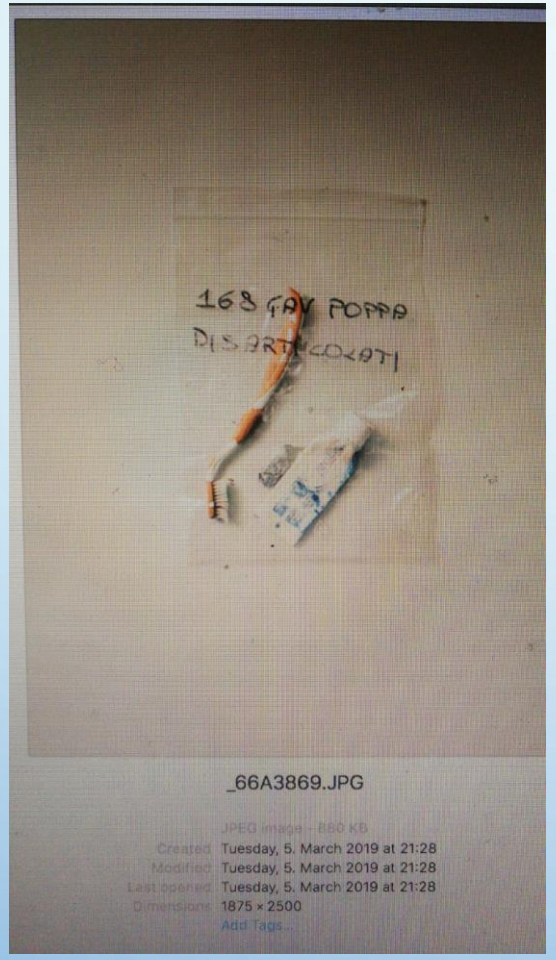
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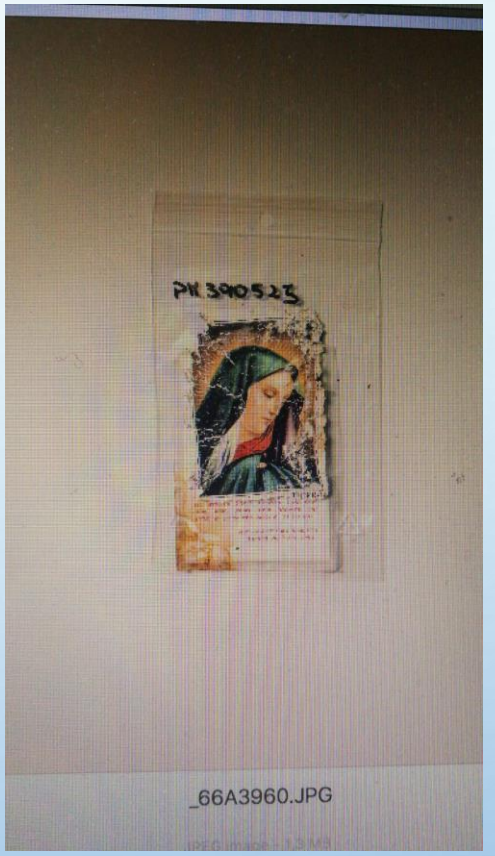
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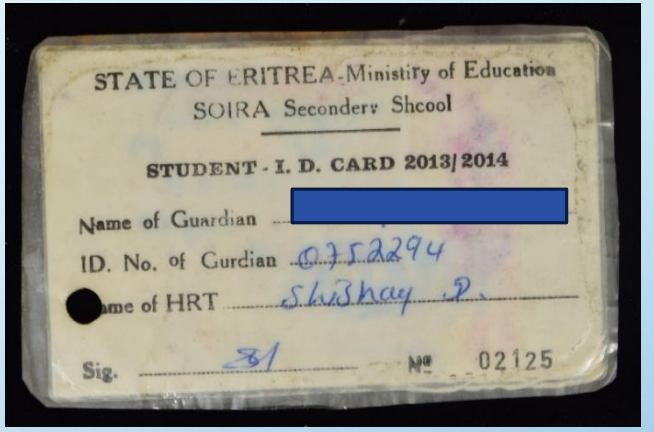
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SOIRA Secondary Shcool
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ID. No. of Gurdian 075294
Name of HRT Shishay P.
Sig.
No 02125

# Museo Universitario delle Scienze Antropologiche, Mediche e Forensi per i Diritti Umani

# A MUSEUM WHERE SCIENCE FIGHTS AGAINST VIOLENCE AND DISCRIMINATION

MANY PEOPLE KNOW THAT MEDICINE AND SCIENTIFIC DISCIPLINES CURE INFECTIONS, CANCER AND MANY OTHER DISEASES, BUT FEW ARE AWARE OF THE FUNDAMENTAL ROLE THEY PLAY IN THE FIGHT AGAINST HUMAN RIGHTS VIOLATIONS AND VIOLENCE.

# A MUSEUM WHICH SPEAKS OF VIOLENCE AND DISCRIMINATION THROUGH THE LANGUAGE OF FORENSIC SCIENCES AND MEDICINE

# HISTORY TEACHES US: WHO WERE THE VULNERABLE IN TIME? CHILDREN? WOMEN?



# SEZIONE IDENTITÀ

**identity section**

*Article 17*
*I Geneva Convention (1949)*

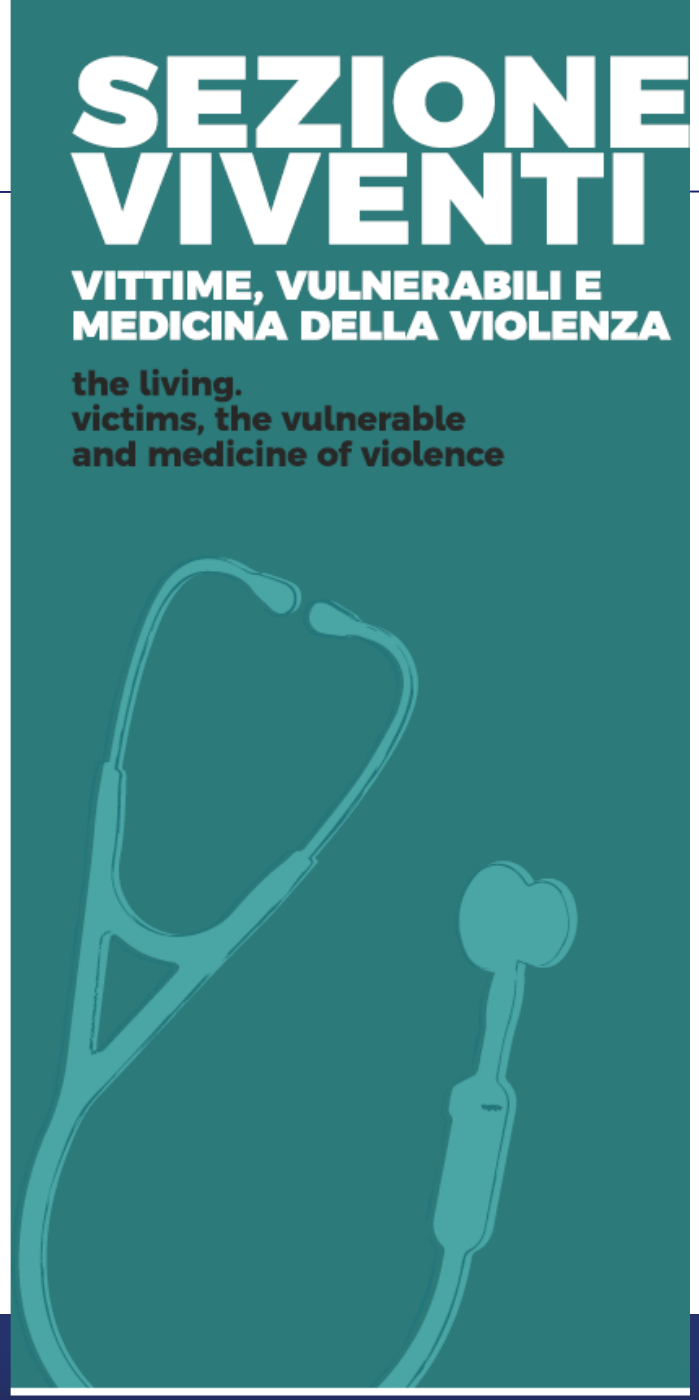
**"[...] l'inumazione e la cremazione dei morti [...] sia preceduta da un diligente esame dei corpi [...] per constatare la morte, stabilire l'identità [...]"**

***"[...] ensure that burial or cremation of the dead [...] is preceded by a careful examination [...] of the bodies, with a view to confirming death, establishing identity [...]"***

# SEZIONE CRIME

crime section


# Indirect violence and poverty




## VIOLENZA INDIRETTA E POVERTÀ

Ghandi diceva che la povertà è la peggiore forma di violenza. Gli antropologi la classificano come "violenza indiretta", il trattamento ingiusto o pregiudizievole che impedisce a persone o gruppi sociali di soddisfare i propri bisogni. La medicina, anche in questo caso, ha obblighi e potenziale per combatterla. Con riferimento ad alcune categorie molto fragili e vulnerabili come le persone senza fissa dimora, il medico è in grado di notare i primi segni clinici di mancanza di cibo e di cure adeguati e, quindi, di richiamare l'attenzione sui rischi per la salute individuale. In senso più lato, le scienze biomediche contribuiscono enormemente a migliorare le condizioni di salute in situazioni di povertà globale, implementando le strategie più efficaci e sostenibili dal punto di vista economico che la tecnologia oggi consente, sia per la diagnosi che per la terapia. Se messe a disposizione in modo uguale per tutte le persone e senza distinzioni, le scienze mediche possono, e quindi devono, contribuire a tutelare i diritti fondamentali alla vita, alla salute e all'integrità psico-fisica anche delle vittime di cui nessuno si accorge a prescindere dalla circostanza che vivano ai margini delle società metropolitane o si trovino nel mezzo di emergenze umanitarie.

## *INDIRECT VIOLENCE AND POVERTY*

*Ghandi said that poverty is the worst form of violence. Anthropologists classify it as 'indirect violence', the unfair or prejudicial treatment that prevents people or social groups from satisfying their needs. Medicine, again, has obligations and potential to contrast it. With regard to certain very fragile and vulnerable groups such as the homeless, the physician is able to notice the first clinical signs of a lack of adequate nutrition and care and, therefore, to draw attention to risks to individual health. In a broader sense, biomedical sciences contribute enormously to improving health in situations of global poverty by implementing the most effective and economically sustainable strategies that technology now allows, both for diagnosis and treatment. If made available equally to all people and without distinction, medical sciences can, and therefore must, contribute to protecting the fundamental rights to life, health and psycho-physical integrity of even the victims that no one notices, regardless of whether they live on the margins of metropolitan societies or are in the midst of humanitarian emergencies.*

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# SEZIONE VIVENTI

## VITTIME, VULNERABILI E MEDICINA DELLA VIOLENZA

the Living. Victims, the vulnerable, and Medicine of violence

# OPERAZIONE MELILLI

## Operation Melilli


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