

MEDICAL JUSTICE

Submission on the United Kingdom's Periodic Report Before the Human Rights Committee.

Medical Justice is the only organisation in the UK that sends independent volunteer doctors into immigration removal centres (IRCs) to document detainees' scars of torture and challenge instances of medical mistreatment. This ground level access means that Medical Justice has a unique insight into the United Kingdom's compliance with the International Covenant on Civil and Political Rights (ICCPR) with a special focus on its performance in relation to immigration detention.

Medical Justice would like to direct the attention of the Committee to the manner in which immigration detention is operated in the United Kingdom and argues that the below practices, in particular the shortcomings in healthcare in IRCs, raises serious concerns about the United Kingdom's compliance with the ICCPR. In particular, we wish to draw your attention to:

- The indefinite detention of immigration detainees and prolonged detention due to delays in case work;
- The continued detention of children in immigration detention;
- Inadequacies in the Rule 35 process to identify torture victims and those whose health is likely to be injuriously effected by detention. Even where individual detainees are identified as 'unfit for detention' by doctors who work at the IRC, very few are subsequently released by the UK's Home Office.
- The failure to identify vulnerable individuals such as survivors of torture, pregnant women, those with suicidal intentions, victims of trafficking, those with mental health issues or serious medical condition as unsuitable for detention;
- Overuse of segregation in detention centres
- The lack of appropriate safeguarding mechanisms for those detained in prisons under the Immigration Act.
- Inadequate access to legal representation in IRCs and for time-served foreign national prisoners held in prisons
- Inadequate healthcare provision in IRCs and immigration detainees held in mainstream prisons
- Failure to exclude those with mental health issues from detention, or to satisfactorily manage mental health conditions in detention, was recognised as contributing to degrading and inhuman treatment in breach of Article 3 of the ECHR in 6 recent court cases of mentally ill detainees.
- Inadequate handling of food and fluid refusers in IRCs

BACKGROUND

MEDICAL JUSTICE is a small charity that facilitates the provision of independent medical advice and independent legal advice and representation to those detained in IRCs. The organisation was established in 2005 and achieved charitable status in 2009. Medical Justice is the only organisation in the UK that arranges for independent volunteer doctors to visit men, women and children in immigration detention. We reach 1,000 detainees a year. The independent doctors document detainees' scars of torture and challenge instances of medical mistreatment, including lack of medication and access to hospital. Medical casework evidence informs our research and we work to identify and highlight developing trends and ongoing issues with healthcare in detention. Medical Justice works to bring the failings of the detention estate to the attention of the Home Office to effect lasting change and works with lawyers to provide them with evidence of systemic healthcare failures.

This ground level access to the day to day situation in detention centres as well as the insight into shortcomings in the provision of healthcare and safeguarding of detainees means Medical Justice is ideally placed to direct the attention of the Human Rights Committee's review of the United Kingdom's compliance with the ICCPR with a special focus on its performance in relation to immigration detention. Evidence of shortcomings in the detention system follows below.

THE INDEFINITE DETENTION OF IMMIGRATION DETAINEES AND PROLONGED DETENTION

Medical Justice would like to draw the Human Rights Committee's attention to the fact that the United Kingdom is the only European country, and one of the few countries in the world, which lacks a maximum time limit on the length of detention, thus leaving detainees subject to indefinite detention. In 2013, 44% of detainees were released back into the community after potentially having been harmed by the effects of detention in the process. Especially so for anyone suffering from mental health issues as the Royal College of Psychiatrists assert that most existing mental health disorders are likely to deteriorate significantly in detention¹. This raises serious questions about the purpose and impact of detention.

In the UK government's response to the Human Rights Committee's periodic review the government states that *"there is a presumption in favour of temporary admission or release and, wherever possible, alternatives to detention are used. Detention is used sparingly and for the shortest time necessary"*²

The UK has derogated from the European Removal Directive 2008 which sets the maximum time limit for immigration detention to 18 months. In 2013, 68% of detainees were held for less than 2 months, 24% were held for 2-6 months and a small, but significant, minority (8%) were held for more than 1 year³. 44% of those detained were granted temporary admission/release/bail and released from detention, their detention seemingly having served no purpose (at least not one proportionate to the potential harm of detention) but comes at great cost to the wellbeing of the detained individual and to public resources.

¹ The Royal College of Psychiatrists "Position Statement on detention of people with mental disorders in Immigration Removal Centres"

² CCPR/C/GBR/7 Consideration of reports submitted by States parties under article 40 of the Convention, Seventh periodic reports of States parties due in July 2012, United Kingdom, the British Overseas Territories, the Crown Dependencies, Page 117-118 -

³ Home Office - <https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2013/immigration-statistics-october-to-december-2013> (Accessed 11/07/2014)

Her Majesty's Inspectorate of Prisons (HMIP), an independent inspectorate which reports on conditions for and treatment of those in IRCs in the UK, has repeatedly voiced its concern over the prolonged length of detention. The 2010 HMIP inspection report of Harmondsworth IRC reports that the "*length of detention and uncertainty over cases caused considerable distress. Some detainees continued to be detained for long periods, despite no prospect of their imminent removal.*"⁴ In fact, HMIP was so concerned about the length of time spent in detention by some detainees that they instigated a joint thematic review by HMIP and the Independent Chief Inspector of Borders and Immigration into the effectiveness and impact of immigration detention casework. The report concluded that it "*is questionable whether the length of detention in some cases was necessary or proportionate to the legitimate aim of maintaining immigration control*"⁵.

Medical Justice is particularly concerned by these practices as prolonged or indefinite detention is an aspect of arbitrary detention set out in article 9 of the ICCPR⁶. The devastating psychological effects^{7,8} and wider human cost⁹ of indefinite detention are well documented. Medical Justice calls for an end to indefinite detention in the UK.

THE CONTINUED DETENTION OF CHILDREN IN IMMIGRATION DETENTION

Despite the government's commitment to end the detention of children for immigration purposes – Medical Justice would like to draw the Committee's attention to the fact that children are still detained in the UK, though in greatly reduced numbers, with ongoing negative physical and emotional impact.

Concerns have been raised that the Cedars Pre-Departure Accommodation at Pease Pottage near Crawley which now holds most of the children detained in the UK is merely 'detention by another name'¹⁰. In addition the HMIP 2013 inspection of the facility raised serious concerns about the continued detention of children and families: "*the distress described in this report of the families passing through the centre and its potential impact on the children involved is disturbing. Among the 42 families held in 2013, force (mostly low level) had been used on 10 occasions, suicide and self-harm procedures had been initiated 25 times and there had been two recorded incidents of actual self-harm. Detainees had been placed on constant watch on 12 occasions. A number of families were still detained on more than one occasion, which was a particularly disruptive upheaval for children, both emotionally and practically.*"¹¹

Due to the limited time spent in pre departure facilities it is difficult to get good quality data on the state of detention for children and families in the UK. According to the Home Office's own statistics¹² 206 children were detained in the UK in 2013. Though the number of children has come down, detention still affects a significant number of children. Of the children detained in 2013, only 41% were removed. This raises questions as to the validity of the detention of the remaining children in the first place.

⁴ HMIP 2010 "Report on an announced inspection of Harmondsworth Immigration Removal Centre", 11–15 January 2010, Page. 31

⁵ "The effectiveness and impact of immigration detention casework A joint thematic review" by HM Inspectorate of Prisons and the Independent Chief Inspector of Borders and Immigration, December 2012, Page 6

⁶ "Human rights and indefinite detention", Alfred de Zayas, Volume 87 Number 857 March 2005 International Review of the Red Cross, Geneva -

⁷ Prison Reform Trust (2007) Unjust deserts (on the impact of indefinite detention)

⁸ Keller AS et al. Mental health of detained asylum seekers. Lancet 2003; 362: 1721–3.

⁹ London Detainee Support Group "Detained lives. the real cost of indefinite immigration detention" January 2009 -

¹⁰ Crawley, H. (2011). "Detention by another name?" Migration Pulse, Migrants Rights Network, London, updated March 21 2011. -

¹¹ HMIP "Report on an unannounced inspection of Cedars pre-departure accommodation and overseas family escort" Prisons, January 2014, Page 5

¹² Home Office - <https://www.gov.uk/government/publications/immigration-statistics-october-to-december-2013/immigration-statistics-october-to-december-2013> - (Accessed 11/07/2014)

Medical Justice is concerned about the trauma suffered by the children in question due to their time in detention, the disruption to their lives and their family life. Medical Justice calls for the government to follow through on the 2010 Coalition Agreement to ending immigration detention of children¹³.

RULE 35 AND THE FAILURE TO IDENTIFY VULNERABLE INDIVIDUALS

The government's response to the Human Rights committees periodic review does not directly address the application of Rule 35 or the process of identifying vulnerable individuals who are unsuited for immigration detention. However, Medical Justice wishes to draw the Committee's attention to the failings of the Rule 35 process, as this is an ongoing issue that places some of the most vulnerable detainees at great risk.

The rule 35 process is a mechanism for identifying those unfit for detention and those for whom continued detention would be injurious to their health thus serving as an essential safeguard for vulnerable detainees. However, the implementation of rule 35 has been plagued by widespread and well-documented¹⁴ failings resulting in vulnerable detainees being harmed by detention. In the case of *Detention Action vs. SSHD Justice Ousterley* stated that "*Rule 35(3) reports are not the effective safeguard they are supposed to be (...). The ineffectiveness of this safeguard may be caused by the quality of the reports, the quality of the response as to whether they amount to independent evidence of torture. But I am persuaded that Rule 35 (3) reports do not work as intended, either by themselves or with Rule 34 to remove from the DFT [Detention Fast Track] those with independent evidence of torture.*"¹⁵ The ruling was in the context of the Detention Fast Track system though Rule 35 applies to, and fails, all detainees.

A recent HMIP inspections found that Rule 35 reports were "*often insufficient or formulaic, and gave limited assurance that the needs of individuals had been fully considered*"¹⁶. These failings have been regularly reported on by Independent Monitoring Boards, HMIP and NGOs but the problems persists. Similar concerns have also been raised by the United Nations Committee Against Torture in May 2013 when they heavily criticised the implementation of Rule 35 in IRCs and its failure to adequately protect survivors of torture¹⁷ - with one Committee member suggesting the rule 35 process has become an "*empty paper pushing exercise*"¹⁸

Recently, the Home Affairs Select Committee also raised concern about Rule 35 in their fourteenth report on the UKBA: "*The Agency cannot plausibly claim to take Rule 35 reports very seriously when its Chief Executive does not understand his own guidance. (...) We are concerned at the enormous gap between the number of reports received and the number of individuals released. The Agency must tell Parliament the reasons for which its caseworkers overrule the advice of medical practitioners. We reiterate our previous recommendation that the Agency should carry out an immediate independent review of the application of Rule 35 in immigration detention. Further intransigence will continue to pose a risk to individuals, as mental health issues may not be properly identified.*"¹⁹

Recognising these failings a new Detention Service Order and Asylum Instruction were introduced in late 2012 and training delivered to IRC healthcare staff in early 2013. Sadly, despite these changes Medical Justice continue to see the same failings around rule 35. A HMIP

¹³ HM Government, "The Coalition: our programme for government", Ref: 401238 / 0510, May 2010, p.21

¹⁴ Medical Justice "The Second Torture": the immigration detention of torture survivors"

¹⁵ *Detention Action v SSHD* Case No: CO/6966/2013, 09/07/2014 - Paragraph 133

¹⁶ HMIP "Report on an unannounced full follow-up inspection of Harmondsworth Immigration Removal Centre", November 2011 - Page 5

¹⁷ "Report of the Committee against Torture, Forty-ninth session" (29 October-23 November 2012) Fiftieth session (6-31 May 2013)

¹⁸ <http://www.freedomfromtorture.org/news-blogs/7329> (accessed 22/07/14)

¹⁹ "The work of the UK Border Agency", (July - September 2012): Fourteenth Report of Session 2012-13" p. 29-30

inspection in 2013, after the revised Detention Service Order, of Colnbrook reported: “the rule 35 process appeared largely ineffective. Reports written under rule 35 did not provide enough clinical opinion. Replies were timely but dismissive. In one case poor case management had led to someone being detained unnecessarily. Fifty-three rule 35 reports had been submitted by the health care department in the three months before our inspection. The reports were written by a doctor and contained body maps. Photographs were sometimes taken, but none were forwarded to the caseworker. The reports did not comment on the consistency between scarring and a method of torture. For example, one detainee claimed he was burnt on his back with cigarettes. While the scarring was documented, the doctor did not provide a comment on whether the scarring was consistent with cigarette burns. Reports were handwritten and in some cases difficult to read. Responses were prompt, but dismissive. For example, a female detainee claimed she was tortured in Iran. The caseworker stated that one of the reasons for refusing to release her was: ‘You arrived without a valid travel document’, ignoring the substantive issue.”²⁰

Medical Justice’s experience of working in detention centres confirms this assessment. Medical Justice continues to see incomplete reports with descriptions of scarring, and even body maps indicating scarring, but often here is no description of any psychological problems and no assessment of the evidence according to the Istanbul Protocol²¹.

Medical Justice has grave concerns about the way in which rule 35 is implemented and whether it is, in its current application, an effective mechanisms for ensuring that the interests of those unfit for detention, or whose continued detention would be injurious to their health, can be safeguarded. We wish to draw the Committee’s attention to a few particularly worrying aspects of the Rule 35 process:

a) Few rule 35(1) and (2) reports done

It appears that very few IRC clinicians do rule 35 (1) or rule 35 (2) reports, when detainees are at risk of suicide or likely to be injuriously affected by detention. Medical Justice frequently see cases where IRC clinicians have recorded in the medical records that they consider the detainee to be ‘unfit for detention’ or that their ‘medical needs cannot be met in detention’, but no rule 35 report is done. Often alternative reporting procedures, which do not get reported to the Home Office case worker, are utilised internally in IRCs instead. Medical Justice is concerned that the low number of rule 35 reports does not reflect the number of seriously ill detainees seen by our doctors in detention. If no rule 35 report is filed and actioned these detainees may remain in detention where their health will continue to deteriorate.

b) Inadequate responses to Rule 35 reports

| | Q1 2012 | Q2 2012 | Q3 2012 | Q4 2012 | Total 2012 | Q1 2013 |
|---------------------------------------|------------|------------|------------|------------|------------|------------|
| Rule35(1) reports in 2012 | 34 | 31 | 9 | 24 | 98 | 16 |
| Detainees relating to the R35 reports | 31 | 29 | 7 | 22 | 89 | 16 |
| Detainees released | 1 | 2 | - | 1 | 4 | 0 |

Table 1. Number of Rule 35 reports filed vs number of detainees released as a result

²⁰ HMIP “Report on an unannounced inspection of Colnbrook Immigration Removal Centre” 28 January – 8 February 2013

²¹ Office of the United Nations High Commissioner for Human Rights, Geneva, Professional Training Series No. 8/Rev.1, 2004

In the recent ruling on the legality of the Detention Fast Track system Justice Ouserley reported that a *“Home Office audit of the outcomes of Rule 35 reports showed that in only 9% of cases did it lead to release from detention, again covering all reports and all detainees”*²²

The Independent Monitoring Board at Harmondsworth reported *“In 2012 there were 125 (109 in 2011) “unfit for detention” reports made to UKBA relating to Harmondsworth detainees, of which only 12 (5 in 2011) resulted in the detainee being released from detention. We are amazed that a doctor’s judgement is overruled by case owners in 9 cases out of 10. These words and numbers do not in themselves tell the story of the real suffering endured.”*²³ HMIP also reports that *“there was little evidence of the effectiveness of Detention Centre Rule 35 procedures”* and that *“[r]esponses from caseworkers were often dismissive and none of those we reviewed led to release.”*²⁴

The figures above related to rule 35 (1), detainees who are being injuriously affected by detention. Though torture survivors can still be detained under very exceptional circumstances it appears that very few detainees are actually released following rule 35 reports. It’s astonishing that in such a vast majority of cases where IRC doctors have found individuals to be harmed by continued detention this has not led to release. Part of the reason for this may be that detention reviews remain superficial, and in many cases fail to take into account relevant information.

We continue to see cases where after a rule 35(3) report describing evidence of torture, detention is maintained on the basis that *“the doctor has not made any diagnostic findings”*, or *“we do not propose to remove you to Syria but to Iran”*, or *“the doctor has not indicated that you are unfit for detention or recommended your release”* despite this not being the relevant issue.

Recently we have seen a high number of Syrians, who have come via Third countries (mainly Italy), who are being detained pending their removal to Italy under Dublin II but whose removal has been delayed as a result of legal challenges. Many of the detainees report significant trauma in Syria and present with medical evidence supporting their account. Despite this not a single one of our Syrian clients has been released as the result of a rule 35 report.

The Home Office had promised a full audit of rule 35, including the quality of reports and the reasons given by caseworkers for overruling the recommendations of doctors. The audit was due to be completed in January 2014 but it appears to have been dropped in favour of a less comprehensive decision marking standards exercise, rather than a full audit. Medical Justice is disappointed at the new format for the auditing exercise as it may not fully answer vital questions around the decision making process and why doctor’s recommendation are so often overruled by case workers.

c) Definition of torture

Medical Justice has observed problems with the definition of torture applied both by clinicians in IRCs and Home Office caseworkers. This is despite a Home Office commitment to revert to the broader definition centred on the severity of ill-treatment suffered, rather than the narrower UNCAT definition. Despite this, in a number of cases seen by us recently, the UNCAT definition is quoted in the rule 35 responses.

We have also seen several cases where detainees reported prolonged domestic violence, or rape by people they were dependent on when fleeing where these forms of ill-treatment were

²² *Detention Action v SSHD Case No: CO/6966/2013, 09/07/2014*

²³ Independent Monitoring Board Harmondsworth *“Immigration Removal Centre Annual Report 2012 Monitoring fairness and respect for people in custody”*, March 2013, Page 13

²⁴ HM Chief Inspector of Prisons for England and Wales *Annual Report 2012–13*, Page 67

thought to be 'not torture' or 'not a rule 35 issue'.

In other cases irrelevant considerations are raised. Case X: the case worker responded to a report documenting a detainee's account to have been tortured by the secret police of his country and corresponding medical evidence: "(...) the definition of torture is: Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such a purpose as obtaining from him or a third party information or a confession, punishing him for an act he or a third party has committed, or intimidating or coercing him or a third party, or for any reason based upon discrimination of any kind" You have not stated what information was demanded of you and/or what the Secret Police wanted you to confess".

This is clearly an undesired approach, as clinicians cannot be expected to take detailed accounts of the substance of the information sought under torture or to analyse legal definitions. Other issues arise in cases where clinicians think they are expected to apply legal definitions, as the case cited below, where a confusion over the definition of torture led to delays in a Rule 35 report being completed.

In one case a detainee requested a rule 35 report soon after his arrival at the IRC but this was not done for over one month as the IRC was unsure whether ill-treatment in a third country amounted to torture for the purpose of rule 35. The detainee reported (and has medical evidence which supports his account) both torture in his country of origin and ill-treatment in a European country he passed through on his way. In their response to the report the caseworker cited as one reason for maintaining detention that the detainee had already been detained for 40 days and had not raised the report earlier.

d) Inadequate training in the Rule 35 process.

Colnbrook and Harmondsworth Immigration Removal Centres Health Needs Assessment, May 2013 states "The Lead GP has been trained in how to carry out a "Rule 35" assessment; this training was provided by the UKBA. It is not clear what training has been provided to other staff and the training received by the lead GP was not cascaded. The clinicians who went on this training reported that they found it confusing with no clear instruction given about how to apply it in practice." This report comes two years after the tragic death of Brian Dalrymple at Colnbrook IRC where the Coroner's inquest found that medical neglect had contributed to his death. Mr Dalrymple's underlying mental health issues were never diagnosed by the IRC healthcare units and no rule 35 report completed. It transpired from the inquest that the GP had not receive any induction training and had never even heard of rule 35. This raises serious questions as to the effectiveness of rule 35 as a safeguard to protect vulnerable detainees.

Medical Justice calls for the full audit of rule 35 to be reinstated, completed and published in a timely manner. Medical Justice also calls for the Home Office to carry out comprehensive training of all staff and subcontractors in the proper implementation of rule 35 in order to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention.

USE OF SEPARATION IN DETAINEE MANAGEMENT IN IRCS

Medical Justice would like to draw the Committee's attention to ongoing misuse of separation in IRCS. Medical Justice is worried about the misuse of separation in IRCS due to the well-documented negative impact separation has on the physical and mental health of individuals detained in these conditions²⁵⁻²⁶.

HMIP audit expectations on the use of force and single separation stipulates that "detainees are held safely and decently in the separation unit for the shortest possible period and for legitimate reasons only. (...) Detainees are separated with the proper authorisation and for reasons of security or safety only, not for punishment or in relation to the management of self-harm or mental illness."²⁷

Despite this, in its latest inspection of Yarl's Wood IRC in 2013 HMIP noted that though the use of separation had been reduced there were still issues with the separation process as "*initial authorisation for separation had often been given by junior managers, and in a few cases, it had clearly been used as a punishment*"²⁸. In addition, the HMIP report from the 2013 inspection of Harmondsworth IRC noted that "*Separation was being used excessively and was not in line with the Detention Centre Rules*"²⁹. The report goes on to state that detainees "*spent too long in separation without evidence of continuing risk. (...) There was high use of separation and detainees were not allowed back to normal location at the earliest possible time. Most uses were over a single night, with a move to the induction unit on the following day. The length of separation was not on the basis of ongoing risk in every case and in many cases the unit was used effectively as a 'cooling off' facility, contrary to Detention Centre rules.*"³⁰

THE USE OF PRISONS, AND PRISON STYLE ACCOMMODATION, FOR HOLDING DETAINEES UNDER IMMIGRATION POWERS.

In their report to the Human Rights committee the UK government states that the "*routine use of prison accommodation to hold immigration detainees ended in 2002. Prison accommodation continues to be used for individual detainees, particularly foreign national offenders pending deportation on release from custodial sentences, for reasons of security and control in line with published criteria.*"³¹

Medical Justice wishes to draw the Committees attention to a) the repurposing of HMP The Verne for immigration detention which means that almost one quarter of those held in immigration detention in the UK are held in prison; b) the continued use of prison style IRC accommodation for immigration detainees and c) the lack of guidelines and safeguards governing the detention of foreign national ex-offenders in prisons³².

²⁵ Physicians for Human Rights and National Immigration Justice Centre - "Invisible in Isolation - The Use of Segregation and Solitary Confinement in Immigration Detention" September 2012

²⁶ BID - "Positive duty of care? The mental health crisis in immigration detention A briefing paper by the Mental Health in Immigration Detention Project": Ali McGinley and Adeline Trude, May 2012

²⁷ HMIP: Expectations. Immigration Detention Expectations: Criteria for assessing the conditions for and treatment of immigration detainees', 2012

²⁸ HMIP "Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre" 2013, Page 27

²⁹ HMIP "Report on an unannounced inspection of Harmondsworth Immigration Removal Centre" 5-16 August 2013, Page 5

³⁰ *Ibid* Page 13-14

³¹ CCPR/C/GBR/7 "Consideration of reports submitted by States parties under article 40 of the Convention, Seventh periodic reports of States parties due in July 2012, United Kingdom, the British Overseas Territories, the Crown Dependencies" (29 December 2012), Page 118

³² London Detainees Support Group "Detained lives. the real cost of indefinite immigration detention" January 2009

- a) HMP The Verne on the Isle of Portland outside of Weymouth has recently been repurposed into an immigration detention holding facility which makes it the second largest facility for immigration detainees after Harmondsworth. However, the facility is still classified and run as a prison. This means that immigration detainees are routinely held in prisons in the UK contrary to the governments above assertion. HMP The Verne has a capacity of 580 male detainees³³ and if the full capacity of prison places (approx. 1000 beds³⁴) are utilised this would mean that almost one quarter of all immigration detainees in the UK are held in prisons³⁵.
- b) Though the routine use of prison accommodation for immigration detainees may have ended in 2002 many of the IRCs still conform to prison style accommodation. Colnbrook IRC was designed according to prison standards and is informally operated to the security level of a Category B prison³⁶. In addition, HMIP has noted that despite recommendations the new wings of Harmondsworth IRC have been completed to Category B prison specifications. In August 2010 five new residential blocks were built at Harmondsworth IRC – the HMIP reported that *“the new accommodation had been built to prison specifications, which was out of keeping with how a detainee population should be managed (...) the prison-like design of the new units is regrettable and such an environment will always be unsuitable for people held under immigration powers”*³⁷. In 2013 the HMIP reiterated their concern over the appropriateness of the use of such accommodation for those held for administrative purpose and noted that the preponderance of the use of razor wire at another centre, Dover IRC, was *“disproportionate to the security required for the population”*³⁸. The HMIP report goes on to state that security measures lacked proportionality and that the stark and austere environment is accompanied by ‘risk-averse practices’ – e.g. the practice of handcuffing nearly all detainees for outside appointments even when the individual had been rated ‘low-risk’ in the risk assessment. These practices must be seen as symptomatic of a culture of fear and disbelief within IRCs and are a key component in the creation of an oppressive regime of control which sacrifices the humanity and dignity of individual detainees to the risk-averse attitudes of the managing and custodial staff.

Medical Justice wants to highlight that conditions in IRCs in the UK are not appropriate for their purpose and prison style accommodation and practices are common in IRCs despite the generally low-risk of administrative detainees.

- c) Despite the government’s assertion that the routine use of prison accommodation was discontinued in 2002, Medical Justice wants to draw the Committee’s attention to the fact that a significant number of immigration detainees are still detained in prisons across the UK. This is of particular concern as the Detention Centre Rules of 2001 which govern the operations of IRC, and which contain within them important safeguards relating to vulnerable detainees, do not apply in the prison setting. As such, there are no guidelines for the governing of immigration detainees within the prison estate, and no dedicated mechanisms for identifying and dealing with vulnerable detainees who are unsuited for detention.

The majority of immigration detainees in prisons are foreign national ex-offenders who have completed their sentence but continue to be detained indefinitely (see discussion on indefinite detention above) in prisons pending removal from the UK. These individuals form a particularly vulnerable group. Statistics for this group are not included in the official Home Office figures, but a Freedom of Information request by the Detention Advice Service showed that in 2012, 550 detainees are detained in prisons under Immigration powers. This number has now increased

³³ Transcript Hansard Debate 11 November 2013, c433W “Verne Prison”, (accessed 22/07/2014)

³⁴ Corporate Watch - <http://www.corporatewatch.org/?q=node/4979%3f> (accessed 21/07/14)

³⁵ BID 2013 – “BRIEFING - Detention under immigration powers in UK prisons: severe restrictions on access to justice, September”, 24th 2013

³⁶ London Detainee Support Group – “Detained lives. The real cost of indefinite detention” – Page 7

³⁷ HMIP “Report on an unannounced full follow-up inspection of Harmondsworth Immigration Removal Centre”, 14 - 25 November 2011, Page 5-6

³⁸ HM Chief Inspector of Prisons for England and Wales Annual Report 2012–13, Page 67

to 1000 immigration detention spaces in prisons³⁹ e.g. on the 2nd of December 2013 957 detainees were held in prisons under immigration power⁴⁰. Details of these detainees were given by Lord McNally to the House of Lords in a snapshot of individuals detained in prison under Immigration powers on the 8th of October 2012⁴¹. This showed that there were 557 individuals spread across 83 prisons on that given day. Immigration detainees in this situation are often isolated and their detention is not governed by the same rules and safeguards that apply to other immigration detainees in IRCs. This is an unacceptable situation that puts individuals at great risk. The prison with the largest number of immigration detainees was HMP Elmley (Sheppey Cluster) with 33 detainees and HMP Pentonville with 25. As per the table below 49 prisons held less than 5 immigration detainees at the time of the snapshot, and 80% of prisons held less than 10 detainees under Immigration powers (see Table.1). This raises serious concerns as to the presences of specialist mechanisms in place to deal with immigration detainees.

| # of detainees held per prison | 1 to 5 | 6 to 10 | 11 to 20 | >20 |
|--------------------------------|--------|---------|----------|-----|
| # of prisons | 49 | 17 | 11 | 6 |

Table 2. Number of prisons holding set number of immigration detainees

The Enforcement Instructions and Guidance 55.10 lists groups of people who should not normally be considered suitable for detention, including those who have independent evidence of torture. This is because it is recognized that individuals who have experience tortured are likely to be more vulnerable to suffering damage as a result of being detained. The Detention Centre Rules of 2001 and Operating Standards set out specific guidance on how IRCs should be run to ensure the humane treatment of all detainees. The main mechanism for identifying those unsuited for immigration detention and safeguarding them against detention are rule 34 and rule 35 of the detention centre rules. Rule 34 requires each detainee to be offered an assessment with a general practitioner and rule 35 requires the GP to report on evidence of torture, suicidal intentions, or other vulnerabilities resulting in the detainee being injuriously affected by detention (Rule 35 1-3)⁴². Ideally, medical staff in IRCs should have been trained in identifying and dealing with the signs of trauma which are common in refugee and migrant communities that may have suffered pre and post migration trauma⁴³, the same is not necessarily true of healthcare staff in prisons. These safeguards do not exist in the prisons setting which may put individuals at risk of serious harm. In addition, as the prison estate has an obligation to incarcerate individuals it may not occur to healthcare, or other staff, that they should be advocating for the release of immigration detainees who are injuriously affected by detention or fulfil other rule 35 criteria.

The policy for protecting vulnerable groups from detention, as set out in EIG 55.10, applies to immigration detainees in IRCs as well as in prisons. However rule 34 and 35 only apply to IRCs. In Medical Justice’s opinion this is of great concern, as there is no reason to think that detainees vulnerable to suffer harm as a result of detention would not suffer the same level of harm whether detained in an IRC or a Prison. Our experience of seeing detainees in prisons, who if detained in an IRC ought to have been identified through the rule 34 and 35 system as being vulnerable to the effects of detention, suffer **significant harm** as a result of their imprisonment.

³⁹ Corporate Watch - <http://www.corporatewatch.org/?q=node/4979%3f> (accessed 21/07/14)

⁴⁰ Transcript of Hansard Debate 12 December 2013, c319W Immigration: Detainees, (accessed 22/07/2014)

⁴¹ Transcript of Hansard Debate 19th of October Column WA493-7 “Prisoners: Foreign Nationals”, (accessed 22/07/2014)

⁴² Home Office, Detention Centre Rules 2001, page 11

⁴³ Sinnerbrink I, Silove D, Field A, Steel Z, Manicavasagar V. Compounding of premigration trauma and postmigration stress in asylum seekers. J Psychol 1997; 131: 463-70.

Case study 1 Mr. A – Evidence from Medical Legal Report:

“In my opinion, Mr A’s mental and physical health would be significantly improved if he were released from detention; and conversely, continuing detention would harm his health still further. The setting of detention is retraumatising to people previously imprisoned and tortured, and perpetuates or exacerbates their trauma symptoms. In Mr A’s case it is very concerning that he is so under-nourished, seriously so in my opinion. It is not likely that his appetite will improve unless his mental state does, and this makes it more urgent to treat his mental health problems by all possible means, not only medication and counselling, but also through increased access to social support and release from a situation which is (to him) reminiscent of his trauma.”

Case study 2 Mr. W – Evidence from Medico Legal Report

“Mr W’s imprisonment and subsequent immigration detention are, in effect, isolating him from his social support in the community. A prison environment even in the UK will tend to contain reminders of being detained elsewhere, which may well be stressful or retraumatising for a person who was ill-treated previously while detained. Thus Mr W’s description of deteriorating mental health during his UK imprisonment is compatible with his account and with his PTSD.”

Since both Mr A and Mr W had significant scarring and psychological problems corresponding to their accounts of torture, this should have led to a review of their detention had they been in an IRC. While rule 35 is primarily about enabling a review of the decision to detain to take place, it also fairly regularly brings to light the existence of further evidence that had not yet been taken into account as part of the immigration/asylum case. While regrettably not every detainee has access to an independent medical assessment (and those who are unrepresented may not know how to access one, especially if they are in prison where groups like Medical Justice do not have a high presence), Rule 34 and 35 ensure that every detainee is offered an assessment on possible severe medical problems or evidence of torture. They are given a copy of the report, and the Home Office is informed.

Again, there is no reason to suggest that detainees in prisons are any less likely to be in need of this: they are not more likely to be represented (in fact they may be less likely to have had immigration advice given the significant barriers to contacting immigration advisors from within many prisons); and there is nothing to suggest that they are less likely than other detainees to be torture survivors or be seriously ill. At a policy discussion meeting in October 2013, the Home Office said it would not extend Rule 35 to immigration detainees held in prisons and that they “accept the risk of doing so”.

The lack of a mechanism aimed at identifying vulnerable detainees, who according to Home Office policy should be protected from detention, is especially worrying given the barriers to accessing legal and other advice. Those held in prisons under immigration powers are not subject to monthly review of their detention which contravenes the assumption of detaining for the shortest period possible. As immigration detainees are no longer detained as part of a criminal conviction but held in administrative detention the Home Office Detention Centre rules state that immigration detainees ought to be held in a “*relaxed regime with as much freedom of movement and association as possible*”⁴⁴ – this is not compatible with a prison environment. Lastly, foreign national ex-offenders in prisons do not have access to legal advice or access to legal-aid solicitors in the same way that detainees in immigration do. Limited access to legal meetings, to phones, fax machines, postage and ready transportation to bail hearing hinders legal communication and threatens effective representation of immigration detainees by both legal representatives and support organisations. In addition, the information about legal advice and legal aid representation is not as readily available as in IRCs and many face significant language barriers to accessing this information. Due to the low number of immigration

⁴⁴ Home Office, Detention Centre Rules 2001 page 3 - <http://www.legislation.gov.uk/uksi/2001/238/made>

detainees held in each prison it seems unlikely that effective mechanisms can be put in place in an appropriate and cost-effective manner.

Further details on the challenges of accessing legal representation for immigration detainees held in prisons can be found in the well-researched and detailed “Detention under immigration powers in UK prisons: severe restrictions on access to justice”⁴⁵ briefing paper by Bail for Immigration Detainees (BID). Medical Justice endorses the BID briefing as it reflects our own experiences of working with detainees in prisons.

Medical Justice wishes to draw the Committee’s attention to this untenable situation and highlight the great risk posed to vulnerable individuals by the lack of effective safeguards in prison settings. Medical Justice calls for an end to the use of prisons to detain those held under immigration powers.

INADEQUATE ACCESS TO LEGAL REPRESENTATION FOR IMMIGRATION DETAINEES

Medical Justice wants to draw the Human Rights Committee’s attention to the ongoing and persistent shortfalls in access to good quality legal representation in IRCs in the UK.

In their report to the Committee the UK Government states that: *“Detainees are informed of their right to legal representation and how they can access this within 24 hours of their arrival at an immigration removal centre. Information about legal services is readily available in all removal centres and detainees have access to free, on-site legal advice surgeries. Whilst some areas of immigration advice will be removed from the scope of Legal Aid as part of the Legal Aid reforms, this service will continue to facilitate legal advice on asylum, aspects of detention and bail.”*

Legal aid surgeries are licensed to certain providers at certain IRCs meaning that immigration detainees are restricted to selecting from these firms and solicitors. Medical Justice is concerned about the quality of some of the legal advice provided through this channel. In addition, Bail for Immigration Detainees regularly runs a survey with their clients on access to legal advice and BID’s research has found a steady increase in the number of detainees who are waiting for more than a week for a Detention Duty Advice appointment (from 32% in May 2011 to 69% in May 2013). The survey is undertaken with detainees across the detention estate. BID found that 79% of detainees that had previously been held in prisons had received no independent legal advice

Lastly, due to the changes to in Legal Aid provision there are a growing number of detainees who have arguable immigration claims but, as they cannot afford to retain a solicitor, are forced to argue their own legal cases. This is particularly difficult for foreign national ex-offenders held in prisons where they do not have access to the internet, have less peer support and more restricted access to organisations that may be able to support them in the process.

INADEQUATE HEALTHCARE PROVISION IN IRC

Medical Justice wants to draw the Human Rights Committee’s attention the ongoing and persistent shortfalls in access to good quality healthcare in IRCs in the UK.

Through our involvement with visits by independent medical doctors to detainees and our ongoing work against medical mistreatment, Medical Justice is in a prime position to observe a

⁴⁵ Briefing paper can be accessed in full here - <http://www.biduk.org/935/briefing-papers/2013-detention-under-immigration-powers-in-uk-prisons-severe-restrictions-on-access-to-justice.html>

wide range problems with healthcare provision in IRCs. We would like to draw the Committee's attention to some of these:

- Failure to identify those unfit for detention⁴⁶
- Initial health screening is often very short, interpreters are rarely used, often they take place in the middle of the night after a lengthy transfer process where the detainees may be exhausted and disoriented.⁴⁷
- Many detainees, because of past or present trauma, have complex health needs and find it difficult to access healthcare. 2/3 report feelings of anxiety and depression, many exhibit signs of PTSD.⁴⁸⁻⁴⁹
- The process of detention is itself damaging to mental health. There is inadequate provision for mental health services within detention despite high demand. The screening processes are inadequate for identifying mental health concerns despite high prevalence of depression, PTSD and self-harm. (*see section on mental health*)
- Negative psychological effects of indefinite detention further add to the negative mental health impact⁵⁰.
- Health staff lack specific training in recognising the signs of trauma and poor implementation of rule 35 leading to torture survivors and other vulnerable groups being re-traumatised. In the inquest into the death of Brian Dalrymple the Coroner found that *"the GP in Harmondsworth, a Dr Hamid, was a locum, had had no induction training, did not realise he could access wing records, and most extraordinarily had never heard of Rule 35 of the Detention Centre Rules 2001, which is the key provision for detention centre healthcare staff. It imposes a duty on medical practitioners to inform the Home Office of detainees who have medical reasons for being released."*⁵¹
- Short consultations, late screenings, poor use of interpreters, poor clinical assessments, clinical concerns not communicated to authorities, and lack of adherence to clinical protocols.⁵²
- Private healthcare contractors may have a conflict of interest. John McDonnell, Labour MP for Hayes and Harlington, has argued that there is an *"underlying conflict of interest"* in allowing a private profit making company to run healthcare provisions in IRCs⁵³. Alistair Burt, Tory MP for North East Bedfordshire, described healthcare as the weak link and argued *"If there is an issue over fitness to travel and the decision is made by a contracted company inside Yarl's Wood, what chance is there of having confidence that it has not been influenced by the contract given to the contractors to get people out of the country?"*⁵⁴
- Privatisation may lead to poor staff conditions, low pay and staffing levels, high turnover, low morale, little training and inexperienced staff which adds to poor relations between detainees and staff at IRC⁵⁵.

⁴⁶ Medical Justice Submission to the Home Affairs Select Committee (HASC) Asylum Inquiry on the Effectiveness of Detention Fast Track, 2013

⁴⁷ Medical Justice "The Second Torture": the immigration detention of torture survivors"

⁴⁸ Care Services Improvement Partnership (2008) Report on Healthcare in Private Immigration Removal Centres, Kate Andrews

⁴⁹ Faculty of Public Health "The health needs of asylum seekers Briefing statement" 2008, Sophie Haroon

⁵⁰ The Royal College of Psychiatrists "Position Statement on detention of people with mental disorders in Immigration Removal Centres"

⁵¹ Hodge, Jones & Allen – "Inquest into US citizen's death in immigration custody finds neglect" (accessed 22/07/2014)

⁵² Medical Justice "The Second Torture": the immigration detention of torture survivors"

⁵³ "Healthcare services at Yarl's Wood detention centre are still inadequate, report says", Helen Mooney, BMJ 2010;340:c1734

⁵⁴ "Demand for investigation of three doctors at Yarl's Wood. Complaint lodged with General Medical Council amid accusations of poor care at immigration detention centre", Karen McVeigh, The Guardian, Monday 22 March 2010

⁵⁵ "Privatised Prisons and Detention Centres in Scotland: An Independent Report", Phil Taylor, Department of Management and Organization, University of Stirling

- Culture of disbelief within IRCs. Culture of control, risk averse practices and even sexual abuse by IRC staff leads to a generalised atmosphere of fear and mistrust between staff and detainees. This carries over to healthcare staff.⁵⁶
- Perceived conflict of interest amongst health staff transfers detainees' mistrust of IRC staff to include healthcare staff and leads to poor doctor patient relationships. When detainees first arrive at the IRC it may not be clear to them that health staff are separate from Home Office case work and they may perceive their medical screening as an additional interrogation which adds to any reluctance to fully disclose medical conditions and past trauma. Recent revelation of the disclosure of non-clinical patient information between NHS and Home Office (12,587 requests for records made by Home Office between July 2010 and December 2013) goes some way towards substantiating these fears⁵⁷.
- Poor doctor patient relationships compounds existing avoidance behaviour due to past experiences. In addition, there may be a reluctance to disclose sensitive information due to mental health issues such as PTSD⁵⁸.
- Frequent transfers between IRCs compromises continuity of care and disrupts doctor patient relationships. This is particularly worrying where there is a failure to transfer medical records – as was seen in the death of Mr Dalrymple at Colnbrook IRC⁵⁹.
- Reported weak clinical governance⁶⁰ combined with poor accountability mechanisms has been compounded by extensive subcontracting of services which has led to 'the transfer of liability from the government to the private contractor [which] has contributed to confusion as to which party is responsible when ill- treatment or abuse occurs, often leaving nobody to answer for it. These elements compound the problems for detainees in detention centres run by the private sector'⁶¹.
- The complaints process is often complex and underutilised by detainees who fear punitive consequences subsequent harassment. When complaints are made these are often poorly investigated⁶².
- Detention of pregnant women despite low prospects of removal and insufficient healthcare provisions (*see section on pregnant women below*)
- Incidents of denial of treatment for serious conditions, e.g. HIV medication refused on occasion and test results withheld⁶³.
- Insufficient treatment and diagnosis of communicable diseases. The detainee population is at increased risk of communicable diseases such as tuberculosis yet no systematic screening is conducted⁶⁴.
- Inadequate protocols for dealing with hunger strikers and inappropriate treatment provided is putting patients at risk⁶⁵.
- Some incidents of medical mistreatment with detainees not being taken to hospital when needed and a generalised lack of capacity to deal with detainees with complex

⁵⁶ "Detainees at Yarl's Wood immigration centre 'facing sexual abuse', Mark Townsend, The Observer, Saturday 14 September 2013

⁵⁷ "Home Office accessing NHS records to help track down illegal immigrants", The Guardian, 13 July 2014

⁵⁸ The Royal College of Psychiatrists "Position Statement on detention of people with mental disorders in Immigration Removal Centres"

⁵⁹ Hodge, Jones & Allen – "Inquest into US citizen's death in immigration custody finds neglect" (accessed 22/07/2014)

⁶⁰ HMIP "HM Chief Inspector of Prisons for England and Wales Annual Report 2010–11", Page 69

⁶¹ Refugee Studies Centre "Working Paper No. 27, The Evolution of Immigration Detention in the UK: The Involvement of Private Prison Companies", September 2005, Page 24

⁶² Medical Justice (2008) "Outsourcing Abuse. The use and misuse of state-sanctioned force during the detention and removal of asylum seekers"

⁶³ Medical Justice 2011 "Detained & Denied: The clinical care of immigration detainees living with HIV" -

⁶⁴ McLaren E1, Baugh V, Plugge E, O'Moore É. (2013), "Describing the burden of infectious diseases among a population of detainees in an immigration removal centre (IRC) in the United Kingdom: a descriptive epidemiological approach." Journal of Immigrant and Minority Health. 2013 Aug;15(4):764-70

⁶⁵ Medical Justice "Briefing for the Home Office on Food and Fluid Refusers" 14th November 2013

health who are none the less held in immigration detention, e.g. elderly detainees, those suffering from disabilities, stroke victims etc.

An inspection report from HMIP of Harmondsworth IRC stated that the provision of healthcare within the detention centre gives *“cause for significant concern”*⁶⁶. In addition, a culture of disbelief and generalised risk averse practices by detention staff puts the humanity and dignity of individual detainees at risk. In 2012, these practices had tragic consequences, as reported by HMIP:

*“Disturbingly, a lack of intelligent individual risk assessment had meant that most detainees were handcuffed on escort and on at least two occasions, elderly, vulnerable and incapacitated detainees, one of whom was terminally ill, were needlessly handcuffed in an excessive and unacceptable manner. These men were so ill that one died shortly after his handcuffs were removed and the other, an 84 year-old-man, died while still in restraints. **These are shocking cases where a sense of humanity was lost.**”*⁶⁷

We are still awaiting the Coroner’s Inquest into the death of Alois Dvorzac, the 84 year old man who died whilst still in restraints after being handcuffed to his hospital bed for 5 hours. A Home Office spokesperson told Channel 4 *“that performance by the contractor running the centre has been below the high standard expected.”*⁶⁸

Medical Justice wants to draw the Committee’s attention to the fact that this is not an isolated incident. Tragic deaths in immigration detention bring to light the shortfalls in the system, including access to adequate and appropriate health care. Chief Inspector of Prisons Nick Hardwick said: *“These were truly shocking cases, and they weren’t isolated, and they reflected a culture where too often the individual human needs of the people who were being held were simply being forgotten.”*⁶⁹

The consequences of inadequate healthcare was brought into sharp relief again by last month’s verdict in the inquest into the death of 35 year old American, Brian Dalrymple, which concluded that neglect contributed to his death in detention. The previous verdict of the inquest into the death of Muhammed Shukat in detention also found that neglect contributed to his death, indicating a systemic issue around quality of healthcare in detention centres in the UK. In addition, there are a string of inquests of immigration detainees yet to be heard, including into the deaths of Khalid Shazad (52), Tahir Mehmood (42), Alios Dvorzac (84), Christine Case (40), and Bruno Dos Santos (in his 20s).

Medical Justice calls for effective mechanisms to ensure that NHS equivalent healthcare is available for all detainees in IRCs.

PREGNANT WOMEN

Medical Justice would like to draw the Committee’s attention to the ongoing detention of pregnant women in immigration detention despite the level of healthcare available in IRCs falling short of NHS guidelines.

Despite Home Office directives to only detain pregnant women in ‘exceptional circumstance’ pregnant women are detained regardless of there often being no realistic prospect of removal. The primary purpose of detention is to effect removal however, of 93 pregnant women seen by

⁶⁶ HMIP [“Report on an announced inspection of Harmondsworth Immigration Removal Centre 11–15 January 2010”](#), Page 6 -

⁶⁷ HMIP [“Report on an unannounced inspection of Harmondsworth Immigration Removal Centre”](#), 5–16 August 2013, Page 5 (emphasis added)

⁶⁸ Channel 4 News [“Left to die in British detention: who was Alois Dvorzac?”](#) Paraic O’Brien, 18th of March 2014

⁶⁹ BBC News [“Immigration detainee 'died in handcuffs'”](#) 20 January 2014

Medical Justice in Yarl's Wood IRC in 2011 only 5% were removed and the remainder released to the community. The details of this research is available in "Expecting Change: the case for ending the immigration detention of pregnant women"⁷⁰. Since the completion of 'Expecting Change' even fewer, in fact none, of the pregnant women seen by Medical Justice in detention have been removed. This raises serious questions about the purpose of detaining pregnant women when removal remains unlikely. Detention often leads to interruption of antenatal care, disrupts continuity of care and introduces additional stress to the pregnancy. In addition, healthcare in IRC falls short of NHS and NICE guidelines which is concerning as it is known that asylum seeking women have poorer pregnancy outcomes than the general population.

Medical Justice calls for an end to the detention of pregnant women.

MENTAL HEALTH

Medical Justice would like to draw the Committee's attention to ongoing failures to identify mental health symptoms in IRCs; failure by IRCs to adequately assess or to refer to specialist mental health services or to compile comprehensive, or indeed in some cases any, treatment plans for those with mental health conditions; a deterioration in the condition of those with mental health conditions when they are in IRCs; failures to pay any regard to mental health needs, or the implications for detention, in decision making about whether to detain or continue to detain; and, lastly, the effect of the failure to identify or effectively respond to mental illness in immigration detainees obstructs the process which detention is intended to facilitate, such as the determination of asylum claims or removal/deportation.

Medical Justice is concerned that the recent change in policy (outlined below) fails to take into consideration the harmful effects of detention on the mental health of detainees and the significant risk of deterioration of those with mental illness are detained. Medical Justice is extremely worried about the negative impact on individuals as the negative effects of detention are well documented leading to the deterioration of mental health during detention⁷¹, sometimes to the point of requiring hospitalisation.

a) Failure to identify detainees with mental health issues.

Despite guidelines stating that those "*suffering from serious mental illness which cannot be satisfactorily managed within detention*"⁷² should only be considered suitable for detention in very exceptional circumstances individuals with unmanaged mental health issues are still detained.

This is in part due to inadequate screening processes. Currently mental health issues can be identified during the Home Office Screening interview where the basic details of an asylum claim are recorded. However, these interviews are conducted in a public setting, are often very short and are not conducive to disclosure of sensitive information such as mental health issues. The second instance where mental health issues should be picked up is in the rule 34 health screening which should take place within two hours of arriving at a new detention centre. However, these health screenings are often very short, are often conducted without the help of an interpreter, may take place in the middle of the night following a long and exhausting transfer from another centre and take place in the context of being 'processed' into the detention centre so that distinctions between custodial and health staff is often unclear. Again,

⁷⁰ Medical Justice 2013 "Expecting Change: the case for ending the immigration detention of pregnant women" -

⁷¹ Keller AS, Rosenfeld B, Trinh-Shvrin C, Meserve C, Sachs E, Leviss J, et al. Mental health of detained asylum seekers. *Lancet* 2003; 362: 1721-3.

⁷² Home Office *Enforcement Instructions and Guidance* (June 2014 update)

these conditions are not conducive to the disclosure of sensitive information such as mental health issues. Lastly, mental health issues could be reported through a rule 35 report at any point during detention – the shortcomings in the rule 35 process have been discussed in detail above.

Lacking proper training in the identification of mental health issues for both custodial and healthcare staff at IRCs means staff sometimes fail to correctly identify mental health issues and instead ascribe symptoms of mental health issues to detainee behavioural issues – recording strange, unusual or bizarre behaviour in case files without questioning whether there may be underlying mental health issues accounting for such behaviours. In addition, the prevailing culture of disbelief means that staff often ascribe behaviour indicative of mental health issues to intentionally disruptive or manipulative behaviour – such behaviour is handled through disciplinary sanctions such as removing the detainee from association and segregating them under rule 40 or rule 42 of the Detention Rules. Separation may further exacerbate mental health issues (see further discussion on use of separation above).

In addition, there is a lack of clarity between the role of custodial and health staff in the management of mental health issues for detainees – e.g. self-harm and suicide is managed through Detention Services Order (DSO 6-2008) and is the responsibility of the Assessment Care in Detention Teams (ACDT) which is operated by custodial staff rather than healthcare staff. There is also additional evidence that ACDT do not catch all those at risk and that the process itself is seen as invasive and damaging to its intended audience who may take steps to avoid the attention of the ACDT thus undermining its effectiveness. *“Only 9 participants reported currently being on an ACDT plan when 35 on the HSCL-D reported thinking about suicide over the past 7 days (...) There was some indication during the qualitative data collection that residents preferred not to talk about self-harm/suicide because they found being ‘on the watch’ very invasive.”*⁷³ Healthcare staff may not have access to ACDT records and, thus, cannot make the connection between self-harm/suicidal intentions and other symptoms.

*“Between 2011 and 2012, there were four separate cases in which the High Court found that detainees suffering from mental illnesses were subject to inhuman and degrading treatment in breach of article three of the European Convention of Human Rights. Two had been held at Harmondsworth IRC shortly before our inspection in November 2011. At our inspection of Harmondsworth we found that detainees’ mental health needs were under-identified, and staff described the inpatients department as a ‘forgotten world’. There had been no mental health needs assessment, no staff training in mental health awareness and there was no counselling service, despite increasing numbers of detainees with high anxiety and low-level depression.”*⁷⁴

Failure to recognise the potential involvement of mental health issues can lead to damaging delays in the diagnosis and treatment of mental health issues – sometime with tragic consequences as in the recent Coroners Verdict on the death of Brian Dalrymple at Colnbrook IRC shows. The verdict ruled that Mr Dalrymple’s death was due to “natural causes contributed to by neglect”. The inquest demonstrated that a failure to diagnose underlying mental health issues and a “shambolic” handling of medical records contributed to Mr Dalrymple’s eventual death from natural causes whilst held in segregation. Further evidence of mental health issues not being taken seriously in IRCs emerged from the inquest when *“two officers said that they were not concerned about people in Harmondsworth “muttering to themselves”, because a lot of people in Harmondsworth did that. It was accepted in questioning that might mean all those people were exhibiting signs of mental illness.”*⁷⁵

⁷³ “Quality of Life in Detention: Results from MQLD Questionnaire Data Collected in IRC Yarl’s Wood, IRC Tinsley House, and IRC Brook House, August 2010 - June 2011”, Mary Bosworth and Blerina Kellezi, Centre for Criminology, University of Oxford, February 2012. (accessed 24/06/2014)

⁷⁴ HMIP “HM Chief Inspector of Prisons for England and Wales Annual Report 2012–13”, Page 67

⁷⁵ Hodge, Jones & Allen – “Inquest into US citizen’s death in immigration custody finds neglect” (accessed 22/07/2014)

This month saw the sixth High Court judgement finding that immigration detention amounted to ‘inhuman and degrading treatment’ in breach of article 3 of the European Human Rights Convention – several of these were Medical Justice clients, including the most recent case of a woman who entered the UK with a valid visa, who had no history of mental illness before her detention, but subsequently became suicidal and psychotic during 17 months of detention.

b) Failure to establish appropriate treatment plans for mental health issues in the detained population.

In August 2010 there was a subtle change in wording of the Enforcement Instruction and Guidance (chapter 55.10) policy on detention of those with mental health issues which effected a drastic change in policy. From stating that persons with mental illness would “*normally be considered suitable for detention in only very exceptional circumstances*”⁷⁶ the wording now reads “*those suffering from serious mental illness which cannot be satisfactorily managed within detention*”⁷⁷. This amounts to a change from advocating detention for those suffering from mental health issues only in exceptional circumstances to advocating detention for all conditions that can be satisfactorily managed in detention.

The current wording hinges on key phrases such as ‘serious mental illness’ and ‘satisfactorily managed’. The Royal College of Psychiatrists Working Group on Detention “Position Statement on detention of people with mental disorders in Immigration Removal Centres”⁷⁸ examines each of these in detail and argues that:

- i. the wording ‘*mental illness*’ is limiting and excluding. The wording should be changed to mental disorders – which include those with intellectual disabilities and those with neuro-developmental disorders such as e.g. autism – as reflected in the Mental Health Act of 2007⁷⁹ in recognition of the mental health needs of the population.
- ii. the wording ‘*serious*’ illness was interpreted in the judgement of R (Das) v Secretary of State for Home Department as: “*To qualify for the protection afforded by the policy, a mental condition must be such that a detainee has a serious inability to cope with ordinary life to the level, or thereabouts, of requiring in-patient treatment, or such that there is a real risk that detention could reduce the sufferer to that state*”⁸⁰ The Royal College argues that in modern therapeutic models hospitalisation would only be recommended in extreme cases and there is a moral imperative (recognised in the Mental Health Act and in the Capacity Act⁸¹) that treatment should take place in the least restrictive environment possible. The Royal College of Psychiatrists therefore considers it “*inappropriate to define seriousness of mental illness on the basis of need for admission*” instead “*As the Royal College of Psychiatrists, we would like to define ‘person suffering from serious mental illness’ as a person with a mental disorder that significantly impairs their ability to engage constructively in society, to care for him/herself and /or to work. We believe it is likely that any person with mental disorder would deteriorate to a level of ‘serious mental illness’ in the conditions of detention, which would also be associated with an increased level of emotional suffering*”⁸².

⁷⁶ Enforcement Instruction and Guidance (EIG) chapter 55.10 – version 9

⁷⁷ Enforcement Instruction and Guidance (EIG) chapter 55.10 – version 10, 2010

⁷⁸ The Royal College of Psychiatrists “Position Statement on detention of people with mental disorders in Immigration Removal Centres”

⁷⁹ Mental Health Act 2007

⁸⁰ Das, R (on the application of) v Secretary of State for the Home Department & Ors [2014] EWCA Civ 45 (28 January 2014 (accessed 22/07/2014))

⁸¹ Mental Capacity Act 2005

⁸² The Royal College of Psychiatrists “Position Statement on detention of people with mental disorders in Immigration Removal Centres”

- iii. *'satisfactory management'*: The Operating Standards 2003 states that "All detainees must have available to them the same range and quality of services as the general public receives from the National Health Service."⁸³ Therefore, the treatment for mental disorders should be commensurate with that offered to the general public under the NHS. Research shows that rates of mental disorders are higher in asylum seeking and refugee populations due to considerable pre and post migration stressors⁸⁴⁸⁵ – and rates of anxiety, depression, self-harm and PTSD have been shown to be much higher in the detained population than in other incarcerated populations. Despite this the provision of mental health services is less than in the community. Current NHS mental health service is focused not just on the treatment of symptoms of mental disorder but on the recovery, relapse prevention and the successful reintegration in society of sufferers. "Successful treatment of mental disorders depends on the patient being in a stable situation, having a good support network, frequent monitoring, access to specialist services and a trust relationship between patient and doctor. Such a plan should also aim to minimise any biological, psychological or social factors that contribute to the maintenance or worsening of the individual's mental health"⁸⁶ None of these conditions can be easily fulfilled in the immigration detention setting which is characterised by fear and uncertainty⁸⁷ and has been shown to have a deleterious effect on mental health and recovery rates⁸⁸ compared with those in the community. Detention adds another layer of stressors: loss of liberty, uncertainty over deportation, unpredictable events, social isolation, fear of abuse by staff, riots, forceful removal, hunger strikes, self harm, the indefinite period of detention, a culture of disbelief in detention which carries over to healthcare staff and the absence of specialist psychiatric services in detention centres. Detention cannot be seen as an alternative to hospital as detention is not set up to be a therapeutic environment. In fact, they go to state that "the very fact of detention (which, unlike imprisonment, has no punitive or retributive function) mitigates against successful treatment of mental illness"⁸⁹ thus raising serious question about whether or not there can ever be satisfactory management of mental disorders within the context of detention. It is not appropriate to consider detention as an alternative or equivalent to hospital. Detention centres are not designed to be therapeutic environments and it would not be possible to provide the same level of care for those suffering from mental disorders in immigration detention settings as would be provided for the general population in the community.

Medical Justice calls for a return to the previous Home Office policy which stipulated that those suffering from mental health issues should only be detained under exceptional circumstances.

FOOD AND FLUID REFUSAL IN IMMIGRATION REMOVAL CENTRES

Medical Justice would like to draw the Committee's attention to shortcomings in the current practices related to detainees who refuse food and fluids in detention centres.

The most recent Detention Service order on Food and fluid refusal in IRCs⁹⁰ sets out guidelines for how food and fluid refusing detainees should be handled in an IRC however, they

⁸³ Detention Services Operating Standards Manual for Immigration Service Removal Centres, Page 34

⁸⁴ Sinnerbrink I, Silove D, Field A, Steel Z, Manicavasagar V. Compounding of premigration trauma and postmigration stress in asylum seekers. *J Psychol* 1997; 131: 463–70.

⁸⁵ Porter M, Haslam N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. *A meta-analysis. JAMA* 2005; 294: 602–12.

⁸⁶ The Royal College of Psychiatrists "Position Statement on detention of people with mental disorders in Immigration Removal Centres"

⁸⁷ Melanie Griffiths Living with Uncertainty: Indefinite Immigration Detention, *Journal of Legal Anthropology* (2013) Vol. 1, No.3: 263-286

⁸⁸ K.Robjant, R.Hassan & C.Katona (2009) Mental health implications of detaining asylum seekers: systematic review, *The British Journal of Psychiatry* (2009) 194: 306-312, doi: 10.1192/bjp.bp.108.053223

⁸⁹ The Royal College of Psychiatrists "Position Statement on detention of people with mental disorders in Immigration Removal Centres"

⁹⁰ Detention Services Order 03/2013 Food and Fluid Refusal in Immigration Removal Centres: Guidance -

lack the required detail in key areas to be a useful guide for action. The guidelines place a welcome emphasis on establishing whether or not the detainee has capacity but lack detailed information on how this should be done. A simple statement of 'has capacity' or doesn't have capacity' is not sufficient and a proper capacity assessment according to GMC guidelines and needs to consider the detainee's ability to comprehend relevant information (such as the possible consequences of food refusal), retain it, weigh it up in order to come to a decision and communicate this decision (see Mental Capacity Act 2005 and Code of Practice)

The guidelines fail to make a sufficiently strong link between food and fluid refusal and mental health issues. In our experience mental health issues are often involved when individuals refuse food and fluids, indeed research showed that 23% of vulnerable individuals react to stress by refusing food and fluids and detainees refusing food and/or fluids often have complex medical and mental health histories. More than 50% seen by Medical Justice doctors have a history of self-harm or suicide attempts, many were on anti-depressant medication and a significant number had been on anti-psychotic medication. All reported hopelessness. This coupled with the impact of starvation on mood and ability to make decision means that it would be appropriate to arrange psychiatric reviews for all detainees refusing food and/or fluid.

Medical Justice is concerned that medical assessments of detainees refusing food and/or fluid is carried out by regular IRC medical staff. Food and fluid refusal is a complex specialist subject which ought to be handled by a multidisciplinary team with regular clinical review meetings. We are also concerned about cases where detainees refusing food and/or fluids have been released on short notice and left at A&E departments in a weakened state with no proper medical handover notes for external healthcare staff to ensure proper continuity of care. The guidelines state that regular updates should be sent from IRC healthcare to the Home Office case worker however, there are currently a number of mechanisms for doing this which results in lack of oversight over the current medical situation as this information may be recorded in a number of places. All such communication should be submitted in the form of a rule 35 (1) report which then forms part of the detainees record, is auditable and easily accessible to all engaged in the detainees case or care.

Medical Justice calls for the referral of all food and/or fluid refusing detainee for psychiatric review to assess involvement of mental health issues, for the establishment of clinical review meetings with oversight over care of detainees refusing food and/or fluids, improved communication between healthcare staff and Home Office case workers through rule 35(1) reports on food and/or fluid refusers, and proper medical handover to external healthcare providers upon discharge.

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