Evidence for the Inquiry into the use of Immigration Detention - Dr Danny Allen

Preamble

1. I am a consultant adult and addictions psychiatrist – currently in private practice. I retired from the NHS in 2011 and worked for 1½ days a week in Colnbrook IRC between April 2011 and the end of March 2012. I was the sole employee, there, of Partnerships in Care, a respected major provider of psychiatric services throughout the country.

2. My employment ended formally in August 2012 when Partnerships in Care withdrew from the contract. This followed on directly from verbal information given to my manager where he was told that I was not to enter the establishment as the governor of the IRC would not allow it.

3. Neither UKBA nor Serco (the then contract holder) would give any written reasons for their decision which Partnerships in Care clearly found totally unacceptable. The decision followed a number of cases where I had stated that people were either unfit for deportation or for detention which the UKBA had not been happy about.

4. My evidence is based on my experience of working in the healthcare department of immigration detention. I am aware (as I now sit on the Health & Justice Clinical Reference Group of NHS England) that changes are afoot due to the NHS taking over commissioning.

The Healthcare Centre Environment

5. The Healthcare Centre is on two floors. Most activity occurs on the lower floor which includes offices and consulting rooms. There are 5 'inpatient' beds on the floor above, the ingress and egress to which were dictated by Serco Civil, albeit sometimes taking into the advice of Serco Healthcare.

6. The building is fully sealed and theoretically air-conditioned. However summer temperatures can often be too warm for comfort.

Confidentiality of Medical Information

7. Detainees were all expected to sign a so-called consent form which ostensibly allowed UKBA to have access to all their medical records, extant and future. They were expected to sign this form at the point of the screening interview – in other words within 2 hours of admission, often in the middle of the night.

8. UKBA would regularly request, look at and quote what I considered to be confidential medical notes or demand information from me based on them, often attaching this so-called consent as support for this request.

9. The normally accepted standard of informed consent where the clinician discusses with the patient what is being requested to ascertain their understanding was absent.

10. Indeed the shared belief was that it was for the UKBA to obtain consent, hence a signature on a piece of paper presented by the UKBA was the ideal method espoused by staff for the release of records, which were often then used by the UKBA in court proceedings.

Staffing

11. Serco provided the nursing staff. Approximately half were RMNs but there seems to be no real differentiation in their roles, which were all very much geared to the security needs and on meeting targets.

12. In my estimation most of the RMNs were 'burnt out' and did not function as such. They saw patients, wrote in the notes, but did not triage and thus they

asked me to see more people than I could reasonably assess in the time available.

13. GPs were on a separate contract and most were from the Farnham Road Practice. My assessment is that they were excellent and very easy to liaise and discuss patients with.

14. There was also a counsellor who was also excellent and we had a very good working relationship with good note keeping and cross-referrals.

15. The (untrained) pharmacy assistants were also excellent and very helpful and on the ball with regard to controlled drugs in particular. I met the pharmacist on a couple of occasions but she did not play any day to day role from my point of view.

Clinics

16. Due to medication rounds in the early part of the day and 'lockdown' around 12pm one is lucky to have 2 hours to see patients. The first hour can usefully be filled with admin work though.

17. Theoretically the clinics are 'set-up' by the RMNs – I have no idea why this cannot be done by an admin person. In practice having all the notes (we still used paper files,) the drug charts and a clinic list ready was the exception.

18. It would be an exceptional clinic where I did not have to search for notes or drug charts myself. Nurses regularly dematerialised during and in-between consultations and sometimes another one appeared in their stead. They rarely if ever introduced themselves to patients – I had to do this.

19. Theoretically they were meant to sit in on the clinics and handover. In practice they were often called away and there was a no feeling of group-

working, continuity of care or 'ownership' of clinical problems amongst psychiatric staff. In other words no team working which is the norm in the NHS.

20. Because of the failure of RMN triage I saw, on average 8 patients per session, meaning that each has no more than 15 minutes – often much less as there were frequent delays.

21. In effect I was doing primary care psychiatry for much of the time, triaging people towards the counsellor, sometimes asking for RMN monitoring (without much hope this will actually happen – due to the absence of communication) or simply noting the absence of mental illness.

Language

22. Maybe 50% of detainees spoke good enough English for a very basic consultation. Perhaps 20% spoke it well enough for an in depth interview. All translation is via 'The Big Word', a telephone service.

23. The standard of translation can be quite good but the method is less than ideal. Often I had to get the interpreter involved even when the individual stated he can speak English because his grasp of the language is insufficient.

Treatment by the Psychiatrist

24. Most treatment was outpatient based but some people were 'looked after' in healthcare beds. There was little real advantage to this as the officers there had no extra training and in most cases (with honourable exceptions) did not understand that observations they may make could help the psychiatrist understand what was going on with the person.

25. Special Units

26. Colnbrook has a number of special units (Rule 40, rule 42, AIU, ENU). Doubtless they have deep significance for the security staff but from our point of view they are simply 'somewhere else' other than the 'wing'.

27. However being moved there often made security staff believe that the person's behaviour was more likely to be due to mental disorder meaning I was more likely to be 'required to see them'. Most were personality disordered.

28. Malingering

29. There is huge perceived value in having a psychiatric diagnosis, both in terms of any immigration case and a perception that this will get the individual out of detention. It was absolutely normal for people to complain of 'voices' without any history to back this up.

30. While some appeared to represent pseudo-hallucinations on the background of a personality disorder, many were malingerers in the DSM-V (Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association, 2013) sense of goal-orientated simulation of illness and were extremely unhappy when no medication was prescribed.

Distress

31. At least 50% of the people I saw were deeply and genuinely distressed human being with no mental illness. If they made unreasonable demands, as many did, I ended up dismissing them because there was nothing I could do to satisfy them as I would not prescribe inappropriate medication.

32. If they were distressed and passive I tried my best to say nice things, offer them counselling and maybe offer to see them again. But this was not psychiatry.

Personality Disorder

33. Perhaps half the detainees were convicts so antisocial personality disorder was common. This combined with malingering was a recipe for angry outbursts which occurred about once a week with officers needing to remove such people from my office.

34. Borderline Personality Disorder was also common and accounted for some of the people presenting with pseudo-hallucinations. The boundary of malingering at one end and true psychosis at the other was hard to discern in that environment, with insufficient background information or nursing support.

PTSD

35. Many people had clear symptoms of PTSD and there was no doubt in my mind that incarceration made them worse or triggered nascent disease. Not much helped and counselling is not a treatment though some benefitted from talking.

36. Depression

37. A few people were truly depressed and some had a convincing past history. But more had some form of dysthymia secondary to their circumstances which started in the community where being an asylum-seeker for years on end is an extremely dispiriting experience. Few responded meaningfully to antidepressants but no-one was ever happy to stop them either, so powerful

is the shared idea that treatment for mental disorder can prevent deportation.

Psychosis

38. One well treated schizophrenic was admitted after being discharged from a forensic unit. His consultant was angry with me for putting him into Colnbrook (I am not overegging this). The only way he could be managed was for me to enlist the aid of a community consultant and his pharmacy to prescribe his Clozapine as we were not a hospital and therefore cannot.

39. There were several other cases of schizophreniform illness. One responded well to medication and was quickly deported; others took medication voluntarily but some required treatment under section 48 of the Mental Health Act 1983 and this took a long time to organise.

40. A common problem is the man with a circumscribed illness who causes no real management concerns. If he takes medication voluntarily the problem is solved to everyone's satisfaction but if not there are dilemmas:

41. One man appeared to have a hugely complex delusional system. I had no doubt he was schizophrenic. But he had spent months in a forensic unit where they had concluded he was feigning illness. Furthermore he was so happy with his grandiose delusions and was causing no-one any harm. So 'nothing' was the best thing to do.

42. Another man was in detention for years. It was generally agreed that he had a schizoaffective disorder but was happy with his delusions and was only occasionally depressed. He had been detained so long because he would not admit he comes from the country others think he is from.

43. His solicitors went to Court and they said he should be admitted to hospital. The hospital did not want him and the community consultant saw him and said he was not even mentally ill.

44. An independent report was commissioned which agreed he was schizoaffective. But we were all concerned about this man's seemingly indefinite detention and his limited ability to challenge this secondary to illness

45. There was a man who believed a device was implanted in his head which interfered with his thoughts and concentration. Anyone could see he was mentally ill.

46. However he was mild mannered (until you suggested he was mentally ill) and the hospital would not admit him. Effectively, in that environment, he was untreatable and must be deported (or not) with his mental illness.

Addiction

47. Generally this was the most simple and satisfying part of the job. Especially since the Department of Health indicated the range of options we had (including maintenance). As a consequence conflicts with UKBA reduced after we had a meeting agreeing guidelines.

48. However one of the cases which enraged UKBA at the end was a man who was deemed unfit for deportation by the GP for suspected TB and by me due to unstable drug use. I was criticised for not following IATA guidance (I checked these and they were much stricter than the DoH guidance – not allowing anyone using drugs to fly).

The Interface with UKBA

49. The core of the job was looking after people with serious mental disorder/addictions which can be effectively treated for so long as they remained in detention.

50. However there were many occasions where the UKBA asked me for information to use in court proceedings and this was a major bone of contention as I saw this as outside my role and, as someone who did a lot of medico-legal work outside this environment, I was aware how much time, preparation and information one report required (longer than my entire half day session inevitably).

51. It was inevitable that there would be conflicts. For example I once felt someone was unfit to fly under any circumstances because he had a marked specific phobia which failed to respond to a properly delivered psychological treatment programme in the past. UKBA was not willing to consider another form of transport.

52. I sometimes stated that someone was unfit to detain because their PTSD was so exacerbated by detention that they were suicidal. I got the very distinct impression that my comments were not appreciated.

53. Real problems arose when I was effectively asked to be the UKBA's assessor. In this scenario – which is clearly what the UKBA expected of me but which I feel is completely unethical, they wanted me to assess people without telling me why.

54. And what I found out was that, in many cases it was because they were fighting a judicial review. So, sometimes unbeknown to me, they have been presented with an expert report and want me to provide a response without showing me the information they had.

55. This could be appropriate – but generally only where the person was someone I was treating and had also given informed consent. This meant explaining my clinical opinion to them and how this information may be used if given to the UKBA.

56. Unfortunately the UKBA thought they could either look at the medical notes (because of that initial consent form) or, in response to a fresh consent form, demand that I produce a report (which was not my role there – see above).

57. Problems often occurred because I had seen someone and not found any reason to treat them but, unbeknownst to me, the UKBA had judicial decisions expressing concerns about, for example, suicidality, which they did not share with me and then demanded information from me which I was not in a position to give because I was not treating that patient.

Training

58. I am an experienced psychiatrist who had given up full time NHS practice. I was interested in the job both for what I perceived it to be, namely adult psychiatry and addictions.

59. The job was very isolating as a doctor who was the sole employee with no concept of teamwork and I later discovered that many others, like me had come and gone.

60. There was a distinct feeling that UKBA wanted the doctor to do their bidding and the ending of my tenure was very much related to this – something I took up with my MP, Dominic Grieve, to no avail.

61. There was no training on induction and therefore I had no idea of the specific rules affecting IRCs. Once I started to understand more this enabled me to challenge detention and this got me into conflict with the UKBA.

62. I would suggest that the job is only viable if combined with work at an external unit with good Continuing Professional Development and colleague support. The high turnover in that unit since my departure confirms this view.

Danny Allen 3rd October 2014

Details of my CV, if required, can be found at www.dannyscv.com