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## HEALTHCARE IN DETENTION

### Written evidence submitted by Medical Justice to the APPG on Immigration Detention

- 1. Summary:** Medical Justice (MJ) has seen hundreds of cases where failing healthcare provision in IRCs causes harm to some of the most vulnerable detainees. Many detainees, because of past or present trauma, have complex health needs and find it difficult to access healthcare and this is exacerbated by short consultations, late screenings, poor use of interpreters, poor clinical assessments, and lack of adherence to clinical protocols<sup>[1]</sup>. MJ frequently sees torture victims, pregnant women, the very sick, disabled or elderly detained against policy, as well as cases where detention has exacerbate existing mental health conditions and even led to detainees developing new mental illness. Indefinite detention is harmful to the health of detainees and some are detained for years. In addition, detainees are harmed by improper use of segregation, instances of medical mistreatment, excessive use of restraints, injuries caused during removal, and inappropriate treatment of hunger strikers. The last few years has seen 6 High Court rulings of ‘inhuman and degrading’ treatment of detainees and two inquest verdicts of neglect contributing to death. The cases seen by MJ are, we strongly suspect, only the tip of the iceberg and reflect systemic failings that affect thousands of detainees each year.
- 2. Background:** Every year, 30,000 people are held in Immigration Removal Centres (IRCs) and other facilities across the UK. MJ believes that:
  - IRCs, and the conditions of detention, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to close the IRCs.
  - all detainees must have access to NHS equivalent treatment.
  - vulnerable detainees should not be detained.
- 3. About Medical Justice:** MJ is the only organisation in the UK to send independent volunteer clinicians in to all the IRCs across the UK. The doctors document detainees’ scars of torture and challenge instances of medical mistreatment. We see more than 600 cases each year and have gathered a sizeable, unique and growing medical evidence base. Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused to detainees by these shortcomings, as well as the toxic effect of immigration detention itself. We and others use our research to secure lasting change to the detention regime through policy work, strategic litigation and by raising awareness of the conditions inside places of immigration detention.
- 4. Shortcomings in health services in detention:** There are serious shortcomings in detainees access to services within detention e.g. lack of access to legal advice (*BID briefing*<sup>[2]</sup>). This submission will focus on the shortcomings in provision of healthcare in IRCs. An inspection report from HMIP of Harmondsworth IRC stated that the provision of healthcare within the detention centre gives “*cause for significant concern*”<sup>[3 p.6]</sup>. The only HMIP themed report into healthcare at an IRC found that though “*basic healthcare provision was usually adequate for those detainees who stayed for only a short time(...)* However, underpinning systems were

*inadequate and the healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being.*"<sup>[4 p.5]</sup> The Home Office's Detention Operating Standards stipulate 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"<sup>[5 p.34]</sup> however this is not the case for many detainees.

## 5. SPECIFIC SHORTCOMINGS:

**5.1 Arrival and health screening:** Everyone who arrives at a detention centre should be seen by a nurse within 2 hours of arriving and be offered a GP appointment with 24 hours<sup>[6]</sup>. However,

- Health screenings are often short. The initial screening should take approx. 30 minutes but in practice are much shorter, usually around 10 minutes<sup>[4]</sup>.
- Detainees often arrive at an IRC after a long and exhausting journey,
- or take place in the middle of the night. A recent MJ study of 20 pregnant women found that 55% of health screenings took place between 22:00 and 06:00<sup>[7]</sup>.
- The initial nurse reception screening asks the usual health questions of height, weight, and history but very little on past trauma or mental health.
- Interpreters are not always used when needed<sup>[8, 9]</sup>, especially late at night.

5.1.1 Screening setting is not conducive to disclosing intimate details to a complete stranger. This raises questions about the quality of information garnered from detainees self-reporting on health issues and vulnerabilities during initial health screening<sup>[1]</sup>.

**5.2 Lack of training and failure to identify vulnerable detainees:** Home Office policy<sup>[10]</sup> stipulates that unaccompanied children, victims of torture or trafficking, pregnant women, the elderly or disabled, or those suffering from serious physical or mental illness that cannot be satisfactorily managed in detention should only be detained in very exceptional circumstances. Despite this, many go unidentified and end up detained, sometimes for prolonged periods of time. Healthcare has a responsibility to identify vulnerable detainees in detention however, a recent HMIP inspection of Yarl's Wood IRC found that "*none of the health services staff had been trained in the recognition of alleged acts of trauma or torture.*"<sup>[11 p.42]</sup>. In addition, many IRCs subcontract their GP services to local GP practices where the doctors may or may not have any particular insight into the issues affecting the detention population or Home Office policies such as Rule 35. Locum GPs may have received limited training<sup>[12]</sup>.

5.2.1 *Mental health:* There are high rates of trauma and complex vulnerabilities due to pre and post migration stressors amongst detainees<sup>[13, 14]</sup> Mental health services are inadequate and detention is itself damaging to mental health<sup>[15]</sup> (*see MJ mental health briefing*<sup>[16]</sup>). One detainee's severe mental health condition went unassessed for 6 weeks eventually contributing to his death from natural causes.

5.2.2 *Rule 35:* Rule 35 is the primary safeguard for vulnerable detainees whose health would be injuriously affected by continued detention. However, the implementation of Rule 35 has been plagued by widespread, and well-documented<sup>[1]</sup>, failings resulting in vulnerable detainees being harmed by continued detention. 90% of Rule 35 reports do not lead to release (*see MJ Rule 35 briefing*<sup>[17]</sup>).

**5.3 Inadequate and inappropriate care:** Most IRCs provide primary care, and some basic secondary care facilities, either directly or through subcontractors, on the premises. However, the range and quality of care in IRCs is not equivalent to that offered to the community or in accordance with NICE guidelines. MJ has observed significant shortcomings in care including:

- Lack of access to specialist healthcare, especially psychiatric assessment. One client waited more than a year for a psychiatric assessment despite repeated references to self-harm, suicide attempts and 'difficult' behaviour in her medical records. Even after an independent psychiatric assessment was carried out it took almost 6 months for her to be seen by an IRC psychiatrist.
- External healthcare appointments cancelled or missed often due to lack of transportation<sup>[11, 18]</sup>. One client missed her scheduled week 20 foetal anomaly antenatal scan due to attending a Home Office interview.
- Incidents of denial of treatment for serious conditions, e.g. HIV medication not provided on occasion and test results withheld<sup>[19]</sup>. One HIV+ client didn't receive his ARV medication for several days due to delays in obtaining his medication from the hospital pharmacy. He developed resistance to his medication which was 'probably' due to the interruption<sup>[20]</sup>.
- Insufficient treatment and diagnosis of communicable diseases. Many detainees come from countries where there is a higher incidence of infectious disease than in the UK yet no systematic screening is conducted<sup>[21]</sup>.

5.3.1 *Seriously ill and disabled detainees*: IRCs are not equipped to deal with complex health conditions or severe disabilities. However, MJ continues to see detainees with serious health conditions inappropriately held in detention. A client suffering from severe OCD found daily life under detention rules so stressful that she rapidly deteriorated to the point where she required hospitalisation.

5.3.2 *Lack of continuity of care*: Detainees often arrive in detention without medical records or their current medication as many are detained in raids or when reporting. In addition, detainees are transferred between IRCs without accompanying records<sup>[12]</sup>. Detainees are removed from the UK despite healthcare provisions in their country of origin being woefully inadequate, sometimes to the point where access to care is unlikely and death almost certain, e.g. a terminally ill Ghanaian woman removed to Ghana despite being unable to afford the life-prolonging treatment she needed<sup>[22]</sup>. 44% of detainees are released into the community many without ensuring adequate healthcare. One of MJ's clients was left at Victoria Coach Station to make her own way home despite the fact that she was unable to walk and did not have access to a wheelchair.

5.3.3 *Self-harm*: Self-harm is a significant problem in immigration detention<sup>[23]</sup> around the world with rates of self-harm as high as 30-35%<sup>[15, 24, 25]</sup> reported. Self-harm and suicidal intentions are administered through Assessment, Care in Detention and Teamwork (ACDT)<sup>[26]</sup> plans where detainees are put on constant or periodic surveillance with regular reviews. ACDT is handled by custodial staff and medical staff may not have access. A HMIP inspection found poor identification of triggers, inadequate care maps as well as insufficient multidisciplinary involvement<sup>[11]</sup>. Data for self-harm in detention is fragmented and unreliable<sup>[23]</sup> but from the available data it is clear that self-harm is an increasing problem in detention and there is reliable evidence that the rates are significantly underreported<sup>[27]</sup>

5.3.4 *Food and/or Fluid Refusers*: Food and fluid refusal is an issue which clinicians working in IRC may not have encountered in their other fields of work and inappropriate care may be putting patients at risk. Home Office guidelines<sup>[28]</sup> fail to make a sufficiently strong link between food and fluid refusal and mental health issues<sup>[29]</sup>. Proper mental capacity assessments<sup>[30]</sup> are rarely carried out<sup>[31]</sup>. There is a presumption of capacity but this often means that doctors fail to document why someone is considered to have capacity. Research carried out by Medical Justice on 50 vulnerable detainees showed that 23% reacted to the stress of detention by refusing food and/or fluids<sup>[1]</sup>. One client lost more than 1/3 of her body weight before receiving appropriate mental health care.

5.3.5 *Segregation*: Rule 40 and 42 of the Detention Centre Rules<sup>[6]</sup> set out provisions for the segregation of detainees however this procedure should not be used "for punishment or in relation to the

*management of self-harm or mental illness.”*<sup>[32]</sup>. Despite this, the 2013 HMIP inspection of Yarl’s Wood found that *“initial authorisation for separation had often been given by junior managers, and in a few cases, it had clearly been used as a punishment”*<sup>[11]</sup>. Segregation is being used as a means of controlling detainees with mental disorders that cannot be satisfactorily managed in detention<sup>[33, 34]</sup> – as was seen in the case of MD v SSHD where she was segregated to manage her mental disorder and handcuffed to stop her self-harming<sup>[35]</sup>.

**5.4 Dismissive and unresponsive healthcare:** Many detainees feel they cannot trust the healthcare staff and encounter a dismissive attitude which raises the threshold for accessing care and leads to poor doctor patient relationships. One client, suffering undiagnosed dissociative motor disorder, was not believed by IRC staff, denied a wheelchair and left to crawl around her room on her hands and knees stripped of her dignity. After release she spent 17 weeks in a ‘re-ablement’ facility to regain the use of her legs.

5.4.1 *Poor doctor/patient relationship:* There is a prevailing ‘culture of disbelief’ within the UK immigration system<sup>[36, 37]</sup> that also extends to healthcare in immigration detention<sup>[38]</sup> and can lead staff to attributing behaviour indicative of mental disorders to intentionally disruptive or manipulative behaviour by detainees<sup>[39]</sup>. There is a generalised atmosphere of fear and mistrust between staff and detainees.

5.4.2 *Sexual Assault:* 10 SERCO staff members at Yarl’s Wood were dismissed as a result of sexual assault and professional misconduct<sup>[18, 39]</sup>. The Independent t Monitoring Board at Yarl’s Wood IRC reported that *“concerns were expressed at male staff entering rooms allegedly without waiting for a reply after knocking”*<sup>[18 p.16]</sup>. Yarl’s Wood IRC still has 52% male detainee custody officers (DCOs) and 48% female DCOs<sup>[40]</sup>.

5.4.3 *Confidentiality:* Detainees often see no distinction between healthcare and custodial staff and fear disclosure to healthcare staff will be reported to Home Office. A recent HMIP report found that *“In one report, a doctor had made unprofessional and pejorative comments (...). This report had been forwarded to immigration staff without the detainee’s consent or knowledge.”*<sup>[11]</sup> Nurses are present during detainees’ consultation with the GP<sup>[11]</sup> and guards are often present during medical consultations outside of the IRCs which breaches the confidentiality of the clinical space<sup>[41]</sup>.

5.4.4 *Complaints:* The complaints process is complex and inaccessible, especially for those with limited English or familiarity with complaint systems. Many detainees are afraid to make complaints fearing negative repercussions in detention or on their immigration claim. Of those complaints that are made, very few are upheld<sup>[42]</sup>, compared to the PPO’s substantiation rate of 80%, which raises concerns about the diligence and impartiality of the process. In addition, the Home Office closed down the Complaints Audit Committee after it found that 83% of complaint investigations were inadequate, subsequently there is no systematic overview of complaints to identify trends or to ensure lessons are learnt<sup>[42]</sup>.

5.4.5 *Communication:* Home Office Case Workers overrule IRC doctors when they advice that a detainee’s health is likely to be injuriously affected by continued detention (*see MJ briefing on Rule 35*<sup>[47]</sup>).

**5.5 Restraint:** *“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.”*<sup>[8 p.5]</sup>. 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.*"<sup>[43]</sup> Generalised risk averse practices by detention staff puts the humanity and dignity of individual detainees at risk. The HMIP annual report 2013 concludes that security measures in IRCs lacked proportionality, e.g. the practice of handcuffing nearly all detainees for outside appointments even when the individual has been rated 'low-risk'<sup>[44]</sup>. New guidelines have been issued this year authorising the use of leg restraints, a waist restraint belt and mobile chair restraint whereby detainees can be immobilised<sup>[45, 46]</sup>.

- 5.6 **Removal:** Many detainees suffer physical and psychological harm during removal<sup>[47]</sup> and many of these injuries are not adequately treated or documented. Injuries seen by MJ include broken nose, fractured bones and a dislocated knee and one case even resulted in the unlawful killing of the detainee<sup>[48]</sup>.
- 5.7 **Detention of pregnant women:** In 2013 HMIP reported *"Some case files for pregnant women showed no evidence of the exceptional circumstances that justified their detention. One woman had been detained for over three and a half months and hospitalised twice because of pregnancy-related complications."*<sup>[11 p.15]</sup> The primary purpose of detention is to effect removal however, of 93 pregnant women seen by MJ in Yarl's Wood in 2011, only 5% were removed<sup>[49]</sup>. Since the completion of this research none of the pregnant women in detention seen by MJ have been removed. Detention often leads to an interruption of antenatal 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<sup>[50]</sup>. In 2013 MJ joined 336 other organisations, including the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists, in calling for the end to the detention of pregnant women.
- 5.7.1 *Malaria Prophylaxis:* Clinical guidance from the Royal College of Obstetricians and Gynaecologists<sup>[51]</sup> advises that pregnant women should only travel to malarious areas if travel is unavoidable as they are at increased risk of developing severe malaria which can lead to foetal and maternal death. Due to widespread drug resistance, contraindications in pregnancy and serious side effects malaria prophylaxis are often not appropriate for pregnant women. MJ frequently sees 'Fit to Fly' certifications issued for pregnant women without consideration of malaria prophylaxis, drugs prescribed without discussing possible complications and prescription of inappropriate drugs<sup>[7]</sup>.
6. **Access to evidence:** Many torture survivors and detainees suffering serious medical conditions have no means to get medical evidence to support their immigration claim. MJ provides medical evidence to the relatively few it has the capacity to reach.
7. **Prolonged detention:** Prolonged detention, sometimes for years, causes harm to the mental and physical health of detainees and comes at great expense to the public purse. A HMIP & ICIBI themed review found that delays and poor quality case work led to prolonged detention. At the time of review 42 detainees had been held for more than 2 years with little prospect of removal<sup>[52]</sup>. The cost of detention per person per year is approximately £40,150 compared to £4620 to asylum support in the community<sup>[53]</sup> added to this is expenditure on 'unlawful detention' cases<sup>[54]</sup>.
8. **Consequences of healthcare failures in detention:** In the last three years there have been 6 High Court cases<sup>[35, 55-59]</sup> which found that detainees suffered "inhuman and degrading treatment" in breach of Article 3 of the ECHR. The Home Office expenditure on compensation in unlawful detention cases is drastically increasing<sup>[16]</sup>. There have been 10 deaths in detention in the last 3 years, including an 84 year old Canadian whose handcuffs were only removed after he was dead, a man who committed suicide, a 40 year old woman, and two men in their 20's. One detainee frantically pressed the emergency button inside his locked cell 10 times for help while his cell-mate was dying from a heart attack, but was disbelieved until he was dead. Inquest verdicts have included 'neglect contributed to the death'.
9. **Indefinite Detention:** MJ believes, in line with academic research<sup>[60]</sup>, that all immigration detention is harmful to the health of detainees, however, indefinite detention is particularly harmful<sup>[60]</sup>. Lack of insight into progress

of their case and likely length of detention means that even detainees that are held for a relatively short period of time suffer the devastating psychological effects<sup>[61]</sup> and the wider human cost<sup>[62]</sup> of indefinite detention. MJ recommends that all IRCs are closed due to the widespread harm they cause but, as long as immigration detention continues to be used, there should be a time limit on the period of detention.

**Medical Justice would like to be invited to give evidence at oral evidence sessions**

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