APPG on Refugees and APPG on Migration Joint Parliamentary Inquiry into the Use of Immigration Detention

2nd Oral Evidence Session.

November 6th 2014

10.00am-12.30pm

Committee Room 6, Houses of Parliament

Panel Members Present

Sarah Teather MP (Chair)
Paul Blomfield MP
Caroline Spelman MP
Lord Anthony Lloyd of Berwick
Baroness Ruth Lister of Burtersett
Baroness Sally Hamwee of Richmond upon Thames
Lord David Ramsbotham

Oral evidence taken from:

Bamidele, ex-detainee, **Penny,** ex-detainee, and **Mortada,** ex-detainee

Dr Naomi Hartree, Medical Justice, **Dr John Chisholm,** Vice-President, BMA, and **Dr Danny Allen**

Justine Stefanelli, Bingham Centre for the Rule of Law, **Dr Adeline Trude,** Research and Policy Manager, Bail for Immigration Detainees, **Kay Everett,** Immigration Law Practitioners Association, and **Laura Dubinsky,** Doughty Street Chambers

Sarah Teather: Good morning, everybody. Thank you so much for coming to our second hearing of the parliamentary inquiry into immigration detention. I'm Sarah Teather and I chair the All-Party Parliamentary group on Refugees. I just want to introduce the panel next to me.

First of all, Paul Blomfield who chairs the All-Party Parliamentary Group on Migration, and we're running this inquiry as two All-Party Parliamentary groups together. And next to me Baroness Ruth Lister. At the end, Baroness Sally Hamwee. And we have Lord Anthony Lloyd and Lord David Ramsbotham here on my right.

We're also- I'm just about to say we're expecting Caroline Spelman as well, another of my colleagues from the Commons has just arrived with us.

I just want to point out, we have somebody from BBC who's doing some recordings and he covered our last inquiry hearing. So, I mean, I think the people who are giving evidence are aware that it's being recorded but if for any reason you would like that to stop at any stage and you want to say

something, that's absolutely fine. And feel free and we will be very sensitive to that and we won't record anything that you don't wish to be recorded and broadcast.

Can I first of all welcome the panel members who are going to give evidence. I'm very, very grateful. I've met two of you already but not met Mortada. So, thank you. We're hugely grateful to you for giving us your time. And we've got about 40 minutes to kick off, and we're really keen to hear about your experience of detention and to tell us as much or as little as you would like to.

We've also read your submissions, which were extremely powerful, so thank you very much for doing that. I wonder if I can ask Bamidele whether or not you might kick off first because I've heard you speak so eloquently on Friday night. But we would like to ask all of you just tell us a little bit about yourself first of all: where you're from and how long you've been in the UK, a little bit about how you came to be in detention, whatever you would like to tell us.

Bamidele: Good morning, everybody. My name is Bamidele. I am from Nigeria. I am a politician from Nigeria. I am a member of the ruling party from Nigeria. I've been in active politics since the inception of the new political system, since 1999, when Nigeria changed from military rule to democratic rule.

I was once a youth leader of my party, and I was once the secretary general of my party in the local level. I aspired to become a chairman of a local government in my state. Shortly after I declared my intention to reach, people from my constituency and people from my local government, some disgruntled elements within the party, kick against my candidature. They started writing threatening letters; they attacked me; I was beaten up several times – just to step down for another candidate.

When it was very hard, I couldn't stand it. I had to run away for my life. I ran to the United Kingdom in October 2007.When I arrived in the United Kingdom, I didn't know how to claim asylum, because I had heard the asylum in the UK was very hectic. It was very stressful. I was hoping that things would become normal in Nigeria so that I would be able to go back.

Within this period I had an encounter with the Home Office. I told them my story. I showed them evidence of my political involvement in Nigeria. They called all my story fabricated stories. They said they didn't believe me. I was detained for ten months. I was detained for ten months in five different detention centres in the UK.

I was moved eight times within the detention centres in the UK. During the time I was detained, I felt sick. My blood pressure went up. They were giving me series of medications. I was taken to the hospital. The first time I was handcuffed to the bed for two days in Illingham Hospital.

After some time, they saw that I had a genuine claim. They came into my case. They started pursuing them. Doctor writes a series of reports. They denied me of my release, of my freedom. I was tortured. I collapsed three times in detention. All the Home Office was saying was that it was a fabricated story – that they should not release me.

After ten months, I got my freedom. When I came out, I've lost everything; I lost contact with friends; I lost contact with my family. I have to start all over again. I was in my NASS accommodation for almost two years. After three years or more, I went to asylum court, immigration courts, to present my case. The judge was able to listen to me and I was granted refugee status for five years to stay in the United Kingdom with my family.

Thank you, everybody.

Sarah Teather: Thank you for that. There are a whole number of things I would like to pick up. I want to ask any other panel members to come in, in particular the point about the long-term impact for you of having been in detention, the fact that you were moved around is something that I'm very interested in.

But you said something in your evidence that I know has happened to Mortada about the fact that you were in hospital, that you were handcuffed when you were in hospital and that was something that Mortada expressed very strongly to us in his evidence, so I wondered if I could perhaps bring Mortada in next and tell us, just tell us a bit about yourself. We were particularly- I certainly was very horrified by your own experience of being in hospital. So, if you say something about that, that would be really helpful.

Mortada: Okay. Thank you very much. I came from Sudan in 2005. Same boat. We're fighting dictatorship in country. I came here and I seek asylum. As usual, everyone refused in the Home Office they don't know how the system works. We struggle, fresh claim after fresh claim with procedure. They detained me in 2011. Only this story I need to talk about the detention.

Detention is not good in general. And the treatment in the detention is not good for many things. First, you can't deal with the Home Office directly, because they hire private companies to do the job on behalf of them. So, everything is through the fax machine. You never talk with the Home Office face-to-face. And no one believes you if you are sick or ill, which has happened to me. And I suffered from bronchitis, for which I took medicine for a long period of time. When they detained me, I wasn't prepared for detention and I missed my medication, and no one noticed or believed me. After five or three days they changed the medication and made my situation worse.

Anyhow, I reached the hospital and I stayed very, very strong and I went to hunger strike for 39 days. And they chained me in the bed many times and all the time you've got this picture if you want to watch this.

Sarah Teather: We saw that in your evidence.

Mortada: I feel useless. Useless with all this system in detention. Even the legal aid. Everything, I put it down and we need change and you need change pretty soon because many people down there are suffering, suffering the same situation, and please act soon. Thank you very much.

Sarah Teather: Thank you. Thank you. The point you made there about not being able to access the Home Office directly because of everything having to be done through fax and particularly in your experience of having been chained to the bed, I'm hoping our next panel, they might pick up on some of those points. That's really, really important.

Penny, would you like to tell us a little bit about yourself and your experience of being in detention?

Penny: Good morning, everybody. My name is Penny. I'm from Rwanda in central eastern Africa. I came to the UK after the 1994 genocide where my family perished, and I managed to survive during that – miraculously survived the genocide.

My hope of coming to the United Kingdom was to escape the trauma I had gone through the genocide. I wasn't- I didn't come to the UK to seek asylum, because to me asylum meant- it meant an institution for severely mentally impaired people. To me asylum never, ever crossed my mind.

Anyway, I'm a former victim of trafficking. I'm a recognised victim of sex trafficking in this country. All my problems began when I had come out of the trafficking situation, and I was trying to look for the basic human rights to survive, and I was arrested and taken to a police cell for almost two nights. On the second night I was picked up and I wasn't told where I was going. I was put in a van in a tiny, confined place that I couldn't- You could barely stretch. I was taken to- After about 9 hours, because I left the police station at around 9 p.m., only to arrive- At that time I got to know it was Yarl's Wood Detention Centre at 6 in the morning.

During the process of being- of travelling to Yarl's Wood, I had lost all memory. I was hysterical. I was- I didn't know whether I was going or coming. I reached detention and I an officer asked whether I had gone through any kind of trauma. To me, the trauma was the genocide which I talked about and the trafficking, I talked about it openly. And I was told oh, sorry, but you are going to be

deported anyway. I asked the officer to where. She said I don't know but all I know is that you are going to be deported. I was- I spent 98 days in the detention centre.

During those almost 14 weeks, I was on suicide watch. I was on medication, which I was deprived of because they didn't know if I was going to overdose. I tried to commit suicide; I was saved by my roommate in Yarl's Wood.

It was a process that I don't- At the mention of detention right now, my body goes cold and I'm thinking is this what- Right now, I live in a place that is just opposite Colnbrook detention centre, whenever I get off the bus, the first thing I think of is, like, am I going back to the place where I was? I've developed very serious- I've been clinically diagnosed with post-traumatic stress disorder. I have mental health issues. I'm seeking therapy for the last seven years and that's still on-going.

Detention is a bad idea. There could be alternatives of less harsh means of looking for detention. Whether you are detained for a day or a month or years, it doesn't matter – detention should never happen. We've been there and it's not a good story. If someone hasn't been in detention, they would never know what actually goes on there. Thank you.

Sarah Teather: Thank you. I would like to bring in some of my colleagues. Ruth?

Baroness Ruth Lister: Yes. I wonder if I could just pick up on that last point you made and ask all of you. You've all given us a very clear account of what's wrong with being in detention and the dreadful effects it has on you. I just wondered whether you feel that that, is there an effect over and above being in detention, not knowing how long it will last and not being a time limit, and, if so, can you tell us a bit about what that feels like?

Penny: To me, being in detention, because from the word go, there's a- You are not certain of whether you will actually get out of detention. The only thing you are sure of is you will be getting on a plane back to your country, any time of the night especially in the middle of the night at around 3. You hear an officer opening the door, and you need to pack your bags all the time. There's that uncertainty of not knowing your future.

Whether you are actually granted status, even when you come out, the impact still remains. And they're both physical and mental impacts that have- Whoever has gone through a detention must attribute to what I'm saying. It happens to everyone.

Sarah Teather: Do either of the other two want to comment on that, that sense of uncertainty Ruth was asking about?

Mortada: In detention it's very bad and this- You are inside eternally and you never saw the light at the end of it. For how long, you don't know. The situation inside the detention is very bad. Treatment, healthcare, access to healthcare, access to small things, access to legal aid, all these things, and you don't know for how long. You face it every day. And no one's there to answer your questions because all the G4S or GEO or private companies. There's no one to deal with him. You know for how long. There's no answer there. Just sit here. Only God knows.

Bamidele: Yes. All the people working in detention, they are working for a purpose, and the purpose is to achieve their aim. Their aim is to remove, not release any detainee back into the community. And in the process of achieving their aim, they threatened us, they maltreated us, they frustrated our efforts. At times hijack our emails. When you have letter from courts or from solicitor, they will open it, they will read it. They will give it back to your caseworker. If you will have letter from family, they will open it. And by six, seven o'clock, after you've eaten, we will be locked up until 8 a.m. – at times 9 a.m. the following day.

We were treated like- Even you can't treat an animal like that. We will be forced to sleep when we are not ready to sleep. We will be moved without telling us. They will just go pack your stuff; we are moving you to Manchester now.

They use all these things to intimidate us, to oppress us, to suppress us. That we don't want to hear. Go back to where you come from. It is highly ridiculous. Our privacy was highly compromised there. They spy on us. They monitor everything about our movements. Even our medical notes – they spy it. They take- They don't just take instructions from the Home Office. If you are unwell, they will certify you well – that you are well, you are lying. Even the mentally sick people who are in detention, they don't believe them that they are mentally sick. They give them wrong medications; they overdose people; they'll be drowsy; they'll be spitting everywhere.

So, all this thing is just to frustrate and to remove people from the United Kingdom.

Sarah Teather: David, you asked to come in and then I wanted to ask Anthony to ask his question.

Lord David Ramsbotham: Yes. Just to explain, I was once Chief Inspector of Prisons, which included inspections of the immigration detention centres. And one of the things that concerned me was that the immigration centres, I was told, were for short-term holdings only while questions were asked, and it was felt that the person was needed to be on hand while the questions were asked. And I found, of course, that people were being left in the detention centres for far too long, and there were not the facilities in the detention centres for long-term holding.

Quite apart from that, what you describe about the attitude of the contracted staff, there was meant to be a Home Office liaison monitor who was there who acted as the intermediary, and it should explain to every detainee what was happening on their behalf. From what you've said, there appeared to be no evidence that the Home Office liaison monitor was doing their job. Was that so?

Mortada: Yes. That's exactly what happened there. You deal with the companies. You never face the immigration officer or UK Border officer. There's no answer for any question there. When you ask them any question, what you get about anything: sorry, I'm the only officer here. I work for the company. This is my job. Stand here. Just no. They don't have answers. They don't have answers.

Lord Anthony Lloyd: Yes. I shall want to ask each of you the same question, perhaps starting with Mr Bamidele You were, I think, in detention for 11 months in all, was it? Did you see a lawyer during that time? And if so, how soon after your detention started?

Bamidele: I made attempts to see a lawyer when I came to the immigration detention centres. They claimed that they cannot assist me, that my case doesn't have merit. Our advice is to go back to your country. For a period of 7 months, I did not have a single solicitor. I had to see them by myself, to write, to caseworker, to High Court, to asylum tribunal, I write by myself. I was prevented from having a solicitor. I didn't have any solicitors.

Sarah Teather: So the first lawyer you saw- Sorry. Can I just ask? The first lawyer you saw: was that somebody who- You saw somebody within detention? It was one of the people who was contracted to work with in detention, was it?

Bamidele: They invited some solicitors. They called them that we should go for legal surgery. Legal advice. They give legal advice. And when they take our papers, they will respond- they will respond back that the case has no merit.

Sarah Teather: Which is clearly untrue because you were later given from refugee status, so it demonstrates the quality of the advice you had was extremely poor.

Bamidele: Yes.

Lord Anthony Lloyd: And what about, if I may ask, were you told you could have, for example, a legal aid to seek advice?

Mortarda: When you claim asylum, they give you only £75, and when they refuse your claim, they transfer you the voucher, so you don't have any money. You only depend on legal aid. When they detain you, they- Automatically they cut the legal aid. So when you are in detention, you don't have any solicitor to represent you. So you have to ask your friend outside, if you are lucky. If they've got

some money, you can give it to any private solicitor to deal with your case. There's no legal aid for asylum inside detention.

Lord Anthony Lloyd: And what about Penny?

Penny: I was- For the first few weeks, we used to go to a communal place to pick up the papers, and that's where we would meet with other, well, I will call them inmates. And we would peruse through the paperwork to look for legal advisors. I didn't have any knowledge of how I could obtain a solicitor, but my therapists outside got me a solicitor eventually. But before, during that period for the first few weeks, I had no idea of what would happen. Actually, I used to go and help people take up their stories, their claims, to be faxed to whether they had to fax them, to the European Court of Human Rights and stuff. I- to try to make yourself busy. I didn't have any legal experience or anything and so on.

Lord Anthony Lloyd: Thank you very much.

Sarah Teather: So, Sally, and then Caroline.

Baroness Sally Hamwee: I wanted to come back to the conditions in detention. When we talk about prisons for people who've been convicted of crimes or on remand because they're about to be tried, there's a lot of focus on things like visits, what visits you're entitled to, the activities, exercise, access to books, contact with other people in prison. Detention centres are not prisons. But the way you're describing the conditions are even more restrictive than prisons, and I wanted you to tell us, if you could, about any activities you were allowed, access to other people, visits. And I think you said, Bamidele, that, you know, you were completely cut off from people you'd already had contact with in this country.

Sarah Teather: Can I bring Penny in first—if I can?—because she's been asked last so far.

Penny: I have an experience of both detention and prison. I was in prison just after my trafficking experience. For a fact that I know I shouldn't have been imprisoned. But to me, to be fair, I prefer prison to detention. Because in prison there was a chance of knowing that eventually you will be released and your case will come to an end. In detention it was otherwise. There was no hope of anything. Apart from sitting down and being worthless and waiting for your" D date" of when you're going to be removed.

The only activities, if you are lucky. There was a small gym. If you are lucky to be among the ten people to wake up in the morning to go to a gym and work out or go to bed and cry yourself to death. There was no other activity.

Sarah Teather: Bamidele?

Bamidele: Yes. I think detention is very horrible. Because there was a guy they brought from prison. We were in the same room. He was telling me that he would prefer to be in prison than in detention. He was just comparing it to that prison was far better, that he would prefer to stay in prison than detention. I asked him why. He said prison was just like- It was like a confinement that there is- He was even asking me how I've been coping here. He said how have you been coping here in detention? I said I've never been to prison. I cannot compare the two. He was telling me that he preferred to be in prison than detention. And when I was first sick he was telling me that it was as a result of being in detention. That was why I was fully sick, continuously – because I was confined. I was restricted and there's no- There's no relaxation here like prison.

So, he was comparing the experience of prison to detention.

Sarah Teather: Mortada…

Mortada: In detention, which I was, explained, eight months there, all they do, they let you go into the courtyard. Nothing to do to occupy you. There's no internet; there's no- table, there's no pool table or game facilities. There's nothing. Even the library – it's a very small library and there's just

not that much to do in there. Just sitting doing nothing, without any help unless someone, like, some organisation outside, they're going to help you. Someone in the IMB organisation, which has helped me a lot. And that's why I'm here today – because of them.

Sarah Teather: And they put you in touch with Medical Justice, didn't they?

Mortada: Yes.

Sarah Teather: Caroline, you wanted to ask some-

Caroline Spelman: Yes. Just in preparation for the next panel, before you go, I would just like to come back to your bit about your health experience, because we're going to deal with that subject. Two of you were handcuffed to the bed, in hospital. Despite, in your case, Mortada, having two officers there.

Mortada: All the time. 24 hours.

Caroline Spelman: What was the reaction of the staff nursing you to being handcuffed?

Mortada: Nothing.

Caroline Spelman: Nothing at all?

Mortada: And I go to them, why treat someone in handcuffs? It's not your provision. She said it's not our job.

Caroline Spelman: They said to you it's not their job. Not their job.

Mortada: Yes.

Caroline Spelman: And what did they say to you?

Bamidele: Yes. There was a time in October- in November 2010. I was taken to Hillingdon Hospital to see the cardiologist. The first time I went there I was handcuffed with my two hands and they used a long chain to … one of my hands. So, all the officers that escorted me to cardiologists, they came into the private room with the consultant. The consultant was very annoyed. He said, look, I cannot treat my client like this. You handcuff him; you want to hear my conversation with him. This is not allowed. He said he will not be able to continue with my treatment. So he was talking to them. They have to release one of the hands for him. He asked me to lie down. All the officers. Four officers that took me in to the appointment, they were there. I have to undress in the presence of the officers. He was asking them that two should go out and two should stay in. They refused. They said they were doing their job.

So, the consultant asked to discharge me, that he will not be able to continue, because they were interfering into the medical treatment that was given to me.

Caroline Spelman: And can I ask; I wanted to ask when you all arrived in detention, were you asked about your medical history or did you signal, in your case, your serious condition?

Mortada: I told them about it.

Caroline Spelman: You told them?

Mortada: Yes.

Caroline Spelman: Did they ask you for details of the doctor?

Mortada: No.

Caroline Spelman: Did you provide details to the doctor who was seeing you?

Mortada: Yes.

Caroline Spelman: And the date of your operation?

Mortada: Yes.

Caroline Spelman: And did they make a note of that, that you were aware? No?

Mortada: I don't think so.

Sarah Teather: And you said in your evidence that you were separated from your drugs when you were picked up.

Mortada: Yes.

Caroline Spelman: And for those of you understandably depressed by this experience, did they make you aware of counselling that you could have within your detention? Penny, were you offered any-

Penny: It was after a few weeks of when I tried to commit suicide that after about a week or two then they brought a counselling session, a therapist who is seeing me once a week.

Caroline Spelman: A couple of weeks?

Penny: Yes.

Caroline Spelman: And Bamidele and Mortada?

Bamidele: I wasn't seeing any therapist or any-

Caroline Spelman: No counsel.

Bamidele: – nothing like that. When I was arrested, I was arrested with medication.

Caroline Spelman: Yes.

Bamidele: They saw the medication I was using. What they did was they started increasing the medication. I was just on one medication before I was arrested. By the time I left the detention, I left with nine medications. I was given a bag of medication when I was in detention.

Caroline Spelman: Was it explained to you what those medicines were for?

Bamidele: They said it was to reduce my blood pressure. But when I used it, this medication worked the other way in my system. At times, it wind me up. It makes me annoyed. It makes me feel uncomfortable.

Caroline Spelman: Did you explain that to them?

Bamidele: I explained to them, it doesn't allow me to sleep. It makes me want to fight with people. I explained everything. They said no. I have to be using the medication. There's nothing they can do. Instead of assisting me, they started increasing the strength of the medication.

Caroline Spelman: Are you on this medication now?

Bamidele: Yes. I'm using six medications with antidepressants at the present, as at the moment. I continue using the medication. It's part of my daily life now. But before I was arrested, I was fine. I didn't- I was not on so many tablets. I was just on one medication. But now I use about five or six medications daily.

Caroline Spelman: Okay. Thank you.

Bamidele: And if I don't use it, I will not feel comfortable.

Caroline Spelman: Yes. Thank you.

Sarah Teather: Can I just ask Penny about her experience of coming into Yarl's Wood? Because I asked myself whether I could come in through the route of which women would come in, what women did as they were received into Yarl's Wood. And I was seen by a male nurse and my first interview was in a wide open space and I just wondered what your experience was, whether or not you were offered an opportunity to see a female nurse. Who did you see first?

Penny: When I arrived there were two officers. They told us they are health assessors. But one of them was a lady. She asked me a couple of questions where we talked about my trafficking experience. And then the male- The male one is that one who did all the tests. And I remember telling him I'm feeling uncomfortable because my experience is- I've had bad experiences with men. So, but that didn't bother him.

And, actually, during the process of when I was in detention, I talked to one of the officers because I was feeling very depressed and I wanted to commit suicide. There was- I've forgotten his name now - he told me when you are ready to leave, let me know so I can help you. I was thinking here I am looking for help, when somebody is telling me to help me to end my life. It's just bizarre.

Sarah Teather: Sally?

Baroness Sally Hamwee: Yes. It's a question for Penny. Having been a victim of sex trafficking, was there any suggestion from the detention centres that you should be referred to the national referral mechanism or go through any of the routes which were supposed to provide to help people who've been in that situation? Was there any liaison at all?

Penny: There was nothing at all. Even up to the time I left, it was- You fabricated these stories. It never really happened to you. And you had to prove yourself day to day of why it has happened and eventually I have just been recognised as a victim of trafficking just about two years ago. It was on a daily basis, no, you are lying, you're telling us lies, it never happened to you.

Baroness Sally Hamwee: Thank you.

Sarah Teather: Paul, can I encourage you the last question?

Paul Blomfield: Yes, of course. The objective of our inquiry is to look at how the detention system might change, how it might be improved, what different approach we might adopt. I wonder if you could just share with us your thoughts from your experience on what you might put in a report if you were preparing a report that we will prepare on how the system should change.

Mortada: It should change its- scrap it at all. You don't need detention. And if, yes, you need detention, make it better. And don't take people by surprise from the reporting centre which they report to previously. They never missed one report. Why they take them to detention? And make it better by access to the healthcare.

Bring their record from their GP. Don't ignore their mental health. And when someone visits you there, they make him frustrated from this visit. They never re visit because they called him a long time and long procedure for five hours. My friend, they hold him five hours to see me. Yes.

Penny: It's funny that you ask that because the United Kingdom is the only European country that detains people indefinitely, at least from statistics. My view, if I was to change something, end indefinite detention. End detention. Start up alternative means. Like, for instance, case management, a case management system where someone can live into the community and be assigned a caseworker to follow the case after the resolution, whatever is the resolution, but without detaining them

Bamidele: Yes. I think there should be a stipulated time for a human being to be detained in that death trap house they call detention centres. Even if it's going to be 30 days, even if it's going to be three months; if they cannot remove you, they should release you to go back to the community. Then they start reassessing or whatever they call it. People stay in six months, one year, two years, three years, in detention centres. It's very, very appalling. It's very backward. By the time the people are released into the community, they are almost half dead. Some doesn't have mental problems by the time they enter into the detention centres. By the time they come out, they are really crazy. They are confused. They cannot match the system again. They don't understand the system again. They are nowhere to be found. I've been released three years now and I'm still trying to find a level up to now.

All my system was disorganised. I was demoralised. I don't know the rules again. When I'm going to Victoria, I will board a train that is going to Woolwich. This is very disgusting. Kindly assist us to get a stipulated time. Two months, three months, release them into the community. Please.

Sarah Teather: Thank you very much to all of you. We really, really appreciate you giving us your time this morning. You've given us some very, very powerful evidence, particularly on top of the information you provided to us in writing. If there's anything else you feel that you need to say that you wish you'd said, please get in touch with us. If you're getting on the train and you think, oh, I should have told them about this that happened, then please let us know, but thank you. We know it's hard to talk about your experience, that it dredges it all back up again, but we're hugely grateful that you've been able to do that. It makes a lot of difference to us to hear first hand, so thank you.

We would like to invite the next panel to come up.

Okay. While everybody is just resettling, we have Doctor Naomi Hartree who's on my right who's from Medical Justice. Doctor John Chisholm from the British Medical Association, and Doctor Danny Allen, who's a psychiatrist, who was formerly employed working in Colnbrook IRC. Danny, I think it might be probably best for both of us if- I'm not going to ask you to comment specifically on the previous case because I think that's probably inappropriate, so if that's okay with you but to speak in generalities would be really, really helpful. Thank you.

Okay. We're going to open with really the question that we're all keen to get your opinion on, which is when- It's to get your sense about what you feel about health care within detention, but if I can begin by asking you first of all when individuals are first detained, are there accurate procedures in place for assessing health needs, which are some of the things that Caroline is picking up from the last panel? I'm going to start with Naomi, if that's okay.

Dr Naomi Hartree: Thank you. So, when detainees first arrive, they have a health screening assessment, and that's supposed to be done within two hours of their arrival. And that is supposed to, in theory, pick up some of the vulnerable people who might be adversely affected by detention. In practice, that whole screening procedure doesn't work very well. So there are lots of reasons why it doesn't work well, which I could go into. Would like to hear some more details about that?

Sarah Teather: Yes. Give us some more detail and we've got some more we can pick up later. And if there's overlap, by the way, people, don't feel the need to repeat if you can respond to what people said earlier on.

Dr Naomi Hartree: Okay. So, first of all, the screening takes place very quickly after the person arrives in detention. They have probably had a very long journey from wherever they have been detained from, so a lot of the screening takes place in the middle of the night, so between 10a.m. and 6 a.m. when the person's just arrived and they're feeling bewildered and exhausted. So it's not a good time for confiding intimate health problems.

Secondly the screening office seems to be quite brief – say, you know, a 10-minute interview. Thirdly, it's often done without interpreters, or at most telephone interpreting – not a face-to-face interpreter. But we will often find in the detention centre records that we examine, we'll see a remark from the screening nurse saying, you know, poor English or something like that, with no record that an interpreter has been used.

Fourthly I think the screening is not really set up to pick up the most vulnerable people. So, for example, they're supposed to be asked a question if someone is a victim of torture or not. But we often get people who very clearly are later found to be victims of very severe torture who have somehow been put down as no for that question. And it may be they couldn't understand the language; it may be they felt too scared to confide; they'd be tortured. It may be the question was asked about torture and some people think that torture is a very narrow definition – you have to be tortured by the police in your country, and that being a survivor of domestic violence or rape doesn't

count as torture. So there are all kinds of reasons why vulnerability doesn't get picked up in that initial screening.

Sarah Teather: I have to say, this was- I'm particularly interested in exploring this because of my own experience of going into Yarl's Wood and being on the receiving end of the questions that were asked - they were utterly closed. I mean, they were closed up in the local space and they were not exploratory. There was no opportunity to explore anything beyond the tick box. It either went into the box that said yes or it went into the box that said no. And my experience of going through that process and thinking particularly effectively what Penny said there about that long journey, it hadn't occurred to me until they talked to me about that that you could be picking up six or seven others en route. So although you might only live half an hour away from the detention centre, you might have been on a big ram-rodding trip in the van before arriving. And that was very, very apparent to me.

Dr Naomi Hartree: It's interesting that you mentioned the closed questions because we obviously don't hear the questions but when we get to look at the medical records of the detainees, we see the screening healthcare forms and certainly the forms look as though they're designed with closed questions. They also look as though they're designed without the population of the detainees in mind. So, for example, there is- On the forms I've seen, there's generally one question which says do you have mental health problems? And there are no questions designed to pick up post-traumatic stress disorder. And of course in a population of asylum seekers what you would really be looking for if you're trying to pick up on more people is symptoms like post-traumatic stress disorder.

Sarah Teather: I suppose of all of those initial encounters, from the first moment at the reception to the open reception interview where they book you in so the first experience of the healthcare professional was that all of the questions were posed. And there was no- I couldn't see any opportunity for anybody to explore. It's not obvious me how they would illicit any useful information from any of those first three accounts, I have to say. So, and I didn't know whether it was just my personal experience of going through. Can I ask John if you would perhaps comment on that question? If you can think of anything that was missing or for you to take on further.

Dr John Chisholm: Well, I think many people who arrive at detention, indeed most, arrive with no accompanying medical records, and so reception and an assessment of health needs at reception is a key time for gathering health information to inform decisions about what sort of support and care and treatment and potentially referral detainees need for identified health problems. And also there needs, obviously, to be an assessment of cultural and language needs and a risk assessment. And certainly the BMA is very much aware of the sort of problems with an initial medical assessment that Doctor Hartree has identified. Language barriers, a lack of interpreting support, many assessments – this has already been said – carried out late at night after a traumatic and disorienting journey. A lack of cultural sensitivity, a lack of- Well, not a total lack of a standardised assessment, but it sounds as if a tick box, a totally inadequate assessment tool that doesn't allow identification of the particular needs that many people coming into detention will have. The physical and mental effects of torture. The effects of sexual violence or a history of sexual violence. Mental health problems in terms of post-traumatic stress disorder, psychosis, anxiety, depression, self-harming, being a suicide risk. Potentially people having tropical diseases or communicable diseases such as TB, HIV, AIDS, and long-term conditions which may not have been detected or may have been exacerbated by poor treatment elsewhere, by deficiencies in health services in countries of origin.

So there are a whole lot of problems with the initial assessment, and certainly the evidence that has come to the BMA from reports we've received is that the initial assessment is frankly very often inadequate.

Dr Danny Allen: Yes. From the mental health point of view, I quite agree. The questionnaire is extraordinarily rudimentary, and the person asking them may have none or not-appropriate training. And part of the problem is that there's really no routine mental health screening, and the quality of the nurses that I worked with was terribly poor. Nothing like the NHS. They weren't particularly

trained in assessing. They'd sometimes see people write a page and the big issue was that they would then send them to me whatever. So there's no concept of triaging.

So, I was the only psychiatrist at Colnbrook and I think there were 400 men. I had realistically four hours a week to see anyone who was sent to me, so I was not doing the job I was trained for. So, what I would have is huge numbers of distressed men, and out of those distressed men I had to tease out those who had a treatable mental illness, and that doesn't even take into account that it's virtually impossible to treat depression or PTSD in detention in a meaningful way. You apply the some treatments you do on the outside but they don't get better because the environment is actually counter-therapeutic.

And the other huge thing, which was actually being referred to earlier, which I felt was absolutely outrageous, is that at that interview in the middle of the night, everyone is effectively forced to sign a piece of paper which says now and in the future I will let the UKBA see my mental notes and do whatever they like with it. It's not informed consent. UKBA would always use that and therefore what you heard was absolutely right. Confidential information was always flying around and was being used in court procedures without doctors' permission. I spent huge amounts of time speaking to my medical defence organisation because of that, and to this day I know it has not been corrected even though there is talk about doing it.

Sarah Teather: Okay. Caroline has a quick supplementary.

Caroline Spelman: Well, I was going to move into the next section which is as the detention continues, then, the initial assessment, not having been great, what is the scope, then, to improve that situation? With specific examples that we've heard. So, coming in with a lack of medication that you need. How quickly does that get corrected if you have a condition that needs regular medicines? How quickly would that be picked up? If a detainee indicated a chronic condition like pancreatitis, what efforts would be made to contact the doctor whose name has been given at the detention centre to follow that through? And how readily- We know it's not easy and, you know, with everything going well, do the medical records get to the detention centre and do they ever actually get there?

Dr Naomi Hartree: Well, I've seen lots of medical records of detainees and done lots of detention centre visits that, you know, could link to mental or physical health problems, so I've quite a lot of experience of those questions that you're asking about.

So, in terms of accessing medication, I think it depends how much effort is made, whether the- If it's medication that has to be collected from a hospital clinic, for example HIV medication, that's often delayed because it has to be collected from a particular hospital, and so a guard has to go to collect it. If there isn't a guard available, there'll be a delay.

If it's less specialised medication, perhaps it will be more readily available from the local pharmacy or from the detention centre pharmacy. So, it's a very elastic answer. But Medical Justice has seen one case where a person with HIV was deprived of their HIV treatment for several days, and became resistant to the drugs, which was thought to be partly because of the delay in supplying medication.

Sarah Teather: This is a point, actually, that Danny, you raised in your evidence regarding clozapine, wasn't it?

Dr Danny Allen: Yes.

Sarah Teather: Did you want to say something about that?

Dr Danny Allen: Yes. Well, clozapine is only prescribable- It's an anti-psychotic, only prescribable by a hospital, and there was only one case but we had to scramble around to find a willing clinician in the community who had a vague connection to the patient in order to continue that patient's prescription.

Sarah Teather: John, is there anything you've got to add to this?

Dr John Chisholm: I think the fundamental point is that detainees are entitled to the same range and quality of health care, including specialist services, as any other patient in the UK and that includes rights to dignity and confidentiality and privacy and consent, and clearly that is not happening.

We hear frequently in the BMA reports of standards of care in immigration removal centres being substandard. We receive reports of access to hospital and to specialist services being denied or postponed, and often being dependent on the provision of escorts and the cost of that. Access to specialist services and the timing of that access should be on the same criteria as for any other patient. And I think there are particular issues in relation to mental health, and in relation to HIV and AIDS.

Paul Blomfield: Thanks. Perhaps I could follow up on the comments you've just made, because I think that would be our starting point as well, as being detained with the same rights to access a free range of health care. And yet you all have heard, as we have this morning, and some early health workers and indeed we did in our first evidence session, that that isn't working. People are neither getting access to support when they need it, or the intervention seems to be inappropriate to their needs. I wonder if you could share with us why you think that's going on in terms of the process that's taking place.

Dr Danny Allen: Yes. I would say something that covers both of those questions. So, certainly looking at it from a mental health point of view, and this is a huge problem, notes might come in, or they might not come in. We might ask and we might not get them. I may not know that notes have come in because there are no systems for telling me so. Someone's psychiatrist may write and I'd never see the patient because there's no system for letting me know that. Similarly a psychiatrist may write and say the person needs a course of treatment or they are having a course of treatment and I have- Certainly I think most doctors when they first start out and deliberately kept in the dark, and so I had no idea for at least the first six months – probably longer – that I could even think about saying that this person needs to be treated outside.

But specifically to your question, if you look at the two big issues, post-traumatic stress disorder and depression: if you want to make someone depressed, take away their hope, lock them up. It's a great way to make them depressed. Anti-depressants do not make people better in those circumstances. So we do all the usual treatments; they don't get better. So it's not possible in detention to give people the same standard of care for depression, in my view.

Paul Blomfield: Can you develop the point that you just made? Deliberately being kept in the dark.

Dr Danny Allen: Well, I have a very strong feeling, you know? The doctors who work in detention are often described as tools of the system, whatever. Actually, what it is is that no one explains to you the sort of things that you can do to say someone should be released into the community because they are not fit to be detained. We were very clearly given the impression by the staff that we work for that our job is to treat people where we are and where they are, and where they are is none of our business. And post-traumatic stress disorder, which is the other big issue, it gets worse in detention – absolutely no question about it – and there is simply no therapy for it. For the simple reason that you need stability in a calm environment. So even if you had the psychologists, it wouldn't work.

Sarah Teather: Can I bring Naomi in? I'm interested to hear your experiences of working with detainees.

Dr Naomi Hartree: Yes. I think when you're talking about on-going healthcare, I think the other speakers have outlined quite a lot of the concerns. And I think the problems with providing good care, you can divide them into sort of three main reasons. So, one is very poor access to medical records, from, let's say, from the person's previous GP, or to and from the detention centre in the

hospital where they may be seen. And the second thing is that there is- we have quite a lot of evidence that there is inadequate training of the doctors and nurses in detention centres in relation to types of problems that they're likely to meet. So that could be psychosis, post-traumatic stress disorder, other mental health disorders. Or it could be other specialised areas that you wouldn't normally meet in primary care. So, for example, people refusing food for a long period have very particular health needs and particular conditions that have to be recognised, and we see those not being met and not being recognised. So, very serious things being missed.

Another example would be pregnant women with malaria where- Sorry. Pregnant women who are being returned to countries where there is malaria, who would need quite specialised advice about malaria prevention medication, and we see mistakes being made in that. So, that's a lack of specialised knowledge and training.

Another important example about a lack of training seems to be in something called rule 35 reports which are detailed in our submissions. But the rule 35 is a kind of mechanism to try to protect vulnerable people from being detained when they shouldn't be. But it seems that the doctors working in detention centres aren't really trained up in how to use the rule 35 reports and how to complete them.

So, in various ways there's inadequate training, as far as we can tell, from what we see.

Then there's one more important area, which is that there does seem to be a culture of disbelief within the Home Office and within detention centres that extends into the healthcare staff so that there is a kind of underlying assumption that if somebody is ill and talking about symptoms or behaving oddly that they're doing it probably in a manipulative way. And it seems to be that if you're in a community and you see a doctor, then your first thought is, well, this patient might have a genuine symptom, whereas the kind of general picture we get in detention is that the doctor or nurse's first thought is, well, this might not be a real symptom; the person may be just playing up or trying to pretend they're ill for some other gain.

Sarah Teather: We wanted to talk about rule 35 but David indicated he had a supplementary.

Lord David Ramsbotham: Well, you've outlined very clearly some of the inadequacies of the system, starting at the beginning, and I'm delighted to hear the culture of disbelief mentioned, which was started by- a phrase by the independent asylum commission. But I'm interested in so what? What can be done about it? Because when you ask the Home Office what- who's responsible, they say NHS England is responsible for commissioning it. Well, we're not talking just about commissioning; we're talking about a code of practice which ought to be followed in every single immigration centre. And a code of practice requires actually somebody to be responsible and accountable for the delivery of that code of practice. And I would suggest that that code of practice in all this, as suggested from the inspectorate once, should start with the assessment, and go on to the primary and secondary care, for which there should be assigned pathways to people consistently having to look after, for instance, Colnbrook – there should be a supporting cast for Colnbrook; there should be a supporting cast for Harmondsworth.

Now, is there any evidence that that structure is being putting in place and do you think, actually, that it would be the structure that might improve a very, very unsatisfactory situation you've described so vividly.

Sarah Teather: Okay. And Danny's indicated he wants to say something. I haven't heard from John for a bit, so-

Dr Danny Allen: Well, I can give some of that answer because one of my current roles is with the clinical reference group, on the health and justice clinical reference group of NHS England where I've been trying to bring IRC Health to the fore, and we actually had a working group, a working day, sorry, workshop, at the end of September, where I learned something about what you're saying for

the first time. I mean, I think NHS commissioning is necessary but not sufficient, as you indicate, but the commissioners do have very clear ideas about what they want to see happen. But we are at an extremely early stage – it only started in September. So, we've got new providers in place. But I think I'd like to pick up just one thing which is incredibly important, which Naomi said, and that is training. And I think she's being kind when she says inadequate training. As far as I'm aware, no training has taken place, and that has to be- That is certainly part of their plan but I've not seen it in action, because the providers, certainly for Colnbrook and the Heathrow group say they can provide it, and that will be part of the- So the code of practice you're describing is there in the commissioning rules, but it's very, very early days.

Dr John Chisholm: Yes. I mean, I would agree that it's far too early to assess the impact of the change of commissioning responsibility, but I think it is worth saying that a similar transfer of responsibility in relation to prisons has started to produce improvements. And I hope that the same will be true of health care in immigration centres.

I think there are, with, if you like, the NHS being in charge of the commissioning opportunities to improve access to and quality of care, and to produce something which is much more closely equivalent to NHS care in the community. And the requirements certainly understand- include, NHS England having a detailed understanding of the commissioning requirements. This is highly specialised commissioning, and it requires an assessment of need and planning and monitoring, and that feeding back into how commissioning can be improved. And it also includes – good commissioning – includes actually engaging with patients placing them at the centre of the healthcare that's being provided of the service design and delivery. And it's vital that all staff, not just health care professional staff, but all staff are trained on the sort of specific health needs that are likely to be encountered as well as on cultural and social issues. And it's vital that interpretation services are available whenever they are needed 24 hours a day.

One particular point I'd like is about time for consultations. These are difficult consultations about difficult and complex health needs. But also language difficulties, inevitably, mean that more time is needed, and that's going to be different from the care that these doctors provide in the community. If you think of the average 10-minute consultation in general practice, that is not going to be something that can be just transferred into a detention centre and thought of as appropriate and sufficient. And so staffing ratios, you know, the level of healthcare input that's available. You know? One psychiatrist with 400 patients is not an effective service. It cannot be.

Sarah Teather: That's a very helpful point, actually. I don't know whether or not you, as a BMA, feel capable of giving us some evidence about what you would consider to be an appropriate staffing level, because that's something we- Detail of numbers is something that we can get at. They're not always forthcoming in providing statistics, but that would be something helpful and useful.

Dr John Chisholm: We'll come back with some further written evidence on that issue. Yes.

Sarah Teather: Yes. Caroline had a brief supplementary. I'm keen to make sure that we do deal with the rule 35 issue.

Caroline Spelman: I understand it's early days in the NHS commission process, but is the provision uniformly bad? Are all the detention centres pretty much as bad as each other or is there actually some variation? Is there any glimmer of hope that there's some best practice emerging as people gather greater experience? They may not have had the training but over time they're going to get more experience at it. Is there any crumb for comfort here?

Dr Naomi Hartree: Well, we're certainly hopeful because the NHS commission does have the potential to change things.

Caroline Spelman: Yes.

Dr Naomi Hartree: And, you know, even in basic things like record keeping and communication that would be a start. At present, there is a variation in how bad the health care in detention centres is and one of the detention centres we find as being better is the one which has had- been commissioned by the NHS for some time.

Sarah Teather: Which is that?

Dr Naomi Hartree: That's Haslar.

Sarah Teather: It's nice to know which ones are better because at the moment we just have a role-call of terror. So it's good to have one pulled out as being slightly better.

And there are- We still have got concerns about what happens so far with the commissioning. Two particular concerns. NHS England has not had a great deal of engagement with some of the stakeholders. So, for example, we have had very little- At Medical Justice we've had very little dealings with NHS England in terms of the meetings and the setting of the service specifications. And that's rather surprising when we've probably got the greatest cumulative evidence base of health care problems in detention centres and the health needs of detainees generally. So, that was a pity.

And, secondly, we've now seen the service specifications for the NHS commissioning, which have just been made public. And there are some worrying things. The most worrying one, I thought, was the- are references to health care staff participation in managing difficult detainees through corrective, punitive and therapeutic measures, and the idea of health care staff being involved in corrective-

Sarah Teather: Where is this from?

Dr Naomi Hartree: This is from the service specifications for the procurement process. It's in our written submissions. I find that very worrying. And this is not a prison system; it's not for people who've committed a crime; it's a detention system.

Sarah Teather: Well, it's not appropriate for health care staff to be involved in that anyway

Dr Naomi Hartree: I certainly wouldn't think so.

Sarah Teather: It doesn't strike be as being in accordance with standard health care ethics.

Dr Naomi Hartree: Absolutely not.

Dr John Chisholm: In a way absolutely the reverse, that health care professionals have a role in identifying and reporting and preventing human rights abuses. And certainly not being involved at the use of restraint, for example, is something which is absolutely- should be absolutely exceptional, and only considered if someone is placing others or themselves at risk. And the sucking in, if you like, of health care professionals into a custodial role is something which should be condemned and resisted.

Sarah Teather: And I think that's a point well taken. I'm keen to make sure we- Can we perhaps incorporate what you want to say to- Sally, can you go back to the rule 35 question? Because it's come up over and over again from detainees who've asked and who've spoken to us. So, I just want to get a bit more information from you about this.

Baroness Sally Hamwee: Well, I wanted to ask about rule 35, and also about training, but it occurs to me, Sarah, that if we can impose on our witnesses further, perhaps the BMA would like, if they're going to give further written evidence, to tell us about the sort of training that is required and attempted to go into, you know, retraumatisation and why victims of torture do not, until they've had many opportunities to do so, talk about it.

Sarah Teather: It sounds as though maybe Medical Justice will have some views on that.

Baroness Sally Hamwee: Yes. Not only what training, but of whom – not just, I suspect, health professionals. Sorry. We are imposing on you. But rule 35, I suppose what it boils down to is how can it be improved?

Sarah Teather: Naomi, you started to say something about that. You said so many interesting things in your answer that we wanted to pursue them all. Do you want to pick up on some other things that you might have wanted to say? And then I'm very keen to hear from Danny in particular on this.

Dr Naomi Hartree: About rule 35?

Sarah Teather: Yes. Because it can- It's so persistent as an issue from detainees.

Dr Naomi Hartree: Well, that's exactly it. It's a very persistent issue. Rule 35 has been documented for years as not working. And what Medical Justice would really like is a review of the whole rule 35 system from start to finish: the way health care staff are trained, the way they're dealt with at the Home Office side of things – the whole process needs to be reviewed, because none of it works. There are a number of different steps in a rule 35 report, and none of them appear to be working properly.

Sarah Teather: Do you want to give us just give us a bit more information, because this is the meat of the issue.

Dr Naomi Hartree: Okay. So, right at the very start of the process, that health care screening interview, there's a lack of understanding about what is or isn't torture and of how to actually illicit an answer about torture in a sensitive way from a detainee in the middle of the night. So, people won't be identified as needing a rule 35 in the first place. Then if later on they are identified as needing a rule 35, the doctor who they see may have very little understanding of what to put in the rule 35. So, some doctors will only put scars; they won't put in that the person has PTSD or that they're feeling suicidal, or that their health is- that their health is being damaged in some other way by the detention system.

So, there's a lack of understanding on the doctors' part on how to complete that assessment in the first place. They may also have a lack of time to do it.

And then there's a lack of any sort of- In most cases it's a lack of an appropriate response at the Home Office end. So, for example, some of the doctors will write these scars are consistent with torture, or I have concerns that this detainee is a victim of torture, and they might document quite extensive scarring or quite severe mental health symptoms. But then the response by the Home Office will simply be that this doesn't count as independent evidence of torture, and they will simply maintain the detention.

We've seen very, very few, I mean, a tiny percentage of people actually getting released on the basis of rule 35 reports. And there was a recent High Court judgement about one case in which the judge said very clearly this rule 35 is not working.

Sarah Teather: Okay. That's very helpful. Danny, is there anything you want to add to this?

Dr Danny Allen: Well, I'll quickly whizz through it and put it all together. So, the CRG had no impact, unfortunately, to those terms, which I agree are not very good. And part of the reason for that is, I think, because they are overly keen to partner with the Home Office, and I think there needs to be some differentiation.

There's a whole issue here which we're teasing out where on-going health care has to be combined with some investigative work to the effects of torture, because at the moment the system is overwhelmed, so you're actually struggling just to treat people with the stuff they present with, let alone look for stuff.

And, again, training: training is one of my big issues. At the moment the commissioners are leaving it to the providers to come up with training programmes; they're going to look at what they come up

with. Now, there's an organisation called MEDAT, which I'm associated with, and we have actually put forward a training programme. We know exactly what's required from some people who are very knowledgeable. And no one's taken it up – largely because the organisations who were in place said, oh, well, we'll have a look at it or we'll think about it later and of course they've been overtaken.

But it does have to include all these things that have been talked about – this is incredibly important – and recognition of PTSD and very importantly and understanding of the detentions of the service rules, which, of course, are unique, and no doctor or nurse would possibly know about it if they weren't trained.

Baroness Sally Hamwee: That is on paper, presumably. Perhaps we could see it.

Dr Danny Allen: Yes.

Sarah Teather: I'm conscious of the time. There's been a whole flurry of sudden interest from my colleagues in what you said. But David, can you just ask a version of question 6?—because this is really important—and then I can bring other people back in on supplementaries, if that's okay.

Lord David Ramsbotham: Well, it is and it seems a fundamental thing, and I think you've answered it in general terms, and it is whether in fact you think that the healthcare needs of the vulnerable people who are in there are being currently met within the immigration system.

Sarah Teather: I think the thing I'm particularly keen about when people answer is about pregnant women. And Medical Justice have some particular expertise here and I was surprised by the number of pregnant women I saw inside the Yarl's Wood, some of whom were very, very pregnant. That's not- That's probably a completely medically inappropriate way of describing someone, very, very pregnant, but-

Dr Noami Hartree: It's fine. I mean, the short answer to the question is no. The vulnerable patients' needs are not met. And, I would say, actually, that there's a paradox that the more vulnerable you are, the less likely are your health needs to be met in detention. And the more likely your vulnerability general problem, health problem, is to get worse.

In relation to pregnant women in particular, yes, we do see a lot of pregnant women detained, and they don't seem to be receiving care that's equivalent to the NHS in many cases, and there are practical problems with trying to give NHS-equivalent care when somebody is locked up and not able to get to normal hospital appointments. And we have seen examples like an immigration interview being prioritised over a 20-week anomaly scan. We've seen lots of problems with the obstetric records not arriving in detention with the patient, not being looked for. We've seen test results not being chased up, and we've seen a lack of specialist knowledge. So, although there are visiting midwives in detention, the day-to-day nursing will be probably done by nurses who are not specialist midwives.

And we've seen things like, you know, the need for specific tests or the need for a specific carer complex pregnancy not being met.

Sarah Teather: Well, I have a constituent - I'm going to abuse the chair's position here at this point because I'm keen to get your response to this - but I had a constituent who has pregnant, in the very early stages of pregnancy, and we-attempted to get her released from Yarl's Wood on the basis that she was pregnant and so she was [unclear] not to be there, and the response that came back was that as she wasn't yet 12 weeks, it didn't count.

Dr Noami Hartree: I've never- It's the first time I've ever heard somebody say that a less-than-12-week pregnancy didn't count and from a medical point of view, that's-

Sarah Teather: I wasn't impressed. Anthony's been trying to get in for a while.

Lord Anthony Lloyd: Yes. It seemed to me that Doctor Allen made a very strong point on confidentiality of medical records. And clearly obtaining consent at the screening interview within two hours of arrival is absolutely indefensible. But could he perhaps explain how he would like to see it done instead, if at all? What should be the process?

Dr Danny Allen: Oh. Well, it's got to be informed and specific – I mean, that's the nature of consent. So, if for example, and this is- And, also, there has to be a differentiation between the court process, tribunal process, and clinical care, and UKBA simply didn't understand this. So, for example, if the UKBA are arguing that the person hasn't got a condition, for example, and they want the opinion of a doctor, they need to commission an independent report from someone to go in and see them, see the person, and they shouldn't be- They shouldn't be extracting limited amounts from the medical notes, particularly as the medical notes are inadequate. I mean, I would be the first to say that because I don't think it's a doable job. And one of the earlier questions was about experience and how you could make it better. There's such a fast turnover because the job is so aversive. I've spoken to so many doctors who've worked there: you're either thrown out or you leave of your own accord because you can't gain that experience.

Dr John Chisholm: Yes. I mean, I think that this really ties in with Lord Ramsbottom's question about meeting healthcare needs and about standards of care because there undoubtedly are poor standards of care; there is a failure to properly identify and investigate and care and refer. But there is a failure to deliver international human rights applications – health-related human rights – in terms of freedom from inhuman and degrading treatment, but also freedom to enjoy the highest attainable standards of physical and mental health, and that includes respecting the normal rules of confidentiality and obtaining consent. And it is absolutely wrong that health care records which are obtained for one purpose should be used for another. And the sort of consent that's, alleged consent, that's being sought when arrived in detention centres isn't consent in any meaningful sense at all. It's non-consent obtained under duress.

Sarah Teather: Ruth if you could ask a last question. We're running a bit behind.

Baroness Ruth Lister: I have a quick supplementary: Can I ask that first?

Sarah Teather: Yes, indeed.

Baroness Ruth Lister: Just a quick supplementary to Naomi about rule 35. In your written evidence you said that the Home Office had promised a proper audit of it and then scrapped that and came up with some other rather less satisfactory exercises. Did they ever explain why they went back on their promise to do a full audit? And was there any information to be gleaned from the policy marking exercise they did?

Dr Naomi Hartree: Well, what they seemed to come up with is what they call dip sampling, but that's not a systematic review of their rule 35s. And any information that has emerged from our freedom of information requests or the other statistics that are available just show time and time again that rule 35 doesn't work. And that's the same with my individual experience of visiting detainees. So, for example, this year I've done several detention visits to people who are, when I see them clinically, it's very, very clear that they are likely to be victims of horrendous torture, and they describe stories that I could not possibly talk about here, because it would be too distressing, and they- some people are quite literally covered in scars, and have PTSD symptoms to the point where they are hallucinating, so they've got psychotic PTSD.

And some of those people have got rule 35 reports from the detention centre GP documenting those things, or documenting some of those things, and some of these people have also eventually got to see a detention centre psychiatrist, and in some cases the psychiatrist has also said this person is not to be put in detention, and the detention is making their PTSD worse. And weeks or months later, they are still detained. And I see that all the time.

Baroness Ruth Lister: Okay. So, if I could just- Our final question. I think you all heard our previous witnesses talk very powerfully about the impact on them of there being no time limit on how long you could be detained. And so we would like to hear from you as the medics what you think the impact is on their physical and mental health of the indeterminate nature of detention.

Dr Naomi Hartree: Shall I start?

Dr John Chisholm: Yes.

Dr Naomi Hartree: The cost of detention in terms of mental health is absolutely enormous. I've not only worked for Medical Justice, but I've worked with refugees in community settings, so I've seen people out of detention, and some people I've seen coming out of detention have been about the sickest patients that I've seen outside of working in an in-patient psychiatric unit. And these are people who will come to the clinic and a colleague will say I don't understand what's going on with this person; they seem a bit confused; they can't really talk. Or somebody who has to be brought by a friend and literally sort of almost manhandled into the room because they are so depressed they can hardly move at all. Things can be that severe. And the example that I saw in the earlier evidence of somebody who had to stand in a supermarket watching other people to remember how to do the shopping, we see and hear a lot of that as well.

And I think it just cannot be emphasised too much how quickly downhill someone's health will go if they've already been tortured in a prison in their own country or some other setting, and then you put them in a controlled environment where they are, number one, locked up, and then, number two, thinking every minute that they're going to be put on a plane and taken back to that country where they think they're going to be tortured again. And, I mean, it is like Danny Allen said – you cannot get people well in that situation and you can only make them worse.

And at Medical Justice we have had some patients who went into detention completely well, with no history of mental health problems whatsoever, and came out with depression and psychosis months later.

We have lots of people who had, for example, post-traumatic stress disorder following a use of torture who were managing while they were in the community and supported and not detained, and then, by the time they'd been detained for a while, they were at a level where they needed intensive psychiatric support or even hospitalisation, and lots of medication and lots of GP input.

So, it is a huge cost. To my- In my experience it's a kind of- It can take years for people to recover, if ever, because I think trauma does stack up. It's not just you do something and you get better and you do something else and you get better; the effects are cumulative, so the cost is huge.

Sarah Teather: Thank you very much. John?

Dr John Chisholm: Yes. Detention in and of itself creates health problems and certainly the BMA believes that there are a lot of people who really shouldn't be detained. We shouldn't be detaining asylum seekers; we shouldn't be detaining victims of torture; we shouldn't detain pregnant women, or children. But the indefinite length of detention makes things worse. The strong evidence of the deleterious impact of that indefinite length of detention on health and wellbeing. And it also creates problems for the health care professionals who are trying to plan and provide and deliver health care interventions and treatment, because they too are the victims of that uncertainty in terms of coordinating proper care.

So, detention in and of itself creates health problems, but the indefinite length of it also adds to those, compounds those problems.

Sarah Teather Danny, if you can be brief?

Dr Danny Allen: Yes. Well, I agree. From the mental point of view, if you remove hope, create uncertainty, it's a fantastic way of making people depressed. And anyone who has PTSD, you stick

them in detention – that's a fantastic way of making them really, really ill. And anyone who has psychosis have had people come in and out, in and out all the time, it makes them psychotic, they get treated, they come back, and if anyone tells you that they can be treated in there- They have a thing called the health care centre, the in-patient unit. Total nonsense. It's run by security staff. No concept at all of health at all.

Sarah Teather: Thank you very much to all three of you. And again, if there are things that we've picked up that you feel that you wanted to explore further, feel free to drop us a note with further information. Thank you. That was very, very powerful and very helpful to have it on the back of the early evidence.

We're divided into three today, really. We've been hearing real-life experience; we've been hearing from some medical experts; and we now have the legal input. I'd like to invite you to switch over. We have a couple of colleagues who were unable to stay for the end.

So, in our next panel we have Justine Stefanelli from the Bingham Centre for the Rule of Law, Doctor Adeline Trude from Bail for Immigration Detainees, Kay Everett from the Immigration Law Practitioners Association, and Laura Dubinksy from Bhatt Murphy, so thank you very much for being with us.

The thing I suppose came out from all of your evidence, particularly a strong reaction from ILPA's submission, the Home Office's own guidance states that detention should be used sparingly and for the shortest possible time. What I'm interested to get your perspective on is to what extent you think this guidance is actually complied with in the real world. And if I can start with Kay, if that's okay.

Kay Everett: Sure. I mean, the presumption of release is enshrined- Obviously it's enshrined in our laws but we think it's far from practice. Just looking at some of the statistics that are out there, we can see from the increasing numbers, over the last decade, there's been a 150% increase in the number of people detained. There are numerous cases before the courts where we can see long-term detention is increasing. I think one of the judges has said it's yet another case of long-term detention.

And the longer you're detained, the less likely you are to be removed. It's a slightly perverse situation. And so we see in 2013 that 62% of the people who were held for over a year were then released and released into the community. And there's just an increasing amount of detention. Proper, considered authority for detention doesn't take place. It's very much a tick box exercise. I think the speakers we've had earlier today talked about the culture of disbelief, and there's certainly, we think, a culture to detain, not for the presumption of release, not to look at alternatives, not to think about what could be done within the community structure. If people are assessed to be at some kind of risk of absconding and not reporting, there are things that can be done with the setting to manage that rather than detention, which is a very extreme end of dealing with those perceived risks.

Sarah Teather: Laura.

Laura Dubinksy: I should perhaps explain I'm not quite from that Bhatt Murphy. I'm from Doughty street chambers. But I frequently work with Bhatt Murphy on immigration detention cases and they've asked me to speak to their written evidence.

In Bhatt Murphy's experience and mine, this guidance is unfortunately often given lip service by Home Office caseworkers when making decisions, but ignored in substance. And there is a pattern, certainly, of continuing to detain people long after it should have been clear that they can't be detained within a reasonable period, or sometimes at all.

And that's been commented on by many authoritative organisations, the ombudsmen, the ombudsbodies with oversight of the prison service and the immigration removal centres, and also international human rights bodies and experts.

Likewise the judiciary, just to give you one example in a case called Mhlanga, there was a case of a Zimbabwean national who'd been detained administratively for five years, and for four years of his detention, the first four there was a moratorium on removals to Zimbabwe. He simply couldn't be removed.

And to give you another way in which we see that guidance being ignored, there are often instances in which a detention is maintained long after information comes to light, which should, even under the Home Office's published policy, have led to a release. So, for example, there was a joint report by Her Majesty's Inspector of Prisons, and the Independent Chief Inspector of Borders and Immigration of 2012, where they describe meeting a young man who had been administratively detained for 15 months and, notwithstanding, that he had already been identified before his detention even started by a competent authority as a victim of trafficking. And I would echo what Kay says – that there seems to be a tendency amongst Home Office caseworkers, notwithstanding the requirement and policy of operating presumption of release, to detain not as a last resort but as a default position. And, you know, it's been particularly prevalent where one is looking at the foreign national or former offenders, people who have completed a custodial sentence and are being held for criminal deportation.

So, to give an example, a particular manifestation of that, we often see the Home Office deferring, not until the end of a custodial sentence but until long after the end of the custodial sentence, the decision on whether to deport.

So, the law changed in 2008 allowing the Home Office to detain while considering whether to deport, even before a decision has been made. And clearly the Home Office is taking the approach that it has its time, after the completion of the custodial sentence.

Sarah Teather: So there's absolutely no preparation. And they're also being pretty obvious when someone has a prison sentence that they should or shouldn't be deported, if they might be eligible for deportation, in a sense, considering that none of that process has taken place.

Laura Dubinksy: Yes, yes. And it's extraordinary and, clearly, in many instances, the decision, not only the decision can be taken before the end of the custodial sentence, but also appeals dealt with. And so this is causing immense human cost in terms of unnecessary detention but also of course a cost to the taxpayer.

Lord David Ramsbotham: It was in 1999 as chief inspector of prisons that I recommended that anyone sentenced to deportation should have that process while they were in prison so that at the end of the prison service they went straight to the airport and out.

Laura Dubinksy: Yes.

Lord David Ramsbotham: That's what happens in the UAE and other places. And why it doesn't happen here, I simply don't know.

Laura Dubinksy: Yes. So we see the government wringing its hands about why the early removal system doesn't seem to be working but of course it's because you can't remove somebody who has still got pending appeals.

And I think if one was to see a particularly extreme manifestation of that tendency to treat detention as the default, not as the last resort, it's that between 2006 and 2008, the government operated a secret and unlawful blanket policy detaining all foreign national offenders upon completion of their sentence. And they operated that unknown to lawyers, unknown to parliament, unknown to the courts, for some two years. And that ultimately came to light only in litigation but ended up in litigation that went to the Supreme Court. But this is the sort of thing that happens where you have

the executive, for all intents and purposes, being allowed to run its own detention system for much of the time subject to its own supervision. This would not have had if one had maximum time limits, and it certainly wouldn't have happened if one had automatic judicial oversight.

Sarah Teather: I just wanted to say that you're under no obligation to speak about every question, there are going to be plenty of questions. Anthony, can I ask whether you might ask question two? Because I know it's a topic you're interested in.

Lord Anthony Lloyd: What barriers do detainees experience and the legal advice and representation available adequate: is it that question?

Sarah Teather: Yes. Exactly. What barriers to legal representation do detainees experience and is the legal advice and representation available adequate?

Dr Adeline Trude: BID runs a survey every six months where we talk to about 150 detainees about their experiences of looking for legal advice and what happens when you get that. We've started to talk to detainees who are held in prisons as well, and we have to do that by post.

So, over the last four years we've spoken to about 1000 – well, over 1000 detainees. We've isolated key points, I think, key barriers, and what I would like to encourage the inquiry to do is to look behind headline figures of the proportion of detainees with a legal representative – that there's a lot more to do with how long people are having to wait and what sort of communication they're having with the provider firms.

So, setting aside language issues, which are obviously huge in terms of seeking legal advice and then working efficiently and effectively with a legal advisor, we've identified four main barriers that affect the ability of detainees to progress their case and then to access safeguards against unlawful detention that are offered by the courts and the tribunal.

And these barriers are: firstly, the inadequate capacity of the legal surgeries and IRCs and the subsequent delays that people face in even speaking to a solicitor.

Once they've seen a solicitor, there seems to be very poor communication, in many cases – this is something quite new – and detainees are left in limbo for weeks or even months not knowing whether they're represented or not. And, during that time they are effectively unrepresented.

Something that one of the earlier speakers referred to was transfers around the estate, and our survey shows very clearly that people are being transferred repeatedly around the estate, and that's affecting their ability to retain their legal advisor. So once they've moved, they then have to join the queue again to see someone in their next IRC, and there's no guarantee that they'll be taken on the next time around, and they may have to wait for months with a long interruption in the time they have advice on their- the fact of their detention.

And then what to us is a huge problem, the fact that longer-term detainees are clearly being left without legal advice on the fact of their detention for very long periods. So they may get a legal aid advisor if they don't have the means to pay for advice somewhere near the beginning of their detention. But if the any outstanding appeals are dealt with and they're left with just the fact of their detention, very often their files are closed.

I can speak a little bit more about how that works if we've got time and the problems that people face.

Sarah Teather: Hold onto it and we'll come back to it, actually. I just want to throw in here, certainly the allegation that I have heard over and over, having been into detention centres, which is usually put in rather colourful language, that the lawyers are crap. And that's almost universally what tends to get said.

They'll say that there's one good firm that they want to see and every other firm should be avoided, and I would be interested to know whether or not, please don't repeat, necessarily repeat the

colourful language, but it was always that word that was used, and sometimes worse words, the three legal firms usually available in detention centres, do you have a perspective on the policy of what's provided.

Dr Adeline Trude: I think a lot of those sorts of evaluations of the nature of advice are about communication and being unable to find out what's going on in a case. That is the biggest frustration that people express to us. You know? I saw someone in the surgery, I heard from them shortly after that and then I haven't heard for months after – I have absolutely no idea what's going on in my case.

The issue of quality legal advice is a huge issue. It's beyond the scope of the inquiry. But then what has struck us is that there appears to be very little appetite on the part of the legal aid agency to tackle the quality of advice that's delivered to people in IRCs. They haven't sought information on customer satisfaction surveys providers are required to collate. That hasn't been part of their audit activity so they have no idea of what advice is like from the perspective of the people who are looking for it and receiving it.

We found out not so long ago that the legal aid agency manager who's responsible for these IRC contracts had never been to an IRC to observe a surgery in operation.

And what the provider firms were having to deal with, particularly now, after the effects of LASPO and the withdrawal from the scope of legal aid of the issue that gets people into detention in the first place and the problems that that causes for providers in managing those surgeries and the intakes. And my colleague from ILPA may be able to speak to that more directly.

But there's an unwillingness, I think, to have a look at the delivery of legal advice on the ground and look at those problems of delivery.

From a detainee's perspective, I think it's important to remember that this is a very vulnerable group of people. Language and reading ability in English may not be good. It's a transient population and people are isolated and anxious. It's very difficult for people in that position to conclude what are often very lengthy complaints procedures if they're not satisfied with the advice they've been given. Or if the advice they've been given is clearly wrong, very often people are unwilling to challenge their legal advice. And although some do, and they do it very effectively, with assistance from visitors' groups and the like, it's not an easy thing to do. And the existence of these exclusive contracts means that there may be no other firm that that person can go to if they're not happy with the advice they've received.

So, it's a captive market and I think that brings its own dynamics in terms of, you know, the administration of advice and communication, if not the quality of the advice that's given.

Sarah Teather: That's a very helpful answer. Has anybody else got anything to add on that?

Kay Everett: Yes. I should also say that I'm a solicitor at one of the exclusive contract firms. So, from the point of view of the practitioner, what we hear from ILPA members and what we experience ourselves when we go to these detention surgeries, is that: detainees are not getting access to us immediately; they're not being informed about the surgeries; they're not being given information about how to sign up for a surgery and what a surgery means and what it could lead to.

Particularly there are vulnerabilities for detainees who are in health care. Those who are disabled and those who have been segregated – often they're segregated because of mental health problems, risk to others, risk to themselves.

And then they don't get to sign on to the surgery. The surgery list is held in the library. They have to go along and put their name down. If they can't get to the library, they can't sign up. Even if they are assisted to sign up, they're not necessarily produced when they've signed up for the surgery. So there are very practical problems with that infrastructure itself.

And then, as advisors, we have 30 minutes with each detainee under the legal aid exclusive contract to diagnose their legal problem, which is often extremely complex. As we've heard, many people have been in the country for a long time already; there may be, you know, historical issues. The legal aid cuts are really affecting what we can advise on and what our remit is. And within that 30 minutes, you also have to do a full assessment of their financial eligibility and merits test – whether the case will be meritorious within the structure of the legal aid contract.

It's very difficult to do even for a very experienced advisor with a client who is anxious, who isn't able to articulate the history of their case in a nice, neat five minute summary. They may come with documents; they may come with nothing. And it's a very unsatisfactory process.

We also see- I understand the complaints. We also see that there is a range of quality of advice – a vast range. And, as my colleague Adeline said, it's very difficult to challenge that. There's a lengthy complaints process and if you did want to move to a different exclusive contractor, let alone another legal aid advisor, you have to go through that process, which lengthy, and you may get moved to another immigration centre in the meantime, which frustrates that whole process once again. And I think some information had been asked from the Home Office about those transfers between-

Sarah Teather: Yes. I tried.

Kay Everett: And they don't keep any-

Sarah Teather: They said it was too expensive to count.

Kay Everett: Yes. So there's no- And we're not informed as advisors if our client is being moved. The first we hear about it is usually if our client has managed to travel with papers, got our number, is a call from them to say last night I was in a van for nine hours; I'm now in Dover, Dungavel. You know? It's very unsatisfactory.

Sarah Teather: David, do you want to ask the next question? I'm conscious we haven't asked Justine anything yet.

Lord David Ramsbotham: Yes. We touched on and Laura touched on the fact that a lot of people are left in prison, not just at the detention centre, and one of the things I used to find in inspecting prisons was that the immigration authorities never, ever visited the prisons. And, therefore, what you're describing is that the lack of information in detention centres was in spades in the prison system, because nobody appeared to know, and they were just left to rot there. And it's again a barrier that could and should be overcome. And I wonder if you could confirm or deny that, the prisons, because I think that any detainee who happens to be in prison should be regarded as part of the overall system, not just that they happen to be in prison.

But you mentioned, Kay, the complaints system, and I'm very glad you did because we had a discussion about this last week. And I think that the complaints system is one of the real barriers to making progress. And nobody seems to be able to speed up all the things that you've been describing, because nobody seems to be able to get a complaint through to the people who could do something about it. Would you confirm that?

Dr Adeline Trude: Are you talking about detainees who are held in prisons particularly?

Lord David Ramsbotham: Yes – absolutely.

Dr Adeline Trude: I mean, they- What I think is worth- Just backtracking a little bit and pointing out that immigration detainees held in prison post-sentence are held entirely outside the statutory detention centre rules. They're entirely outside the detention centre operating standards and detention service order. So, their detention is administrative detention within a criminal justice framework, if you like.

Their numbers are not included in the published Home Office statistics, so the numbers of detainees and the lengths of their detention are hidden entirely from parliamentary scrutiny and from public view. So it's a very hidden population.

They face incredible problems – the hundreds of detainees who are held in prisons – in accessing immigration legal advice. And obviously our focus at BID is one's access to justice. There are other lacunae as well, like the absence of a rule 35 process.

But anyone who's held in one of the 80 prisons where detainees were being held as recently as a few months ago has to find an immigration solicitor or immigration advisor entirely by themselves. There are no on-site surgeries as there are in IRCs. If they manage to get a solicitor, it's incredibly difficult for them to communicate with their advisor. They're not allowed to hold mobile phones; post arrives quite late on the wing. You can't have the same two-way exchange with your client when they're held in prison as you can in an IRC. You have to either write to them and let that letter go through the prison postal service, or you have to hope that they'll call you and it makes it incredibly difficult to take instructions from your detained client in the sort of circumstances where you often need to act very quickly. You want to be able to lodge an application for bail or you need to do something within a short space of time. They're not allowed to send faxes other than at the discretion of prison officers.

So, the whole system is entirely unsuited to the legal advice needs of people who are held in administrative detention. They can't communicate with the courts; they can't even, when you think about it, communicate properly with the Home Office, so it doesn't actually benefit anybody to hold detainees in prisons.

There are particular problems with bail. People who are detained in prisons who are seeking release on bail very often, we find now, are losing their grants of a Home Office bail address, simply because it takes too long to reach them on the wing. They've got a 14-day grant of an address from the Home Office, and by the time it reaches them, they may have a day or two at the most to try to lodge a bail application. It's impossible to communicate with people in those circumstances, and very often they're losing those addresses, having waited weeks or even months to get them.

Even if they are granted release, my feeling is that the Home Office hasn't really thought through the implications of detaining people in prisons. They certainly haven't thought through the implications of their being released on bail. It's quite common for people to be released and they're not provided with a travel warrant to travel to their Home Office bail address, leaving them with no money, often with no possessions, and no means of getting to their bail address and standing in the tribunal entirely at the mercy of their barrister and at risk of being in breach of their bail conditions, and possibly their licence conditions as well. And that just hasn't been thought through by the Home Office before deciding to use the prison estate to hold immigration detainees.

There'll be plenty of other examples of things that haven't been thought through, but those are the sort of key problems.

Sarah Teather: There's an awful lot in there, I think, for us to pick up and consider. Anthony, you wanted to come in on a supplementary.

Lord Anthony Lloyd: Yes, yes. I would simply like to say that I've- I think we have four papers on this subject, and I found them all completely convincing. And, in particular, I entirely agree with the four legal barriers to legal advice, which are mentioned, I think, in thinking Doctor Trude's paper. But what I'm not quite so clear about is what we're going to do about it. And does it need- Is it simply a question of getting more money to it or what? I mean, what is the best way of solving the problem?

Laura Dubinksy: I think the obvious answer would be not to detain those people in the first place.

Lord Anthony Lloyd: Ah. I think we all agree about that. But I think assuming for the moment that, let's say, there's going to be, which I should hope, maximum detention of 12 months or something, what should happen during that 12 months to make it easier for people to get legal advice?

Laura Dubinksy: I might ask my colleague from ILPA to talk about that because you have some thoughts about-

Kay Everett: Yes. We have experienced the absolute difficulty of, A, identifying clients who are in prisons, and, B, having any contact with them. There aren't advice surgeries. I think the same thing I said for the I- for the detention centres – there needs to be a mechanism for a person when they're put on immigration detention, when that detention is authorised at that point to have a referral to a legal advisor.

Lord Anthony Lloyd: Yes. I see.

Kay Everett: So that there is an immediate tie-up because we otherwise have no ability to know that unless they're an existing client in some way or unless BID or other organisations have been on visits to prisons to identify who these people are and then they go through a referral process which can often be lengthy, it's very difficult to have an immediate identification of who has been detained, and to give them advice about what the remedies are, and assess the legality of that detention.

Sarah Teather: Can I just bring Laura in?

Laura Dubinksy: I wonder if the answer isn't simply to tie up automatic judicial oversight with legal representation. So, if we think about how it operates in the criminal justice system, in pre-charge detention, if you're going to be held more than 36 hours, you've got to be brought before a court.

It's an inter-parties application. You're entitled to legal representation and you're entitled to disclosure about why you're being held. Terrorist detention is 48 hours and yet we have this extraordinary situation where immigrants who have such difficulties in obtaining legal representation have barriers of literacy, other vulnerabilities, are expected to instigate their own bail applications before the tribunal and even instigate their own challenges in the high court to the legality of their detention, and that's an extraordinary state of affairs, and it's one that's an anomaly in our own legal system and an anomaly also in the EU.

Lord Anthony Lloyd: But to change that, would that need legislation or could it be done somehow by some directive from the Home Office? If we could persuade the Home Office.

Laura Dubinksy: Well, why should it not be in primary legislation? The problem of policy is that it's changeable by the Home Office at will, and also of course that the Home Office is entitled to depart from its own policy when it has good reason, so we'll never have proper protection unless it's in primary legislation.

And one point I might come back to later is of course although my own view of that Bhatt Murphy's is that the time limits in that directive are far too generous, there is an example out there which is the returns directive that now applies to all member states other than the UK and Ireland, which actually operates tight time limits, and the returns directive does require automatic judicial oversight where detention is prolonged.

So, we know it's out there. We know that every other member EU state is doing something like this, and there's simply no good reason why the United Kingdom can't do it.

Lord Anthony Lloyd: Yes.

Sarah Teather: Jessica, do you want to come in on this point?

Justine Stefanelli: Just to underscore the automatic judicial oversight, I think it might be helpful to give some examples of some of the EU countries where they do have rules and laws in place that require detainees to be put before a judicial authority either as soon as possible or within a set

amount of dates, and the Bingham Centre would advocate that a clear time period such as 48 hours would be preferable to an as soon as possible standard.

We've got Danish law which requires that a non-citizen deprived of liberty be brought before court within three days, and the court must then rule on the lawfulness of detention and whether it should be continued.

In Switzerland, the detention must be reviewed within four days – at an oral hearing, so again, I think that's an important point to mention. It shouldn't just be based on a paper review; they should have the opportunity to be heard by the judicial authority.

And in France, similar laws require an oral hearing within 120 hours.

So, I just echo everything that my colleagues have said.

Laura Dubinksy: And, sorry, one thing I should also say is of course it's not enough for people to come before a court at the start of detention because very often the reasons why someone is being detained unlawfully become clear only as the detention becomes protracted – for example, it is impossible to obtain a travel document. And so what I think we have said and we're common on this is that there has to be regular review.

Justine Stefanelli: Yes. It's definitely a hand-in-hand process. And the regular reviews should be able to take into account any new facts which arise, precisely because of that point.

Baroness Ruth Lister: I think just the second part of the next question, which is- And you've sort of touched on it, Laura, is how specifically the bail process could be improved.

Dr Adeline Trude: I'll have a go at that. I think on paper an application for release on bail to the first tier tribunal has potential to act as a safeguard against arbitrary long-term detention. But it has to be supported by structures and practices that would ensure fairness in outcomes. It's got to ensure fairness in outcomes for people who have no legal advisor, who have no one representing them at their bail hearing. It has to ensure fairness for people who are detained longer-term, and, by that, I'm talking about sort of over three or four months. And obviously it has to work for people who are detained at the upper limits, which we're seeing at the moment, which could be four, five, six years. And I think fairness relies on, amoung other things, on regular and timely access to the tribunal.

What I think is quite striking is that a year ago an application for bail to the tribunal was essentially an independent decision on the merits of release, but that process is now entirely hedged in by a couple of new provisions in the immigration act that have taken away the discretion of judges, of independent judges, on whether or not to release people under certain circumstances, or whether or not to even consider an application for release.

On top of that, there are huge problems with access to simply lodging an application for a number of people, and then typically ex-offenders, people who have no private address that they can offer up as a bail address and who must rely instead on what's called a Section 4 bail address from the Home Office.

We've done some research this year. We've been very worried by the extreme periods that it's taking people to get these addresses, which act as a very effective barrier to even asking for one of these. We've found that the average time for a self-contained bail address was 14 weeks, and the range was 1 to 72 weeks. So, people are waiting, in some circumstances, an incredibly long period of time before they can even seek release. And of course if they're then refused they have to go all the way back to the beginning and start again.

We think this needs to be sorted out by the Home Office as a matter of urgency and it's something that we're talking to them about. But it's a huge barrier for a lot of people to even using the bail process.

Over the last four years we've carried out two detailed studies of bail decision-making. In our last one we were looking particularly at whether the bail process served longer-term detainees and our conclusion was that it doesn't, and I can tell you why in a bit of detail.

We made a number of recommendations to the tribunal at the time in relation to improvements in infrastructure, which actually have a huge bearing on how effective it is for legal advisors to talk to their clients – so things like longer and better video links; facilities for detainees to consult with their reps for more than the ten minutes that they get at the moment, which is what barristers always tell us they need more of; more time for judges to review what are often very lengthy bundles is someone's been detained for a long time; and a bit more imagination in the treatment of sureties. All of that is in our written submissions and in our published reports.

The one thing that we think would make a huge difference, and this is particularly for long-term detainees, to avoid this sort of endless cycle of people coming back before the tribunal, is around the question of disclosure of supporting evidence. What's very striking is that although the burden of proof in a bail hearing is on the Secretary of State to justify on-going detention, when you look at bundles of evidence that are being prepared by a solicitor or a legal advisor, the evidence is all offered up by the detainee. There's often no supporting evidence at all from the Home Office. They're providing a document called a bail summary which contains their case against release.

Increasingly, these are produced using standard paragraphs and these are available online and anybody can see them. And what is not happening is that evidence supporting assertions around things like risks of absconding or availability of a travel document and hence the imminence of removal are simply not provided to the tribunal.

So, the tribunal and the applicant are in a disadvantaged position, if you like, when it comes to the position. They're the ones who are having to operate with less information than the detaining power who's a party to that.

It would be very simple, we think, for more attention to be paid by the Home Office, and we would suggest by the tribunal as well, to a greater degree of provision of supporting evidence. If someone's travel document is imminent, then it would be helpful to the tribunal to slip in to the- attached to the bail summary a note of a conversation with the embassy or an email or whatever it is to show that that is actually happening. All too often Assertions are made about a travel document being backed up here. Release is not granted because it appears that that person is about to be removed, and then months later, you know, we're trying to get them a bail hearing again, to argue the exact same issue.

There's a lot that the tribunal could do to sort out the underlying evidence around assertions. It would help people who are detained long term because if the evidence is there the tribunal can make a decision and more properly consider release and just avoid this sort of cycle of inaction that comes across.

Sarah Teather: That's extremely helpful. We're running quite late. I want to make sure that my colleagues have had a chance to ask, because you've kind of ranged across the questions, which has been very helpful, but I want to make sure that they don't feel there any other elements that have not been picked up? Sally, you didn't-

Lord Anthony Lloyd: I certainly want to come back, if I can, on legal limits. Because, as will be known, we did try to do this in recent legislation, which I supported an amendment. But the trouble in that case was that the period chosen, although I supported it, was much too short. I think there were six weeks, which clearly was not going to be acceptable.

The Bingham Centre seems to me to have hit the point here in relation to the returns directive, because there we do have what has been, although we're not party to it, we at least have something which would give us an idea of what we ought to be aiming for.

Justine Stefanelli: Yes. I think it's a good model of what the rest of Europe is doing, including even now Denmark, which used to not participate in the directive. And even Ireland, which doesn't, has its own maximum that ranges anywhere between 21 and 56 days, so- And I think it's important to underscore that the limit in the returns directive is actually six months.

Lord Anthony Lloyd: Yes.

Justine Stefanelli: But you can extend it by an additional 12, but that's in extremely limited circumstances. However, I think it is really important to emphasise that now the UK is a complete outlier in this scheme, and it's a scheme that's there

Lord Anthony Lloyd: But, just to come back on that, yes, six months plus 12, I can absolutely understand that. But tell me: am I right in thinking that we are in fact the only country in Europe now that doesn't have some sort of-

Justine Stefanelli: That's correct.

Lord Anthony Lloyd: Certainly it would be very helpful of us, I think, because I had some figures on this, to know roughly what other countries are doing. I know it varies very largely, but perhaps you could let us know that.

Justine Stefanelli: Yes. I've got some examples here and I can get you more if that would be helpful.

Sarah Teather: It would be very helpful if you could write to us with more examples.

Justine Stefanelli: That's not a problem at all.

Sarah Teather: David, was there anything further that you want to ask?

Lord David Ramsbotham: No.

Sarah Teather: I'm going to wrap us up because I did promise I'd wrap this up by 12 and in fact we got later and later and it's now nearly half-past-12 and I'm about to lose most of my panel. But thank you. That's been hugely, hugely helpful, and three very different panels that we've managed to pick up on lots of things that other people said and flesh them out and explore them, and I'm really grateful to you all for making the time, and thank you. Again, if there are other things that you are burning to say, please let us know. Thank you.