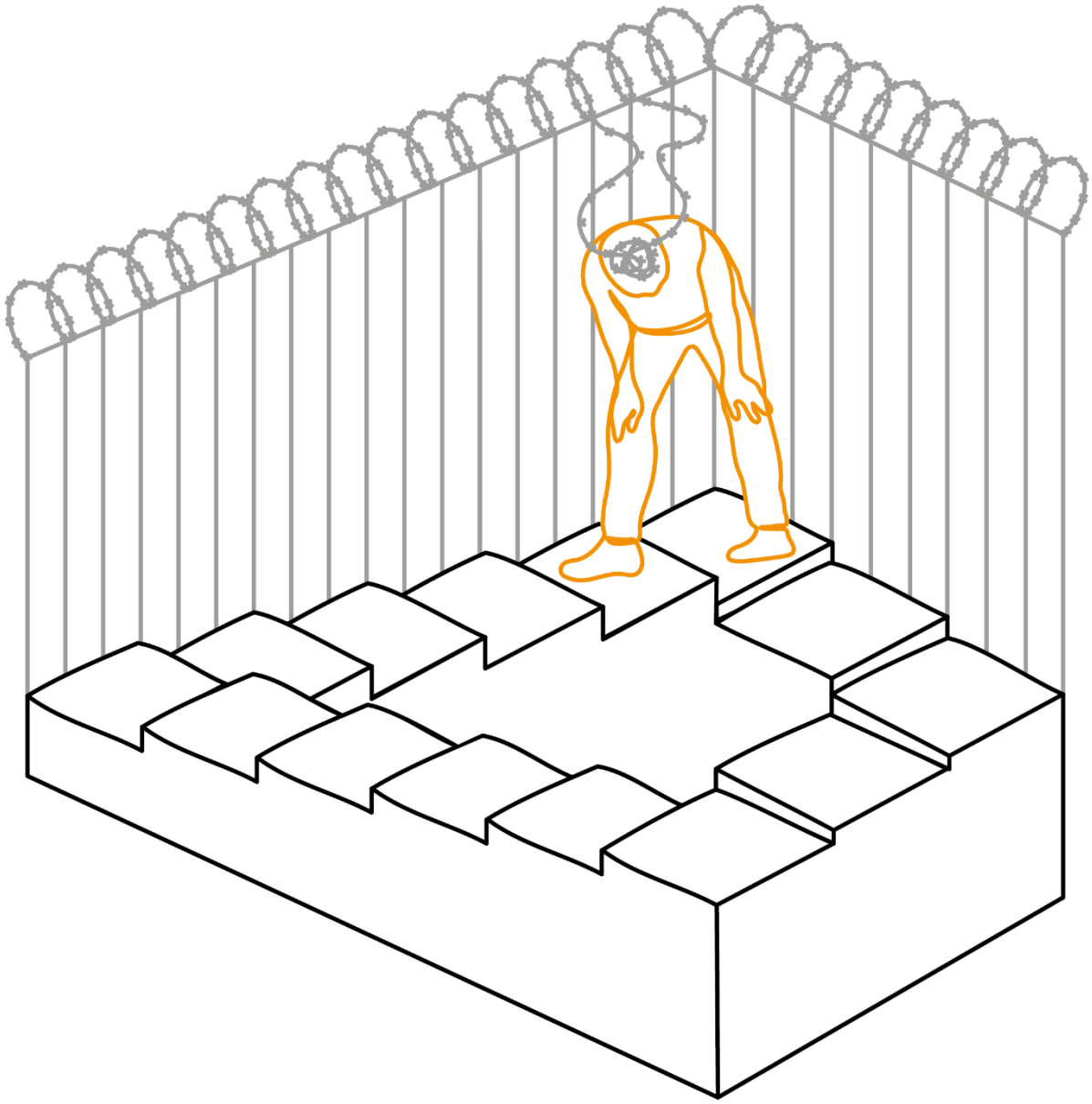
HARMED NOT HEARD

FAILURES IN SAFEGUARDING FOR THE MOST VULNERABLE PEOPLE IN IMMIGRATION DETENTION

April 2022



Medical Justice
seeking basic rights for detainees

Medical Justice

Medical Justice is the only charity in the UK to send independent clinicians to all the Immigration Removal Centres (IRCs) across the UK. Our medical reports document scars of torture and challenge instances of medical mistreatment. We receive around 600-1,000 referrals from people in detention each year and have gathered a sizeable, unique and growing evidence base.

We help clients access competent lawyers to harness the strength of the medical evidence we generate. Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused by these shortcomings, as well as the toxic effect of immigration detention itself on the health of people in detention. Evidence from our casework guides our research, policy work and strategic litigation to secure lasting change.

The British Medical Association believes that the use of detention should be phased out; Medical Justice agrees. The only way to eradicate endemic healthcare failures in immigration detention is to end immigration detention.

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EXECUTIVE SUMMARY

Immigration detention can cause serious harm to people who are detained. This is recognised by research, clinical professional bodies and government policy. Medical Justice has many years of witnessing the human cost of detention through working with detained people. This report examines the extent to which safeguarding mechanisms are effective within Immigration Removal Centres (IRCs): whether they operate as intended to ensure the identification and release of people at risk of harm. It concludes that there are serious defects.

Independent medico-legal assessments of forty five Medical Justice clients conducted whilst the person was detained between July and December 2021 found that all were at risk of clinical harm due to detention. These clients had numerous indicators of vulnerability: including histories of severe trauma, significant mental health issues, at risk of suicide and with evidence of deterioration in their mental state that had been caused by detention. However, safeguarding systems led to only one person being released from detention due to being recognised as at risk.

This research set out to understand why safeguarding systems had not been effective to ensure the release of a case set of such vulnerable people before the involvement of an independent clinician from Medical Justice, a small, over-stretched charity with a long waiting list. There were failures at all levels of the safeguarding process:

- Lack of identification of patients at risk of harm and lack of communication of that risk by clinicians working in detention healthcare departments.

  None of the highly vulnerable clients had safeguarding reports made by IRC healthcare departments to identify them as at risk of harm to their health caused by detention under a process known as Rule 35(1). 67% had no communication of any type by the IRC healthcare department explicitly addressing the risk to their health from detention, prior to their assessment by a Medical Justice clinician.

- Inadequacies in clinical care, including an absence of screening for post-traumatic stress disorder (PTSD), inadequate exploration of suicide risk and prolonged administrative delays that undermined detained people's access to doctors and so undermined safeguarding processes.

  87% of the case set of vulnerable people had suicidal and/or self-harm thoughts recorded by a Medical Justice clinician at their assessment, and all were at increased risk of suicide in view of their mental health issues and other factors. Only 44% had suicidal or self-harm thoughts or episodes recorded in their detention medical records by IRC healthcare staff, including references to suicide risk management procedures. None had a safeguarding report made by the IRC healthcare department identifying their risk of suicide under a process known as Rule 35(2).

  There was a failure to screen detained people for PTSD, even though people in detention are known to be at increased risk of this condition. 76% of the case set of vulnerable people were assessed by Medical Justice clinicians having symptoms or a diagnosis of the condition.

Only 51% of the case set saw a GP within twenty four hours of admission to the IRC, a serious breach of the safeguarding system. Where people were identified as needing a safeguarding medical assessment in detention, the average wait between identification of the need for an appointment and this taking place was twenty five days. These administrative delays impact on the ability of safeguarding systems to be effective and to enable the prompt release of those identified as at risk of harm.

- Home Office caseworkers discounting information about the harm of detention and refusing to release people that had been identified as at risk.

  Analysis of the available information to explain decision-making by Home Office case workers to maintain detention when provided with evidence of vulnerability showed a failure to release people recognised at heightened risk in detention including a high proportion of torture survivors.

- Wider systemic failures including opaque and inaccessible information about detention safeguards and that government policy has had the effect of reducing protection for vulnerable people at risk.

  Explanation of the safeguarding system is not contained in single, publicly accessible place and the relationship between the statutory rules placing obligations on clinicians are not clear. The various aspects of the policy framework are disjointed and the key Home Office policy addressing the need to release vulnerable people, Adults at Risk in Immigration Detention, has been drafted to reduce protection for people at risk.

Minor changes within healthcare departments are unlikely to be sufficient to resolve safeguarding deficiencies whilst there are such widespread, national level policy failings. Nevertheless, we include recommendations in this report for some ameliorative steps: better clinical training, introduction of pre-detention and PTSD screening, and increased auditing of all aspects of safeguarding systems.

Medical Justice continues to hold the view that since detention carries a risk of serious harm, the only safe way to avoid this is to end the use of immigration detention.

GLOSSARY OF TERMS

ACDT: Assessment Care in Detention and Teamwork is a national level policy to identify detained people at risk of self-harm and/or suicide and their care needs.

Adults at risk policy: A Home Office policy for determining whether a person is vulnerable and suitable for detention. Its stated purpose is to protect vulnerable people who may be at increased risk of harm in detention. The guidance states that vulnerable individuals or 'adults at risk' should not normally be detained and can only be detained when 'immigration factors' outweigh their indicators of risk.

DCR 2001: Detention Centre Rules 2001. This is the statutory framework for the management indefinite immigration detention. The Rules span all aspects of the regulation of IRCs including use of force, segregation, access to healthcare and safeguarding responsibilities.

IRC: Immigration Removal Centre. These are detention centres which hold people subject to immigration detention procedures.

IRC Healthcare: The healthcare team is responsible for the provision of healthcare for those held in IRCs and is commissioned by NHS England. Primary level care is provided in detention with some limited access to secondary level care such as visiting psychiatrists.

IRC staff: Custodial staff in IRCs.

Medical Justice medico legal assessments: These are detailed assessments completed by independent clinicians working with Medical Justice, which when drafted into reports, provide evidence for asylum cases and other legal decisions. These may include details of the person's physical and mental health, examination findings, forensic assessment of scars and psychological consequences of ill treatment or torture, consideration of the impact of detention on the person's health, and identification of unmet health needs. These assessments are completed to medico-legal standards.

Part C procedures: This is completion of a document titled IS91RA Part C which may be filled out by any member of IRC staff and those working in IRC healthcare to report information concerning a detained person to the Home Office.

Rule 34: The legal requirement contained in the Detention Centre Rules 2001 for detained people to be offered an appointment with a GP at the IRC within 24 hours of arrival to provide a review of their physical and mental health needs.

Rule 35: The safeguarding mechanism contained in the Detention Centre Rules 2001 which aims to ensure that particular groups are brought to the attention of those within the Home Office with direct responsibility for reviewing detention and the power to order the person's release.

Rule 35(1): The requirement for IRC GPs to report to the Home Office if their patient's health is likely to be *"injuriously affected"* by continued detention or the conditions of detention.

Rule 35(2): The requirement for IRC GPs to report to the Home Office if they suspect their patient has *"suicidal intentions"*.

Rule 35(3): The requirement for IRC GPs to report to the Home Office if they consider their patient may have been the victim of torture.

Rule 35 DSO: The Detention Services Order 09/2016, guidance issued by the Home Office to provide policy information about the preparation and consideration of Rule 35 reports.

Rule 35 Response letter: This is the letter drafted by a Home Office caseworker to reply to any Rule 35 report to explain the application of the adults at risk policy to the detained person's case and any decision concerning detention.

Standard D annex letter: a template letter provided by the Home Office for use by IRC healthcare departments to refuse to issue a Rule 35(3) report.

STHF 2018: Short-term Holding Facility Rules 2018. This is the statutory framework for the management detention up to a period of 7 days (24 hours in a 'holding room') for locations designated as short-term holding facilities. The Rules span all aspects of the regulation of such places including use of force, segregation, access to healthcare and safeguarding responsibilities.

INTRODUCTION

Immigration detention is the practice of detaining people who seek asylum or those with an unsettled immigration position for administrative purposes. It is not part of any criminal sentence. Detention decisions are made administratively by caseworkers employed by the Home Office applying legal principles and government policy. Although there is a process of regular internal reviews of the decision to detain, there is little independent oversight, and no upper time limit. Individuals do not know in advance how long they will be held in detention.

Historically the power to detain people was intended to be used on a very limited basis, but since its introduction in 1971, the numbers of people subject to such detention have rapidly increased. 24,497 people entered immigration detention in the year ending December 2021.[1] The current government has demonstrated a commitment to continuing the practice of immigration detention since it opened a new IRC for women (Derwentside) in September 2021. This brings the total number of IRCs dedicated to detaining people only for immigration reasons within the UK to seven.[2]

Both UK law and Home Office policy require that a person's vulnerability is considered as part of all immigration detention decisions. This is a key element to ensuring that the detention is lawful. All IRCs are required to provide primary level medical care on site, with the healthcare department having an integral safeguarding role for detained people: identifying vulnerability and communicating this information to the Home Office.

This report summarises the research consensus concerning the adverse effect of detention on the mental health of detained people, immigration detention safeguarding law and policy and Medical Justice's analysis of the systemic failure of those safeguards for vulnerable people.

[1] Figures published by Home Office, National Statistics (3 March 2022) Available at: https://www.gov.uk/government/statistics/immigration-statistics-year-ending-december-2021/how-many-people-are-detained-or-returned [Last accessed 6 April 2022].

[2] This excludes other sites of immigration detention such as short term holding facilities and time served foreign national prisoners who may continue to be held in prisons.

METHODOLOGY

This report collates and analyses aggregate anonymous data based on forty five medico-legal assessments conducted by Medical Justice doctors between July and December 2021, referenced in this report as a case set of people.

The data is reported as percentage, unless it refers to a number of five or fewer people. For clarity, where there is a different total number, other than the case set of people, this will be specified.

Clients were selected for inclusion in the case set purely on the basis that they had a Medical Justice clinical assessment during July and December 2021, conducted whilst held in an IRC, and there was access to their IRC medical records during that period of detention.

Overall, the analysis is based on the following types of document: the Medical Justice clinician's assessment, IRC medical records obtained for casework purposes, Rule 35 reports and Home Office response letters to these reports.

Records Analysed

Prior to each medico-legal appointment, Medical Justice requests the client's IRC medical records to inform the assessment. For the case set of people, these included thirty four Rule 35(3) reports, one standard Annex D letter refusing to provide a Rule 35(3) report and all Part C documents included within the records disclosed by the healthcare department. Where clients had been subject to previous periods of immigration detention, this report only analyses the Rule 35 reports that had been completed for the period of detention during which the Medical Justice assessment took place. These documents provide an evidence base to assess the extent to which IRC healthcare had identified people at risk of harm due to detention and communication of information to the Home Office concerning patients' clinical risk.

In addition, Medical Justice had access to twenty seven response letters from Home Office caseworkers to the Rule 35(3) reports addressing whether the patient should be released. These have been evaluated to understand how clinical safeguarding information was factored into decisions concerning detention. Such response letters should be routinely provided to IRC healthcare and so included in the person's medical records, but this does not always occur and therefore some response letters were missing and could not be analysed.

Medical Justice's approach to medico-legal assessments

This report considers the information obtained from medico-legal assessments and information in letters sent by Medical Justice to IRC healthcare departments shortly after an appointment to communicate urgent medical issues. Medical Justice medico-legal appointments with clients are not subject to a time limit and are supported by an interpreter if needed. Assessments can take between ninety minutes to four hours, depending on the client's circumstances.

To undertake a medico-legal assessment, Medical Justice requires doctors to have full registration, a minimum of five years' post qualification clinical experience and recent clinical experience with adults.

Psychologists are required to have at least two years' post-doctorate experience or relevant extensive experience in a refugee or trauma services and recent clinical experience with adults. All clinicians are required to undertake training with Medical Justice, comprising studying medico-legal requirements, including an understanding of consent processes and assessment to the Istanbul Protocol Standards[3] and then a subsequent program of observation and review, with clinicians with experience of medico-legal assessments. Each report is also subject to internal clinical peer review.

Since the covid pandemic, Medical Justice has completed both face-to-face and remote medico-legal assessments; accordingly, this sample includes both types of appointment. The use of remote assessments has been based on the widespread recognition of the need to provide safe alternatives during the pandemic and Medical Justice has been able to provide many detailed assessments in this manner; as have many medical and mental health services across the NHS.

However, the limitations of such assessments mean it is important for the clinician to recognise it is harder to assess aspects of demeanour, body language and other indicators of emotional reactions which can be an important part of face to face assessments. It can also be more difficult to determine the safety and appropriateness of asking potentially distressing questions. The Istanbul Protocol recognises the importance of sensitive questioning of torture survivors with eye contact, where possible, and discusses the risk of re-traumatisation when asking questions about their experiences.[4]

The limitations of remote assessments may lead to clinicians identifying clinically significant symptoms and signs of mental illness, yet having insufficient detail to provide a formal diagnosis at the high threshold required for a medico-legal conclusion. Where it is not possible to reach a formal diagnosis, but the clinician considers significant mental health problems are present requiring further assessment, this is stated in the medico-legal report. For clarity, both types of conclusion by a Medical Justice clinician are referenced here as the client being assessed as having mental health issues.

Two bases of detention

People held in immigration detention can be held either indefinitely under the regime of the Detention Centre Rules 2001 (DCR 2001), or for up to seven days under the Short-term Holding Facility Rules 2018 (STHF Rules 2018). Both sets of Rules use identical safeguarding report templates for reporting clinical concerns in respect of the detained person's health, risk of suicide and history of torture. The same national safeguarding policy explained below, (Adults at Risk in Immigration Detention) applies to both regimes. People can move from initial detention under the STHF Rules to indefinite detention under the Detention Centre Rules 2001.

There is one key initial difference in the systems of safeguarding. People held under STHF Rules 2018 are to be assessed by a nurse or a doctor within two hours of admission and both types of clinician can complete safeguarding reports. People held under the DCR 2001 are to be assessed within twenty four hours of arrival by a GP and only such doctors can complete safeguarding reports.

Some clients that form part of the case set of people considered in this research may initially have been detained under SHTF Rules 2018 before being detained under DCR 2001. The medical records disclosed

[3] Office of the United Nations High Commissioner for Human Rights (2004) *Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*.
[4] Office of the United Nations High Commissioner for Human Rights (2004) *Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* Paras 146-149, 152.

to clients do not identify the basis under which the person has been detained. This is only apparent on the clinical record if the person is held at a specific institution which is only a short-term holding facility (currently Larne House and Manchester). However, the Home Office may designate areas within other IRCs as short term holding facilities but does not publish this information.

Given the lack of clarity in the clinical records about the legal basis for detention, this this report does not differentiate between the initial screening on arrival in detention between the two types of detention arrangement. However, to ensure the information in this report is as accurate as possible one individual has been excluded from the Rule 34 analysis since it was possible to identify from separate information held by Medical Justice's casework team that the individual was initially held under STHF Rules 2018. All people in the case set were subsequently detained under DCR 2001, if initially detained under STHF Rules 2018.

Limitations of the Research

The remit of Medical Justice is to work with detained people with substantial medical issues, providing a detailed clinical assessment whilst the person is detained in an IRC and addressing any risk of continuing detention. Not all referrals can be accepted, and priority is given to people who may have a history of torture that has not been previously properly medically explored and documented. This means that the case set of people analysed in this report is not representative of the clinical issues of the whole population of people in immigration detention. The evidence base of the safeguarding mechanisms for the case set of people is also not adjusted for uniformity across the UK's IRCs, since the information has been collated based on a complete set of the referrals that were accepted for casework purposes and met the criteria for inclusion in this research set out above.

Instead, this analysis allows a review of the extent to which safeguarding systems have been effective for a set of individuals at heightened risk in detention and has a particular focus on people who have survived torture. Conversely, since this report is based on those individuals who were able to communicate a level of vulnerability to trigger a referral to Medical Justice, the data may also fail to include particularly clinically vulnerable individuals who were unable to access information about our work, or to identify (or communicate) their medical concerns.

RESEARCH ON THE EFFECT OF IMMIGRATION DETENTION ON MENTAL HEALTH

It has been known for many years that the prevalence of mental health problems is very high in immigration detention.

A recent systematic review of the existing clinical literature on this topic by Verhülsdonk and colleagues (2021)[5] including four separate studies of people in immigration detention in the UK, shows the extent of this issue: three quarters of people in immigration detention experienced depression, more than half experienced anxiety and almost half experienced post-traumatic stress disorder. The prevalence of all three disorders was around twice as high in detained refugees and migrants compared to non-detained refugees and migrants.

This analysis confirms previous research, which has consistently found an adverse effect of immigration detention on mental health, as summarised in Bosworth's review of the mental health literature for Shaw's report (2016) to the Home Office on the Welfare in Detention of Vulnerable Persons: *"literature from across all the different bodies of work and jurisdictions consistently finds evidence of a negative impact of detention on the mental health of detainees".*[6]

This adverse effect is proportionate to the time spent in detention. A systematic review by Von Werthern and colleagues (2018) found that the five adult studies reviewed, which examined the association between detention duration and mental health deterioration, showed a significant relationship with the duration of detention correlating with the severity of mental health symptoms.[7]

It is thought that there are multiple underlying mechanisms leading to the extent of this negative impact, although further research into these mechanisms may be helpful. People in detention have described a range of factors contributing to this including fear for their safety, criminalisation, and experiences of physical and verbal abuse. All of these contribute to experiences of loss of agency, entrapment and feelings of hopelessness. Accordingly, Verhülsdonk and colleagues conclude*, "The only efficient way to improve the detainees' mental health is to release them from detention."*[8]

There has been a consistent professional concern expressed by the Royal College of Psychiatrists (the College) about the inability of people with a mental illness to access adequate treatment in IRCs. This was originally expressed in a statement produced by their working group on the health of asylum seekers and refugees in 2013. The College subsequently published a detailed position statement in February 2021[9] which summarised the current research concerning the adverse impact of immigration detention

[5] Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) *Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis*. BJPsych Open 7(6).
[6] Bosworth M. (2016) Appendix 5: *The Mental Health Literature Survey Sub-Review. Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office.*
[7] M von Werthern, K Robjant, Z Chui et al. (2018) T*he Impact of Immigration Detention on Mental Health: A Systematic Review*, BMC Psychiatry 18: 382.
[8] M von Werthern, K Robjant, Z Chui et al. (2018) *The impact of immigration detention on mental health: a systematic review,* BMC Psychiatry 18: 382.
[9] Royal College Psychiatrists Position statement: *The Detention of people with Mental Disorders in Immigration Detention* PS02/21, (April 2021).

on mental health and the fact that the detained environment impedes access to treatment for mental disorders.

The research evidence summarised by the College in their position statement that detained people with pre-existing vulnerabilities such as mental health issues or survivors of torture and other forms of cruel or inhumane treatment, including sexual violence and gender-based violence, were at particular risk of harm as a result of their detention. The position statement also concludes that IRCs were likely to precipitate a significant deterioration of mental health in most cases.

The position statement also provides clear information about significant limitations to successful treatment in immigration detention for people with a mental disorder. This was on the basis that the fact of detention impedes community rehabilitation, psychotropic medication alone is unlikely to achieve good outcomes without a broader multi-model therapeutic approach, the experience of detention itself is likely to be a barrier to achieving full recovery after treatment and consideration of the fact that detention is not a therapeutic environment.

The particularly adverse effects of detention on those suffering from post-traumatic stress disorder (PTSD) and/or depression were also explained. People suffering from PTSD were more likely to have their illness aggravated by detention, triggering reminders of the original trauma. It was also noted that treatment of PTSD requires specialist psychological intervention in a setting conducive to a sense of safety and a growing sense of trust toward the therapist, and that trauma-focused therapy is not possible in detention settings.

When considering detained people with a depressive disorder, the College noted that asylum seekers often have significant symptoms of depression and anxiety which may occur independently or coexist with PTSD as part of complex traumatised state. The position statement concluded that detained people with depression were likely to have their illness exacerbated by detention owing to arrest, indefinite period of stay, threat of imminent return and exacerbation of a sense of helplessness and state of intense fear.

In summary, the consistent professional and research consensus over many years shows a significant harmful impact of immigration detention. As a consequence of detention, people who did not have a mental health condition prior to incarceration are more likely to develop one, those who do have a mental health condition are likely to deteriorate, and these risks continue to increase the longer people are detained. The harm this causes also does not end when the person is released: three clinical studies which went on to reassess people after release from immigration detention identified that symptoms of depression, anxiety and PTSD persisted well beyond release, persisting at ten months, three years, and four years.[10]

[10] M von Werthern, K Robjant, Z Chui et al. (2018) The impact of immigration detention on mental health: a systematic review, BMC Psychiatry 18: 382.

SAFEGUARDING LAW AND POLICY

Given this level of harm, it is worth noting that the Detention Centre Rules 2001 (DCR 2001) provide a statutory obligation to IRC healthcare departments to identify vulnerability and communicate it to the Home Office. The foundation of the safeguarding regime rests on the role of the general practitioner (GP).[11]

Under Rule 34 DCR 2001, all people arriving at a detention centre must be offered an appointment with a GP within twenty four hours. At the appointment the doctor is required to undertake a mental state and physical examination of their patient. At this consultation, or at any subsequent meeting, the GP has specific reporting obligations to the Home Office under Rule 35 DCR 2001 if the patient is identified as at risk in detention.

Rule 35 DCR 2001 requires GPs to formally report safeguarding concerns in the following circumstances:

- Rule 35(1) DCR 2001 requires a report is filed if the doctor considers that their patient's health is likely to be *"injuriously affected"* by detention.
- Rule 35(2) DCR 2001 requires a report if the doctor suspects that their patient *"may have suicidal intentions."*
- Rule 35(3) DCR 2001 requires a report if the doctor is concerned that their patient *"may have been the victim of torture."*

The Home Office has published a template for provision of Rule 35 reports in Detention Services Order 09/2016 (Rule 35 DSO).[12] The reports can only be completed by a GP, not other members of the healthcare team. Historically, Rule 35 reports were very brief template documents completed with very limited commentary or additional information required. However, the length of the Rule 35 template report was significantly increased when further versions of the Rule 35 DSO were published.

Rule 35(1) reports

The template requires an explanation of the doctor's opinion about why a detained person's physical or mental health is likely to be *"injuriously affected"* by detention or the conditions of detention; the medical treatment the individual is receiving and whether such treatment is provided externally; details of whether a mental health assessment has been carried out, including details of the assessment's findings and recommendations.

[11] Rule 33(1) *Detention Centre Rules 2001* (SI 2001/238) states all IRCs must have a registered general practitioner.
[12] *Detention centre rule 35 and short term holding facility rule 32* Annexes A – C. Detention Services Order 09/2016 version 7 (5 March 2019).

The report also requires the doctor to address the following clinical questions:

i) *What impact is detention or the conditions of detention having (or likely to have) on the detainee's health and why?*
ii) *Can remedial action be taken to minimise the risks to the detainee's health whilst in detention? If so, what action and in what timeframe?*
iii) *If the risks to the detainee's health are not yet serious, are they assessed as likely to become so in a particular timeframe (ie in a matter of days or weeks, or only if detention continued for an appreciably longer period)?*
iv) *How would release from detention affect the detainee's health? What alternative care and/or treatment might be available in the community that is not available in detention?*
v) *Are there any special considerations that need to be taken into account if the detainee were to be released? Can the detainee travel independently to a release address?*

Rule 35(2) reports

The template requires the doctor to address the following questions:

i) *Please state the reasons for suspecting that the detainee has suicidal intentions?*
ii) *Is the detainee being managed under Assessment Care in Detention Teamwork (ACDT) arrangements? If not, why not?*
iii) *Can the suicide risk be managed/reduced satisfactorily through ACDT, medication and/or appropriate interventions such as talking therapies?*
iv) *What arrangements might be needed to manage the detainee's suicide risk in a non-detained setting?*
v) *Has there been a mental health assessment? If so, what was its result/recommendation? If not, is an assessment scheduled to take place and, if so, when? Please attach the report of any assessment or give a brief overview.*

Rule 35(3) reports

The report template requires the doctor to provide a summary of the detained person's account of their experience including details of any injuries, scarring or symptoms, including psychological findings. The clinician is also required to include information about the medical treatment or support the detained person has received and any information about physical or mental health problems arising from the experience of torture.

The template also requires the doctor's written response to this section:

> *"Please set out your reasoned assessment of why, on the basis of the detainee's account together with your own examination and clinical findings, you are concerned that the detainee may have been a victim of torture. This should include your assessment of:*
>
> - *the consistency of any physical (eg scars) and/or psychological findings with the detainee's allegations, including any evidence to the contrary*
> - *whether there might be other plausible causes for the findings*
> - *the impact detention is having on the detainee and why, including the likely impact of ongoing detention."*

Home Office policy states that where a GP has a patient that falls within more than one of the categories set out in Rule 35, separate reports must be completed.[13]

The link between safeguarding responsibilities: Rule 34 and Rule 35 DCR 2001

Rule 34 and Rule 35 DCR 2001 are interlinked safeguarding mechanisms, which are crucial to the system working in practice. However, there is no explanation on the face of the DCR 2001 that one important purpose of completing medical examinations of detained people within twenty four hours of their arrival into an IRC under Rule 34 DCR 2001 is to enable early identification of vulnerability via a Rule 35 report that will trigger a review of whether the person should be released. This information is also not included in the Rule 35 DSO which explains the operation of the Rules.

The fact that Rule 34 examinations and Rule 35 are interlinked is set out in the legal judgment in the case of R (on the application of D and K) v Secretary of State for the Home Department [2006] EWHC 980 (Admin). This case required the judge to consider the overall operation of the DCR 2001 in immigration detention. The judgment was clear that the Rule 34 examination was not simply an opportunity to ensure general identification of any medical issues, but it was *"a part – an important part – of the safeguards"* to ensure that vulnerable individuals were not inappropriately detained. The judge also explained Rules 34 and Rule 35 were linked, with Rule 34 examinations being capable of leading to a report under Rule 35(3).

In order for the system of safeguarding to work effectively there needs to be proactive attempts to elicit information at the Rule 34 appointment to enable the medical opinion about a detained person's vulnerability and their risk of harm in detention to be communicated to the Home Office. Any failure in safeguarding at this stage of the process that means a vulnerable person is not swiftly routed out of detention is particularly troubling in light of the evidence that the adverse effect of detention increases with the length of incarceration.[14]

[13] *Detention centre rule 35 and short term holding facility rule 32* version 7 (5 March 2019) Pg 11.
[14] Bosworth M. (2016) Appendix 5: *The Mental Health Literature Survey Sub-Review. Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office.*

The lack of accessible information about the purpose of Rule 34 and the initial appointment arranged within twenty four hours does not assist IRC GPs to understand their particular safeguarding responsibilities at this key moment. This is a particularly troubling omission since this early GP consultation is the only time IRC healthcare is specifically required to offer a detained person the opportunity to consult a doctor. All other GP appointments will be arranged in response to a request by the detained person or when referred by others if a medical issue is identified.

Actions required from Home Office staff upon receipt of a Rule 35 safeguarding report

Upon receipt of a Rule 35 report, the Rule 35 DSO requires consideration of the report by the Home Office caseworkers responsible for reviewing the individual's detention, in line with the Adults at Risk policy. The policy requires that a Rule 35(1) and (3) report will always lead to a review of detention. There is no such automatic obligation for a review of detention when a Rule 35(2) report is received, instead the policy states that this will depend on the content of the report.[15]

When detention is reviewed, a decision must be taken by the Home Office caseworker within two working days as to whether detention is in accordance with legal principles and Home Office policy, taking account of the information contained in the Rule 35 report. If the decision is to release the person, such action must be taken promptly.

Receipt of a Rule 35 report also requires the Home Office to ensure a copy is forwarded to the individual or their legal representative if they have one. A letter explaining the detention decision must be shared with the healthcare department, the detained person and any legal representative.

There is no statutory obligation on the IRC's healthcare department to respond in writing to the Home Office's decision. However, the British Medical Association has drawn its members' attention to doctors' ability to challenge the Home Office's decision concerning detention if they disagree.[16] Moreover, Home Office policy is that if the GP completing a Rule 35 report does not feel their concerns have been properly addressed in the response letter, then they should escalate this within the Home Office.[17]

Other mechanisms for sharing clinical information with the Home Office

The Home Office and IRC healthcare departments can also share information concerning detained people under a process known as 'Part C'. This is an internal process which entails completion of a much shorter document form IS91RA Part C (risk assessment).[18]

There is a stark contrast between the detailed level of information required by the template for Rule 35 reports and the discretion about the level of detail that can be included in the more limited template for Part C documents. For the latter, there is no requirement to explain any clinical assessment, or to include

[15] *Adults at Risk in Immigration Detention*, (first published 26 May 2016, came into force 12 September 2016, version 7: 8 November 2021) Pg 26.
[16] *Locked Up, Locked Out.* British Medical Association (2017) Pg 42.
[17] *Detention centre rule 35 and short term holding facility rule 32* Detention Services Order 09/2016 version 7 (5 March 2019) Pg 26.
[18] A copy of the template for this document is annexed to this report.

information concerning the impact of detention on the patient, or any specific level of detail concerning their vulnerability in detention. The Part C system is also capable of being used for various administrative purposes such as advising the Home Office of external medical appointments that would be disrupted if the person was transferred to another detention centre, or addressing management of a detained person's property.

Receipt of this document by the Home Office does not require a review of detention and there are no obligations to provide a formal response. There are also no requirements to ensure any aspect of the process is shared with the detained person or any legal representative. The Court has found that use of a Part C form is not a substitute for a Rule 35(3) report[19] and given the limitations of the clinical information required by the form there is no reason consider it would be generally appropriate to use in place of safeguarding reporting via Rule 35 processes.

Home Office approach to vulnerability and detention decisions

Given the range of potential harm described above, and the legal and policy demands to prevent this, safeguarding by the Home Office for those held in immigration detention has been troublingly erratic. Although there has consistently been a commitment to considering medical risk factors when subjecting people to detention written into policy,[20] this has not always been borne out in practice. As a result, legal challenges have been required to prevent unlawful watering down of policy protections for vulnerable people.

Historically, the approach of the Home Office to vulnerability and its effect on detention decisions was set out in a policy document: Chapter 38 and subsequently Chapter 55 of Instructions and Enforcement Guidance. This provided that where a person had a mental illness or a history of torture they would not be subject to detention, save in very exceptional circumstances. In essence, all that was required for the person to be released from detention, absent very exceptional circumstances, was clinical information that put the Home Office on notice that a person fell within a category of person likely to be at risk in detention (for example having a mental illness or a history of torture). There was also a further option for doctors to report clinical concerns about any harmful effect of detention on their patient's health under Rule 35(1).

The Home Office subsequently sought to reduce the safeguards against detention for people they had previously categorised as vulnerable. In August 2010 the policy was amended to provide protection against detention for only those whose mental illness *"could not be satisfactorily managed in detention"* as well as introducing additional protected categories recognising vulnerability due to old age or disability.[21] The Home Office also sought to amend the definition of people with a history of torture in September 2016 to reduce its previously broad scope which included people with a history of severe

[19] *R (on the application of Medical Justice and others) v. Secretary of State for the Home Department [2017] EWHC 2461 (Admin).*
[20] The white paper *Fairer, Faster, Firmer* published in 1998 indicated an intention to increase the use of immigration detention powers whilst also recognising the need to consider physical and mental health needs of people when using such powers and that a history of torture would weigh heavily against detention.
[21] Chapter 55.10 of the Enforcement Instructions and Guidance is available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307995/Chapter55.pdf [Last accessed 8 April 2022].

trauma, to only include those who had suffered torture by state actors. Both amendments were subject to legal challenges, with the amendment to the definition of torture being considered unlawful.[22]

The definition of torture that currently applies includes the experiences of people suffering trauma arising from physical or mental assault when in a situation of powerlessness.[23] This definition is intentionally broad to include people with a history of family abuse, sexual assault and other situations of extreme suffering, in recognition that people with such a history would be at heightened clinical risk in immigration detention.

In 2015 the Home Secretary appointed Stephen Shaw to undertake an independent review of the policies and procedures affecting the welfare of people in immigration detention. The decision to request this review followed decisions by the UK's courts in a number of cases that detained people had been subject to inhumane and degrading treatment breaching their human rights, as a result of being detained whilst mentally unwell. These were rare legal decisions indicating the seriousness of the level of ill treatment of people who were severely ill in immigration detention.

This review was published in January 2016, with a focus on the mental health and welfare of detained people. It concluded that the Home Office had adopted too restrictive an approach to understanding the vulnerability of detained persons. There was overt alarm at the continuing detention of people with a mental illness, with the review concluding: *"…it is perfectly clear to me that people with a serious mental illness continue to be held in detention and their treatment and care does not and cannot equate to good psychiatric practice (whether or not it is 'satisfactorily managed'). Such a situation is an affront to civilised values."*[24]

In response, the Home Office published the Adults at Risk policy in February 2017, with the stated aim of improving safeguarding of vulnerable people with fewer vulnerable people being detained and for shorter periods of time.[25] In line with Stephen Shaw's recommendations, the Adults at Risk policy removed the explicit reference to the notion of 'satisfactory management' of people with a mental illness in detention and expanded the definition of vulnerability to include a longer list of indicators of risk. However, whilst the policy purported to offer more protection to vulnerable people, it instead set up a complex new system which permitted greater scope for Home Office caseworkers to justify the continued the detention of those at risk.

The new policy required detained people to provide evidence of their vulnerability in detention, with three levels of evidence of risk. The first evidence level (level 1) being a declaration by the detained person about their medical or other aspects of their history that would indicate they had an indicator of risk. The second evidence level (level 2) was where a professional person provided information that the detained person had indicators of risk. The third evidence level (level 3) was evidence from a professional that the person fell within the categories of risk and detention would be likely to cause them harm. The

[22] The definition of "torture" was considered by the Administrative Court in *R on the application of EO and other v. Secretary of State for the Home Department [2013] EWHC 1236 (Admin).* This was a legal case where five individual claimants who had survived torture and been subject to immigration detention in the UK were supported by Medical Justice to successfully challenge the Home Office's attempt to narrow the definition of torture. The Court found that the definition of torture for detention policy was wide: "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based upon discrimination of any kind."

[23] The current definition of torture is set out in Rule 35(6) *Detention Centre Rules 2001* (SI 2001/238), as amended by the *Detention Centre (Amendment) Rules 2018* (SI 411/2018): '*any act by which a perpetrator intentionally inflicts severe pain or suffering on a victim in a situation in which - (a) the perpetrator has control (whether mental or physical) over the victim and (b) as a result of that control the victim is powerless to resist.*'

[24] *Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office* (2016) Para 4.36

[25] *Adults at Risk in Immigration Detention*, (first published 26 May 2016, came into force 12 September 2016)

policy then allowed 'immigration control factors'[26] to be considered when taking a decision about whether the vulnerable person would be released. Only persons with level 3 evidence of risk would have the greatest protection against continued detention.

From a clinical perspective the new policy has placed an increased safeguarding responsibility on IRC healthcare staff. This arose from the Home Office's requirement for professional evidence that the individual was at risk and that a period of detention would be likely to cause harm in order for the policy to offer the highest protections against continued detention. Since the main mechanism for detained people to access medical evidence of harm was via IRC healthcare reporting it was clear that this would place additional duties on doctors. This is reflected in the introduction of more complex Rule 35 template reports.

The key role of GPs and safeguarding in Home Office detention decisions

Home Office safeguarding policy to prevent the detention of vulnerable people who are at risk of harm from detention, as set out above, has a chequered history. This has led to a troubling outcome: there is a lack of accessible, straightforward guidance on the specific safeguarding processes in IRCs in a single source for IRC healthcare staff.

However, it is clear that the GP at an IRC has a crucial safeguarding responsibility. In order for the system to be effective it requires a proactive approach by doctors to identify patient vulnerability; in particular, to identify whether the person has already suffered harm in detention or is at risk of this. Without GPs reporting these concerns through potentially multiple Rule 35 reports, the system of safeguarding is undermined. A lack of reports means the Home Office will not be required to review detention and will not be supplied with the medical information needed to take account of vulnerability when taking decisions about releasing vulnerable people.

IRC doctors are also placed in difficulty when seeking to discharge their safeguarding responsibilities when considering patients at risk of suicide and with a history of torture due to the lack of joined up safeguarding processes. The template for a Rule 35(2) report provides questions as to how the detained person is being managed within the IRC but does not ask the doctor to directly address the risk of harm caused by detention or even whether they have an indicator of risk, for example a mental illness. This results in a disjointed process, as GPs are required to complete a separate Rule 35(1) report if they consider that detention is harming their patient's health.

Overall, the former 'category based approach' of Home Office policy to assessing vulnerability was a simpler system of safeguarding. The extent of the clinical information that was needed in order to enable a review of detention and the highest level of protection against continuing incarceration was primarily identification and reporting of an indicator of risk, such as mental illness or a history of trauma. This is in striking contrast to the current requirements; GPs may be obliged to complete potentially multiple Rule 35 reports, each of a length of five or six pages.

[26] 'Immigration control factors' is defined widely and can include compliance issues such as having failed to agree to voluntary return, previous failure to comply with immigration bail conditions, restrictions on release from detention and conditions of temporary admission.

Clinical identification of harm in detention

The population of detained people in immigration detention presents complex clinical challenges for primary healthcare. This has been recognised by the British Medical Association: *"The immigration detention population is diverse and can present with various complex needs, high rates of mental health problems and specific vulnerabilities as the result of past traumatic experiences. Doctors working in IRCs must meet those complex needs in an environment that militates against good health and wellbeing".*[27]

In addition, IRC healthcare staff may face cultural and practical barriers when seeking to provide medical care to detained people. Initial health screening is completed shortly after a person arrives in detention, often in the middle of the night after the distressing and tiring experience of having been detained and transported to the IRC. Many detained people will also be in fear of being forcibly removed. Clearly, this an unhelpful situation to elicit disclosure of sensitive information of relevance to safeguarding, including a history of torture. Those arriving in detention may also have had no previous medical care in the UK and so no records to provide any clinical history. A perception of a lack of independence from the Home Office can also inhibit any relationship of trust between detained people and healthcare staff.

The need for appropriate clinical relationships is a prerequisite for all medical care. National Institute for Health and Care Excellence (NICE) guidance of general application for all healthcare settings states *"establishing trusting, empathetic and reliable relationships with competent and insightful healthcare professionals is key to patients receiving effective, appropriate care".*[28] In the context of working with such a vulnerable patient group, open and sensitive exploration of potential mental health concerns, suicide risk and any history of trauma needs to be considered during any clinical contact.

In addition to offering healthcare within a challenging situation, GPs are also faced with negotiating the Home Office's complex and opaque system of safeguarding responsibilities. In order to discharge these obligations, there is a need for doctors to focus on the possibility of symptoms of trauma and mental illness in order to be able to then assess the patient's ability to access treatment whilst incarcerated, and to be able to report on the likely effect of ongoing detention.

There is also a particular need to give careful consideration to the possibility of trauma-related mental illness given the evidence referenced in the Royal College of Psychiatrists' position statement[29] and the explicit recognition in NICE Guidance of the increased levels of post-traumatic stress disorder for people seeking asylum[30]. In addition, GPs will also need to consider whether the traumatic history that gives rise to PTSD symptoms also fulfils the definition of torture and so triggers safeguarding reporting obligations under Rule 35(3).

[27] *Locked Up, Locked Out.* British Medical Association (2017) Pg 4.
[28] *Patient Experience in Adult NHS Services: Improving the Experience of Care for People Using Adult NHS Services*, Clinical guideline (published: 24 February 2012, updated: 17 June 2021).
[29] Position statement PS02/21, (April 2021) https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/position-statement-ps02-21---detention-of-people-with-mental-disorders-in-immigration-removal-centres---2021.pdf?sfvrsn=58f7a29e_6
[30] *Post-traumatic Stress Disorder*, National Institute for Health and Care Excellence (2021) para 1.1.2.

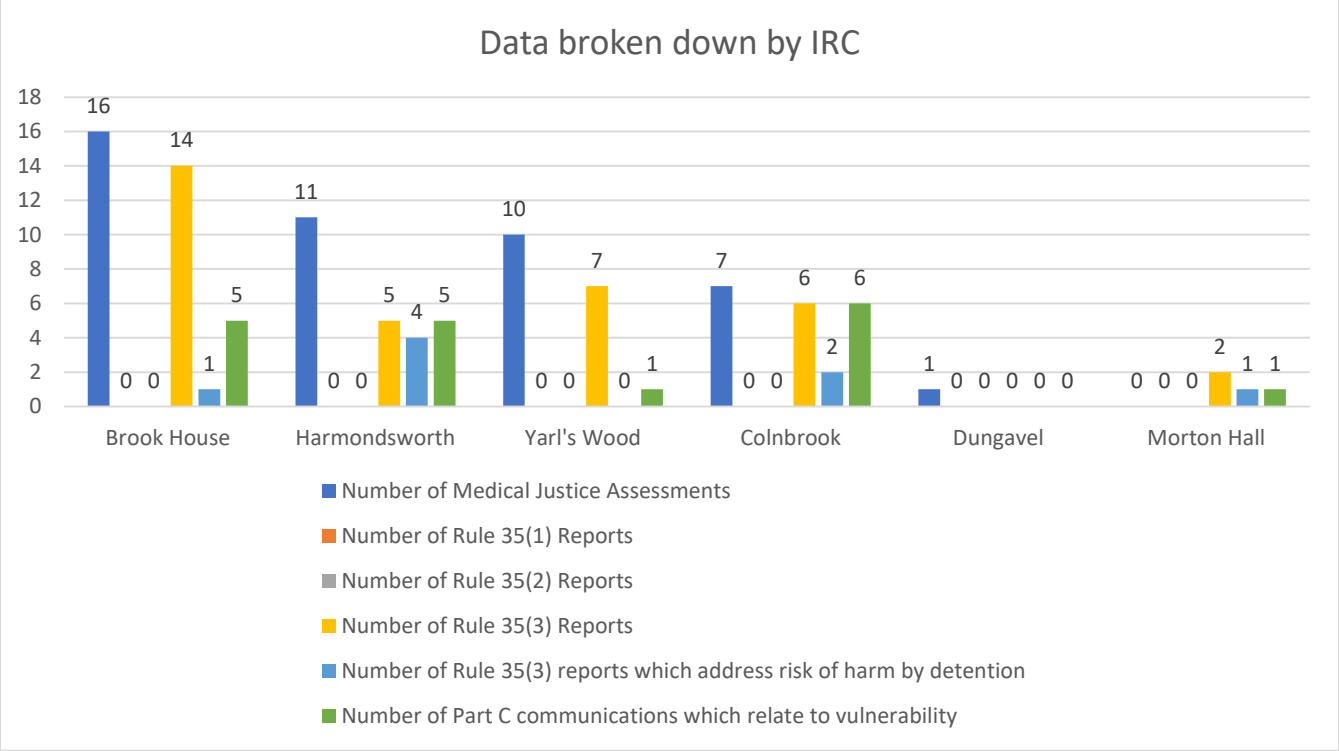
FINDINGS

This section presents the findings from the case set of people to detail the level of vulnerability identified by the Medical Justice clinical assessments and information concerning safeguarding processes.

Table 1: Data broken down by IRC

This table and corresponding graph shows the breakdown of the spread of assessments and safeguarding reports by location for the complete case set of people considered in this report. People often move between different IRCs, so they may have been assessed by Medical Justice in one place, and had their Rule 35 report or other communication by the healthcare department in another.

	Number of Medical Justice Assessments	Number of Rule 35(1) Reports	Number of Rule 35(2) Reports	Number of Rule 35(3) Reports	Number of Medical Justice assessments identifying the client to be at risk of harm	Number of Rule 35(3) reports which address risk of harm by detention	Number of Part C communications which relate to vulnerability
Brook House	16	0	0	14	16	1	5
Harmondsworth	11	0	0	5	11	4	5
Yarl's Wood	10	0	0	7	10	0	1
Colnbrook	7	0	0	6	7	2	6
Dungavel	1	0	0	0	1	0	0
Morton Hall	0	0	0	2	0	1	1



Systemic failure of IRC healthcare to identify harm

The entire case set of forty five people seen by Medical Justice clinicians for a medico-legal assessment had mental health issues. 87% had two or more diagnosed mental health conditions. The identified issues comprised:

- 69% had a depressive disorder, and a further 22% had depressive symptoms requiring further investigation;
- 45% had a diagnosis of PTSD and a further 31% had clinically significant symptoms of PTSD requiring further investigation;
- 29% had clinically significant levels of anxiety in addition to other symptoms;
- 16% had a personality disorder, neurodevelopmental disorder or other diagnosed mental health problem;
- 11% had psychotic symptoms, indicating severe mental illness.

82% of the case set of people were identified as experiencing a deterioration in their mental health as a consequence of detention by the time of the assessment.

Medical Justice assesses the risk of harm of detention by reviewing the impact of detention on a person's mental health and identifying symptoms of mental illness that can be attributed to detention. Clinicians also identify clients as at risk of harm where they have mental health issues and cannot appropriately access treatment in the IRC or would more effectively access treatment in the community.

All of the case set of people assessed by Medical Justice clinicians were considered to be at risk of harm due to detention. None had a Rule 35(1) report included or referenced in their medical records to identify that their health was likely to be harmed by detention. A review of the information in the medical records completed before the Medical Justice assessment found that 67% of the case set of people had no communication explicitly addressing the risk to their health by continued detention.[31]

This information suggests a serious systemic problem. The safeguarding system relies upon IRC healthcare identifying any harm likely to be caused by detention and reporting this via Rule 35(1) reports. Yet the evidence here is that this did not happen for an overtly vulnerable group of individuals, all identified by Medical Justice clinicians as having mental health issues and the vast majority having already experienced deterioration in their mental health.

The lack of clinical recognition of symptoms of potential mental illness, and the lack of communication of the harm of detention by IRC healthcare staff in these cases, is difficult to explain. This is especially so, given the research evidence about the adverse effect of detention reflected in the position statement of the College.

[31] Assessing communication of the risk of continued detention is complicated by incomplete disclosure of Part C communications in the IRC medical records explained below. Where information was available, it was reviewed to understand whether these procedures addressed the issue of harm of detention. Rule 35(3) reports were also assessed as to whether these addressed the risk of harm of detention within section 6.

The lack of use of safeguarding procedures: clients with thoughts of suicide and self-harm

87% of the case set of people had suicidal and/or self-harm thoughts recorded by a Medical Justice clinician. All of this group were at increased risk of suicide in view of their mental health issues and were isolated from their usual sources of support in detention. Remaining in detention carried a high risk of further deterioration in their mental health and, with this, an associated increasing risk of disturbed behaviour, self-harm and suicide. 44% of the group had suicidal or self-harm thoughts or episodes recorded in their detention medical records by IRC healthcare staff, including references to suicide risk management procedures (ACDT).

However, no individual had a Rule 35(2) report completed by IRC healthcare staff. The lack of such reports is concerning as the clinical threshold for reporting is low. It is particularly difficult to understand why no such safeguarding reports were completed in light of the information in the medical records suggesting a significant proportion of people needed active management of their suicide risk in detention.

Safeguarding procedures for people with a history of torture

82% of the case set of people were identified by Medical Justice clinicians as having clinical evidence of a history of torture. However, these individuals appear to have suffered various failures in safeguarding systems associated with identifying a history of torture and associated risks to their health.

Four of those identified as torture survivors by Medical Justice doctors did not have a Rule 35(3) report included in their detention medical records.

Of the 34 Rule 35(3) reports completed, 76% did not directly identify the patient as at risk of harm caused by detention and no one had a separate Rule 35(1) report to identify the risk of harm to their health due to detention. The failure to directly address harm in a substantial majority of Rule 35(3) reports and to complete a separate Rule 35(1) to address the risk of harm to health caused by detention, is concerning given the research consensus about the likely harmful effect of detention on torture survivors. The consequence of the failure to directly identify the risk of harm caused by detention makes it difficult for those with responsibility for detention decisions to apply the adults at risk policy and therefore downgrades the level of protection afforded against people's continuing detention.

Two people were refused a Rule 35(3) report by IRC doctors on the basis that they did not consider that their description of trauma fulfilled the policy definition of torture. Both individuals were subsequently diagnosed with a mental health condition by a Medical Justice clinician and had suicidal thoughts in detention, but no Rule 35(1) or Rule 35(2) reports were completed for either person.

The pattern of failure to complete Rule 35(1) and Rule 35(2) reports fits within national data obtained under the Freedom of Information Act showing that these reporting mechanisms are rarely used when compared with Rule 35(3) reporting.[32] This means in practice, Rule 35(3) is the primary mechanism to identify those at risk of harm in detention, despite such reports only applying to survivors of torture. This

[32] Comparative data for the period of the Medical Justice clinical assessments is not currently available. A response to a freedom of information request made by Medical Justice by the Immigration Enforcement Secretariat dated 3 February 2022 (FOIA reference 67755) provided data on the number of Rule 35(1) Rule 35(2) and Rule 35(3) reports made for the period 1 July 2020 – to 30 June 2021 in a spreadsheet. The following data has been extracted: 17 Rule 35(1) reports were received; 7 Rule 35(2) reports were received; 1,062 Rule 35(3) reports were received.

is concerning as, whilst people with a history of torture are likely to be highly vulnerable in detention, there are other indicators of people who will be at risk of harm in detention which fall outside this definition. Such individuals without a history of torture will not be identified and therefore their risk of harm cannot be considered by the Home Office caseworkers responsible for reviewing their detention.

Clinical concerns about the quality of detention healthcare

Lack of exploration of PTSD symptoms

The College has specifically drawn attention to the invidious position of people with PTSD who are subject to detention[33], a view also supported by Shaw in his first review[34]. People with PTSD symptoms are likely to have their illness aggravated by the detention environment triggering reminders of the loss of agency and powerlessness that are strongly associated with traumatic events. Additionally, such patients will be unable to access treatment, since trauma focused therapy is not possible in detention settings. Given this evidence base, IRC healthcare systems should have a focus on identifying people who may be suffering from this disorder in order to then be able to identify and report safeguarding concerns.

As set out above, NICE PTSD guidelines explicitly recognise that refugees and asylum-seeking people are at heightened risk of the condition. So, given the nature of the population of any IRC, there should be a focus on the possibility of this condition by IRC healthcare staff. The nature of avoidance symptoms which can form part of a diagnosis of PTSD means that clinicians must proactively look for trauma-related symptoms, rather than being reliant on patients volunteering their symptoms and background history.

However, none of the individuals included in the case set of people had evidence in their medical records that there was any screening for symptoms of PTSD by IRC healthcare staff. This general lack of screening is contrary to the approach recommended by NICE.[35] The systemic lack of identification of this condition is concerning given that 76% of the case set of people either had symptoms of PTSD or a diagnosis of the condition by a Medical Justice clinician and none were identified as requiring a Rule 35(1) report to identify their risk of harm from detention.

Lack of clinical identification of suicide risk

36% of the case set of people (16 individuals) were found to have had self-harm or suicidal thoughts or a history of such behaviour by the Medical Justice doctor, which was not referenced in their detention centre medical records. This indicates a substantial proportion had a suicide risk that was not identified by the IRC's healthcare providers.

On review of the medical records of the those where suicide risk was not identified, four individuals were noted to only have had one brief inquiry made by healthcare staff, with this comprising a single question asked at screening on arrival in detention. The other twelve clients were recorded as being asked about self-harm or suicidal thoughts on a number of additional occasions (between one and seven times), but never identified as having self-harming or suicidal thoughts or intent. Overall, review of the content of the medical records indicated little or no follow-up to further assess suicide risk. This is a concerning approach given that these individuals were from a case set of people who reported histories of trauma, and also had significant depressive and post-traumatic symptoms and so were likely to be heightened risk of suicide.[36]

[33] Royal College Psychiatrists Position statement: *The Detention of people with Mental Disorders in Immigration Detention* PS02/21, (April 2021) Pg 11.
[34] *Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office* (2016) Para 4.37 – 4.40.
[35] *Post-traumatic Stress Disorder*, National Institute for Health and Care Excellence (2021) para 1.1.9.
[36] Royal College Psychiatrists Position statement *The Detention of people with Mental Disorders in Immigration Detention* PS02/21, (April 2021) Pg 11. Also Gonda X, Fountoulakis KN, Kaprinis G, and Rihmer Z (2007) *Prediction and prevention of suicide in patients with unipolar depression and anxiety Ann Gen Psychiatry.* doi: 10.1186/1744-859X-6-23. Also Gradus JL, Qin P, Lincoln AK et al (2010) *Posttraumatic stress disorder and completed suicide*. American Journal of Epidemiology, 171, 721-727.

It is known that non-disclosure of self-harming and suicidal thoughts is common and that relationship quality with the person asking about suicidal thoughts is critical for disclosure: the College's report 'Self-harm and suicide in adults' states that *"A review of 70 major studies of suicidal thoughts (McHugh et al. 2019) showed that about 60% of people who died by suicide had denied having suicidal thoughts when asked by a psychiatrist or GP. This highlights the value of a compassionate and therapeutic relationship, so patients feel freer to disclose".*[37]

Disclosure of self-harming and suicide risk is very likely to be adversely impacted by the nature of the detained environment, including people in immigration detention frequently seeing different healthcare providers. This results in poor continuity of care and there appears to be little consideration given to the need for clinicians to develop a trusting therapeutic relationship with patients to facilitate the disclosure of psychological symptoms including self-harming and suicidal thoughts and intent. Given the integral safeguarding role of IRC healthcare staff in identifying and reporting risk and the possibility that they may have contact with detained people who remain in detention for a prolonged period, there needs to be a clear focus on the development of such clinical relationships, with training and oversight to ensure this takes place.

Detained people lacking decision-making capacity

Medical Justice assessments for two clients indicated a concern that the individual may have lacked decision-making capacity to engage in legal processes whilst in detention. This arose in the context of one client with a potential learning disability and another person whose history of trauma led to concerns he would be unable to manage an interview in detention due to the impact of his history on his mental state.

People in immigration detention may be subject to a variety of potential legal processes. These can include addressing their immigration position or making an asylum claim, with the fact that they are subject to administrative detention adding further legal complexity to their situation. In 2018 the Court of Appeal[38] found that the Home Office had unlawfully detained and had breached its equality duties to a mentally ill detained person who was not provided with reasonable adjustments to take account of his disability arising from his mental illness. This led to him being unable to engage with legal processes specifically concerning his detention and the decisions to place him in segregation. The Court found that the Home Secretary had a power to introduce a system of independent mental capacity advocates to address the absence of safeguards for people who may lack decision-making capacity in immigration detention. To date the Home Office has not put any such safeguards in place.

[37] Royal College Psychiatrists Report *Self-harm and Suicide in Adults* CR229 (July 2020) page 46.
[38] *R (on the application of VC) v. Secretary of State for the Home Department [2018] EWCA Civ 57.*

Administrative flaws in IRC healthcare processes concerning potential vulnerability

As explained above, Rule 34 DCR 2001 requires that detained people are offered an appointment with a GP for a mental and physical examination within twenty four hours of arrival. A Rule 35 report may be completed at that time if appropriate. This is to enable vulnerable people to be identified and to ensure an early review of their detention. There is also an obligation on GPs to consider the need for a Rule 35 report if a safeguarding issue subsequently arises at any other consultation.

Rule 34 failings

Barely half (51%) of the case set of people saw a GP within twenty four hours of arrival at the IRC[39] as required by Rule 34 DCR 2001.

Of those who did not see a GP within twenty four hours of arrival, 38% were recorded to have seen a 'Medical Technical Officer'. Whilst the role and qualifications of a 'Medical Technical Officer' are unclear, these people appear to be acting in a clinical support role and were not registered doctors. The appointments were focused solely on prescriptions, including recording whether the detained person had any medication in their possession. Such a focus on medication certainly does not fulfil the purpose of a Rule 34 GP appointment as there was no reference in the individuals' IRC medical record to a mental or physical state examination.

According to their medical records, 20% of the case set of people had a GP appointment scheduled to take place within twenty four hours of arrival but either did not attend or declined the appointment. There was no information in the medical records to suggest that the purpose of the appointment had been explained to these people. Five individuals did not see a GP within twenty four hours according to their medical records, and were not offered a follow up appointment.

For those that did not have a Rule 34 GP appointment, the average time to see a GP from arrival in detention was twenty nine days.[40] The longest time between arrival in detention and an individual consulting a GP was sixty five days, followed by sixty four and sixty two days.

Rule 35 delays

There were delays identified throughout the Rule 35 process. Delays occurred between the identification of the need for an assessment and a Rule 35 appointment taking place. Of those that that had Rule 35 appointments[41] the average time between identification of need for an assessment and the appointment taking place was twenty five days. The longest time it took for someone to have their Rule 35 appointment after identification that this was indicated was 253 days.[42]

[39] Medical Justice was unable to access the medical records of one individual at the time of their arrival in detention and one person who was held under STHF Rules 2018 and so was required to have a different type of screening.
[40] This statistic is based on an assessment of the records of 19 people, since it was not possible to determine the timing for 2 individuals.
[41] For 8 people out of 34 that attended a Rule 35 assessment, it is not known what triggered the appointment from the medical records.
[42] For this individual it was 119 days until the appointment was scheduled, but the person did not go to the appointment and it was rescheduled twice resulting in the appointment taking place with a 253 day delay.

This data suggests the system of safeguarding is simply not operating effectively to ensure early clinical identification of vulnerable people on arrival in detention and that there are extended delays where the need for a Rule 35 assessment has been identified. This indicates that the safeguarding system does not function as intended, to quickly identify vulnerable individuals and enable an urgent review of their detention and consideration of the need for release.

Failure to proactively offer a Rule 35 assessment

32% of the thirty four clients who had a Rule 35 report had to specifically request a Rule 35 assessment before a report was completed. The appointment then took place between one and fifty one days later. Four individuals who had a Rule 35 report did not have to request the assessment; instead the need for the appointment was identified by a member of healthcare staff and subsequently offered and booked. For these individuals, the appointment then took place between one and five days later.[43]

Medical Justice considers the fact that a high proportion of people had to directly request a Rule 35 appointment that then led to a safeguarding report indicates the system is not operating effectively to proactively identify vulnerable people. In order for an individual to know they need to request a Rule 35 assessment they need to have technical knowledge of detention safeguarding systems. This suggests the person is likely to have been reliant on others to identify a need for an assessment by a GP. Aspects of mental illness and other elements of vulnerability e.g. language barriers, may also inhibit people from requesting an appointment. A system which has such a high reliance on people proactively requesting assessments is therefore not operating effectively. If the system was working correctly, a request for a Rule 35 appointment that ended in completion of a report would be a rare occurrence.

Lack of responsiveness of clinical reporting

There were no follow-up or second Rule 35 reports amongst this group of thirty four clients who had a first Rule 35 report.[44] Two people were refused a second Rule 35 assessment.[45] For one individual, no further action was taken and for the second, a Part C communication was sent to the Home Office communicating vulnerability due to the patient's mental health.

Medical Justice clinicians identified deterioration in the client's mental state had already occurred for 82% of the case set of people and yet this was not captured in a Rule 35(1) report by detention centre healthcare as it should have been. Given the level of mental health issues and high levels of suicide risk in this group, it is hard to explain why no one had any type of second Rule 35 report, particularly since research evidence is that detention is likely to cause exacerbation in mental illness.[46] The fact that no additional Rule 35 reports were completed for such a vulnerable group evidences that the current safeguarding system is static and unresponsive.

[43] It is unclear from the medical records for the remaining 56% who requested the Rule 35 appointment or what circumstances triggered the booking by healthcare.
[44] The medical records for one person stated that the Rule 35 report would be updated with additional information, but there was no record this took place.
[45] One individual was booked for an such an appointment by IRC healthcare but when the GP noted the previous Rule 35 report the detained person was referred to the mental health team and no Rule 35 assessment was completed. The medical record was unclear for the second individual, simply stating that the person had attended for a Rule 35 but that one had already been completed. No further assessment was undertaken at that time.
[46] *The Detention of people with Mental Disorders in Immigration Detention* PS02/21, (April 2021) Pg 11.

Part C as a safeguarding reporting mechanism

A review of the medical records was undertaken to collate information on Part C procedures being used by IRC healthcare to identify patient vulnerability to the Home Office, i.e. any reference to a history of trauma, suicidal ideation or a detained person's mental state. This showed 40% of case set of people had some reference to Part C procedures in their medical records.

This exercise was limited by the fact that the medical records did not include complete information about the Part C process. Of the medical records disclosed to Medical Justice where Part C was used, only five included a copy of the document and nine (50%) recorded in the clinical note that the procedure had been used but did not include the document itself. For the remaining four clients, the only means of identifying that the procedure had been used at all was by reference to Home Office letters, otherwise the medical records disclosed to Medical Justice made no reference to use of the procedure.

Clinical problems with Part C as an alternative safeguarding mechanism to Rule 35

The Part C process appears to pose a number of potential ethical problems for IRC healthcare departments. The first difficulty concerns the lack of consent by the detained person to share any aspect of their medical information with the Home Office. Whereas the Rule 35 DSO that underpins the Rule 35 reports process states the patient's explicit consent is needed to share their medical information with the Home Office for safeguarding purposes, and the template report requires the written consent of the individual in order for this to occur; this is not addressed within Part C procedures. The Part C document itself lacks any requirement for written consent of the detained person for their information to be shared with the Home Office and various policies referencing the use of the procedure also do not address the issue.[47]

These concerns about the gap in policy regarding consent are demonstrated by the medical records of the case set of people. It was only possible to identify that the procedure had been used for four individuals by reference to other documents issued by the Home Office. There was no explanation in the IRC medical records of how consent for disclosure of medical information was discussed or whether this was provided.

Part C is an inappropriate alternative to formal Rule 35 reports. As explained above, it is an ineffective safeguard as it does not require a review of detention and there is no requirement for the Home Office caseworker to provide any response to the information provided. This is inappropriate from a clinical perspective as there is no communication with IRC healthcare staff to address the risks identified in the form or to seek further information and so no opportunity for clinicians to address errors. The lack of obligation to provide a response potentially also places the clinician completing the form in difficulty, since they will be unaware of the response to their concerns and so whether they have concluded their safeguarding responsibilities or need to engage in further communication.

The form itself is not designed to address the issues required by the adults at risk policy and may be completed in very short form with little information. The form simply states it should be completed *"as soon as possible as either a) further information becomes available or b) the detainee's behaviour and/or*

[47] The procedure is referenced in *Adults at Risk in Immigration Detention*, (July 2019) paras 23, 25-26 without reference to the issue of the detained person's consent.

statements indicate a possible alteration to this detainee's risk factor." Again, the lack of joined up procedures concerning safeguarding places a clinician working within an IRC in potential difficulty. It is unclear what clinical information needs to be provided and so it is more difficult for the healthcare professional to be sure that they have discharged their safeguarding obligations when completing the document.

The only other section that requires completion on the Part C form is *"Will this individual comply with removal directions?"* The purpose of a broadly drafted question concerning compliance with removal directions on the Part C form is unclear. The broad question *"whether the individual will comply"* with removal directions lacks a clinical focus, specificity of the information the clinician needs to address and seems inappropriately worded: inviting speculation instead of requesting clinical information.

For a clinician completing the form, the issue of compliance involves consideration of the potential use of force, as this is legally permitted to enforce a person's removal. Medical opinion that may be linked to use of force is a complex ethical issue for clinicians working in immigration detention. Specifically in this situation, healthcare professionals are required to limit their assessment only to information concerning medical factors which may limit the person's ability to comply with removal. This could concern a spectrum of issues: physical conditions that could be exacerbated by stress or particular mechanisms of restraint; to mental health issues, particularly if there are likely to be anxiety, trauma-related symptoms, or suicidal thoughts relating to removal. Further relevant clinical factors could also include issues relating to the patient's ability to understand and engage with legal processes relating to removal. It is important that the Home Office is clear in what is being asked of clinicians in this context, to avoid 'blurring the lines between welfare and security', as the British Medical Association have described the potential 'dual loyalty' of healthcare professionals working within IRCs.[48]

[48] *Locked Up, Locked Out.* British Medical Association (2017) Pg 34.

Home Office Responses to Rule 35 and Part C Communications

This section analyses the evidence available in the medical records for the twenty seven Home Office response letters to Rule 35 reports and also the information available about how caseworkers addressed safeguarding concerns communicated within Part C processes.

Home Office Delays in Responding to Rule 35 Reports

According to the Rule 35 DSO, Home Office "*Responsible officers have two working days after accepting receipt to provide a response to the Rule 35 report*". However, Medical Justice evidence found that:

30% of the twenty seven people who had a Rule 35 report and Medical Justice had access to the Home Office response experienced a delay in the Home Office providing a response (beyond two working days). This is a concerning finding since the system of safeguarding is premised on urgent review of detention for vulnerable. This suggests it is not operating in a sufficiently timely manner.

Home Office decision-making on vulnerability and Adults at Risk

On a review of the available Home Office response letters to clients who had a Rule 35 report, 74% were assessed as level 2 and 26% were assessed as level 3. However, only one Rule 35 report led to a release of the client.[49]

There is evidence that Part C is not an effective safeguarding process. Of the eighteen individuals where Part C procedures were used, no one was released within forty eight hours of a Part C being sent and no response was provided by Home Office caseworkers to IRC healthcare staff in reply.

Overall, the clinical assessments completed by Medical Justice doctors indicate that the adults at risk policy is not operating to provide effective protection for highly vulnerable people in detention. Despite the serious level of vulnerability of the case set of people: independent clinical assessments concluded that all individuals were at risk of harm to their health caused by detention, yet only one individual was released as a result of a Home Office caseworker considering the evidence of vulnerability provided under Rule 35.

Of the twenty people assessed as level 2, 95% were assessed as such by the Home Office referencing their torture history, with one person assessed as such on the basis of information concerning their mental health contained in a Rule 35(3) report, but had their torture claim rejected.

Of those assessed as having level 3 evidence under the adults at risk policy, one person had already been assessed as such on the basis of their Covid vulnerabilities, prior to the Rule 35 response from the Home Office.

[49] Another person was released within 48 hours of a Rule 35(3) report but the Home Office response stated that the decision to release had already been taken and was not as a consequence of the report.

People with mental health issues

All of the case set of people were identified by Medical Justice clinicians as being at risk of harm due to detention, including people with both mental health issues and risk of suicide. Yet this risk was not identified through the IRC and Home Office mechanisms. 74% were categorised as at only having level 2 evidence under the adults at risk policy and did not therefore attract the highest level of protection against continued detention.

In order for someone to obtain level 3 evidence, and therefore be afforded the strongest presumption against continued detention, the adults at risk policy requires evidence demonstrating *"that the individual is at risk and that a period of detention would be likely to cause harm*". This data shows that Rule 35 reports were not effectively providing that level of evidence. Whilst the assessments completed by Medical Justice clinicians show a disturbingly high level of vulnerability and found that these individuals were at risk of harm due to detention, they were not clearly identified as such by detention safeguarding systems.

This lack of identification of clinical vulnerability may partly be explained by the lack of joined up approach to safeguarding in the Home Office's policy framework. The system of clinical reporting of concerns under the three limbs of the system of Rule 35 does not clearly align with the indicators of vulnerability set out in the adults at risk policy. The disjointed system adds an unhelpful degree of confusion suggestive of a lack of coherence in the overall approach by the Home Office to safeguarding.

There is a statutory obligation on IRC GPs to report concerns under Rule 35(2) if they suspect their patient has suicidal intentions. However, in contrast to receipt of other types of Rule 35 reports, there is no absolute obligation on the Home Office caseworker to review detention. Rather, such review of detention is dependent on the information provided in the report. There is also no direct explanation of how suicidal ideation applies to the adults at risk policy as this is not included as an indicator of risk, so there is a clear lacuna about how such information should be factored into decisions concerning detention. There is also no direct question in the Rule 35(2) template as to whether the person has an indicator of risk under the AAR policy such as a mental illness. This is a troubling situation given that expression of suicidal feelings is a highly relevant factor to understanding to the clinical risks of continuing the detention of a vulnerable person.

People with a history of torture

The downgrading of protection afforded to people recognised as having a history of torture under the adults at risk policy is demonstrated by the high proportion of this group of highly vulnerable individuals when reliant on IRC healthcare safeguarding procedures were only able to provide evidence at level 2.

This means that twenty individuals who disclosed a history of torture were not identified by IRC healthcare as at the highest level of risk in detention, or that detention would be likely to cause them harm. This is in marked contrast to the outcome of the Medical Justice assessments which concluded all such individuals were at clear risk of harm in detention and provided evidence of their mental health issues.

Under previous Home Office policy those recognised as being survivors of torture would have received the highest level of protection against detention simply as a consequence of recognition of their history and their detention would have been permitted only in *"exceptional circumstances."* In contrast, for these twenty people with clinical evidence of torture who nevertheless were deemed to only have level 2 evidence, the effect of the adults at risk policy has been to reduce their level of protection against detention. This demonstrates the lack of safeguarding protection inherent in the adults at risk policy: highly vulnerable

people, where there is research consensus and expert opinion to demonstrate that detention is likely to be harmful to them, are simply not recognised as at the highest risk.

Of the four clients assessed by the Home Office as having level 3 evidence of risk on the basis of their torture history, the Home Office only took the decision to release one person.

Lack of clinical follow-up following safeguarding reporting

Overall the evidence from the available IRC medical records shows a complete lack of engagement over clinical risk of detention by IRC healthcare departments, with no communication in reply to Home Office letters concerning their patients' detention.

Two of the twenty seven Home Office response letters to a Rule 35 report raised indirect concerns including suggesting that the medical practitioner had not given sufficient detail about treatment options or the possibility of mitigating the effect of detention. These two examples did not receive a response from IRC healthcare. This may be unsurprising given these concerns were not directly drawn to the attention of the doctor completing the Rule 35 report as these were included within a letter addressed to the detained person. There was no reference in the medical records of the Home Office directly contacting the IRC healthcare department to express concern about the content of the Rule 35(3) report or to request additional information.

Of the eighteen Part C communications accessible in the medical records that addressed issues of vulnerability, on no occasion did the Home Office respond in writing to the healthcare department. This data shows a lack of interaction between healthcare staff raising safeguarding concerns and the Home Office. Although the Home Office only ordered the release of one individual following a Rule 35 report, there was also no effort to directly request further information from healthcare in the other examples when safeguarding concerns were expressed under Rule 35.

There is also no requirement for follow up of those who have been recognised by the Home Office to be vulnerable, including if they have been accepted as an adult at risk, and who remain in detention. This is clinically concerning given that risk is correlated with the length of detention.[50] As a result, where the Home Office takes the decision to maintain detention, there is no obligation to monitor whether that person subsequently does suffer deterioration and harm. This is a further significant gap in safeguarding systems.

Longstanding failures of safeguarding in detention

Medical Justice's findings in this set of cases indicates that the safeguards designed to protect vulnerable people are failing to operate effectively and to route such persons out of detention. This evidence builds on criticism of the operation of Rules 34 and 35 DCR 2001 repeatedly expressed in our earlier research reports dating back as far as 2007.[51]

As a clinical organisation, Medical Justice has focused on these procedural elements of safeguarding since these are the primary methods for vulnerable people at risk of harm in detention being able to access a review

[50] M von Werthern, K Robjant, Z Chui et al. (2018) The impact of immigration detention on mental health: a systematic review, BMC Psychiatry 18: 382.
[51] Medical Justice has published research about the lack of effectiveness of Rules 34 and 35 DCR 2001 in terms of inadequate safeguarding of people with a history of torture, symptoms of PTSD and other mental illnesses, people exhibiting self-harm and suicide risk in *Beyond Comprehension and Decency: A report on medical abuse in immigration detention* (2007), *The Second Torture: The Immigration Detention of Torture Survivors* (2012), *Mental Health in Immigration Detention* (2013), *Death in Immigration Detention 2000 - 2015* (2016), *Putting Adults at Risk* (2018), *Failure to protect from the harm of immigration detention* (2019).

of their detention and therefore potentially release. This report builds on our earlier research and again provides clear evidence that the system is ineffective for the most vulnerable. It is also worth noting that the concerns we have raised about the operation of Rule 35 are shared by others; including organisations responsible for oversight of immigration detention such as HM Inspectorate of Prisons, Independent Chief Inspector of Borders; clinical organisations such as the British Medical Association[52] and independent thematic reviews ordered by the Home Office itself.[53]

The premise of the Rule 34 and Rule 35 system of safeguarding in seeking to identify people at risk of harm in detention is obviously clinically appropriate; but it is troubling that the implementation of these Rules has been recognised as ineffective for such a long period. Since the Home Office has overall responsibility for safeguarding when using the most draconian of powers such as detention for administrative reasons, it is perturbing that there appears to be a studied lack of curiosity in auditing and investigating repeated evidence of systemic failings.

Against these concerns, the introduction of the adults at risk policy in 2017 has been a regressive step, diluting the protection against detention for the people most likely to be harmed by this environment. This is partly as it has downgraded the effectiveness of Rule 35(2) and Rule 35(3) reports as they are no longer expressions of clinical concern likely to obtain a patient's release, instead introducing additional requirements for professional evidence of harm to provide the strongest level of protection against detention. The recasting of the policy to permit detention of people already identified as an adult at risk based on 'immigration factors' rather than permitting their detention only in 'exceptional circumstances' represents a further troubling downgrading of concern for the welfare of vulnerable people.

[52] *Locked Up, Locked Out.* British Medical Association (2017) Pg 59.
[53] *Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office* (2016) Para 4.118.

CONCLUSION

This report highlights systematic flaws in the systems designed to safeguard vulnerable people in detention. There is a failure to identify people at risk of harm, protect them, and route them out of detention.

This adds further weight to a growing consensus amongst professional bodies and research, as well as Medical Justice's own evidence based on casework and clinical assessment, that immigration detention is a seriously harmful practice. The only certain way to prevent this harm is to end the practice of administrative detention entirely.

Whilst immigration detention continues, healthcare staff working with detained people will always have a key safeguarding role as they have the relevant expertise and access to confidential medical information that may identify their patient as at particular risk. Whilst individuals' willingness or ability to disclose sensitive information relevant to risk may be hampered by the environment of detention, such disclosure is most likely to occur in ongoing appropriately attuned, trusting relationships, rather than with non-clinical detention staff.

The nature of fluctuations in the level of risk caused by detention, for example people who develop a mental illness whilst detained, means clinical staff will always have safeguarding obligations. IRC GPs currently have this safeguarding obligation set out in their statutory duty to engage with processes under Rule 35. Further, IRC GPs also have an ethical obligation to identify patients whose health may be harmed by detention since the General Medical Council requires doctors to *"… take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised."*[54]

This report provides evidence of systemic failures in safeguarding systems in IRCs by considering the situation of forty five individuals who were at heightened risk, all of whom have been identified by independent clinical assessment as being at risk of harm due to detention. GPs did not complete safeguarding reports under Rule 35(1) and Rule 35(2) to identify these patients as at risk of harm in detention despite multiple indicators of vulnerability including mental health issues, risk of suicide and a history of torture. Where reports under Rule 35(3) were made, these were often deficient for safeguarding purposes as they failed to address the issue of the harm of continued detention.

The immigration detention population has complex needs but this report highlights serious failures in healthcare for highly vulnerable people, often with a history of trauma: failures to screen for post-traumatic stress disorder, inadequate identification of risk of suicide and a lack of identification and reporting of safeguarding concerns. The situation for vulnerable people is worsened when IRC healthcare departments do not appropriately prioritise detained people's access to GPs; such administrative delays then serve to undermine the entire system of safeguarding. Better clinical training to support GPs and healthcare staff to identify people at risk, and improved audit of safeguarding systems, might mitigate some of these deficiencies.

Fundamentally, the responsibility for the legal and policy framework for adequately safeguarding vulnerable people in detention rests with the Home Office as the government department using immigration detention powers. Whilst this report provides evidence of systemic failures within the IRC healthcare departments, these have occurred within an inadequate and opaque Home Office safeguarding policy framework which fails to prioritise safety and safeguarding in detention decisions.

[54] *Good Medical Practice* General Medical Council (April 2013).

There is no clinical pre-detention screening to seek to identify vulnerable people before they enter detention and there has been disinterest by the Home Office at repeated evidence that the system of Rule 35 is ineffective once people are detained and at risk of harm caused by detention. This situation was actively compounded by the government's introduction of the adults at risk policy, which on its face widened the discretion of caseworkers to subject vulnerable people to detention and placed increased evidential obligations on the vulnerable and those providing their medical care.

It is unsurprising in this policy context, that only one individual was released following the operation of safeguarding systems from a sample of forty five highly vulnerable people at clear clinical risk from detention. This is a system in which those held in detention are, ultimately, harmed and not heard.

ANNEX 1: KEY INFORMATION

Summary of the conclusions of the medico-legal assessments

45 medico-legal assessments relating to detained people completed by Medical Justice doctors in the period July 2021 – December 2021 whilst the client was held in immigration detention:

- All individuals were assessed as at clinical risk of harm due to detention
- 37 individuals were identified as torture survivors
- 2 individuals were suffering from a mental illness or a learning difficulty to an extent that their decision-making capacity to engage with legal processes in detention was affected

All were identified as having mental health issues. 87% had two or more diagnosed mental health conditions:

- 69% had a depressive disorder, and a further 22% had depressive symptoms requiring further investigation
- 45% had a diagnosis of PTSD and a further 31% had clinically significant symptoms of PTSD requiring further investigation
- 29% had clinically significant levels of anxiety in addition to other symptoms
- 16% had a personality disorder, neurodevelopmental disorder or other diagnosed mental health problem
- 11% had psychotic symptoms, indicating severe mental illness

82% of the 45 individuals were identified as having already suffered deterioration in their mental health as a consequence of detention by the time of the medico-legal assessment.

Safeguarding processes

All Medical Justice clinical assessments concluded that each client was at risk of harm from detention yet:

- No clients had a Rule 35(1) report from IRC healthcare to the Home Office to identify that their health was likely to be harmed due to detention
- 67% had no communication of any type by the IRC healthcare department explicitly addressing the risk to their health from detention, prior to their assessment by a Medical Justice clinician
- 22% had no Rule 35 report of any type included in their detention centre medical records before their contact with a Medical Justice doctor.

Risk of suicide:

- No Rule 35(2) reports were completed for these 45 cases yet 44% of the group had information in their detention centre medical records that they had been identified as needing management for suicide risk

within the IRC. 87% of the group had a suicide risk identified by a Medical Justice doctor; all of those individuals were also assessed as having a mental health issues.

Risk of harm to torture survivors:

- 4 individuals who were identified as having a history of torture at the Medical Justice assessment did not have a Rule 35(3) report included in their medical records.
- Where a Rule 35(3) report was completed (34), only 24% of those documents provided a clinical assessment directly addressing whether the patient was at risk of harm from detention.

Home Office responses to medical safeguarding information

27 Home Office responses to Rule 35(3) reports were available. Only one client was released as a consequence of such a report.

18 individuals had at reference to at least one Part C communication identifying vulnerability in their records. No one was released within 48 hours of communication under Part C processes.[55]

[55] Records assessed for release within 48 hours as this is the time frame for a decision concerning detention when a Rule 35 report is made.

ANNEX 2: COPY OF A PART C FORM

Home Office

Port Ref
H O ref

IS 91 RA Part C
(Revised)

IS.91RA Part C: Supplementary Information to S.91 RA Part A

Details of Port/Unit Responsible For Case					
Port:		Officer:		Grade:	
Fax:		Email:		Tel:	

Details of Individual					
Full Name:					
D.O.B		Nationality		Sex	

This form should be completed as soon as either a) further information becomes available or b) the detainee's behaviour and/or statements indicate a possible alteration to this detainee's risk factor.

to

Will this individual comply with removals directions?

Unclear if this patient understands and will comply with removal directions.

In the light of this:

- It is considered that the risk factors associated with this detainee may have increased in which case a new IS.91 should be issued.
- You may also wish to consider whether a change of detention location is appropriate.

Signed: Print name: Date:

For Completion by DEPMU/MODCU

- This detainee's location does/does not need to be changed.

The reasons for any change, for example from one removal centre to another or to prison or vice versa, **MUST** be recorded in the comments section above and be accompanied by the issue of a revised IS91

Detaining Office to issue new IS91: **Yes/No**

Signed: Print name: Date:

Signature to be at EO level.

Distribution: By DEPMU following consideration of changes in risk factors.

i) DEPMU
ii) Detention Location (UKBA and Contractors/Prison Service)
iii) UKBA Office/Unit dealing with case


Medical Justice
seeking basic rights for detainees