THE BROOK HOUSE INQUIRY

FIRST WITNESS STATEMENT
OF THERESA SCHLEICHER

I, Theresa Schleicher, of Medical Justice, 86 Durham Road, London N7 7DT, will say as follows:

1. I am the Casework Manager for Medical Justice. This statement provides an overview of the recurrent systemic issues in respect of the methods, policies and practices related to the treatment and conditions of immigration detention at Brook House Immigration Removal Centre ("IRC") that Medical Justice had encountered over many years, both prior to and since the relevant period under investigation. I provide Medical Justice's analysis on how they contributed to the types of abuse and ill-treatment shown on the BBC Panorama documentary. I also set out Medical Justice's engagement in policy reform proposed by the Home Office in the light of the BBC Panorama Programme, *Undercover: Britain's Immigration Secrets.* Finally, this statement will address the Inquiry on Medical Justice's recommendations for change and for lessons to be learnt.

2. Information for this statement derives from Medical Justice's direct experience of case work, research and engagement in policy work. In my second witness statement, I set out Medical Justice's analysis of our case work related to clients who were detained at Brook House during the relevant period from 1 April to 31 August 2017 and detail our experience of the operation of Brook House following the BBC Panorama programme. That analysis in my second statement should be read in conjunction with this statement as the recommendations that Medical Justice sets out toward the end of this statement is informed by our case work analysis.

A. CASEWORK AT MEDICAL JUSTICE AND MY ROLE

3. The witness statement of Emma Ginn, Medical Justice's Director, provides an overview of Medical Justice's work in the field of immigration detention since its inception in 2005. In this section, I focus on a description of Medical Justice's casework and the policy work that the organisation has done arising from its direct work with immigration detainees.

4. People in immigration detention generally seek our assistance to document evidence of their past torture or severe trauma. Our assistance is also sought due to concerns about the individual's health, or their medical treatment in detention. On average we receive approximately 800 to 1,000 referrals a year, although that number went down for a period between March to August 2020 and again in the first quarter of 2021 during the Covid-19 Pandemic.

5. Medical Justice's Casework Team is the first point of contact for referrals from people in detention and those assisting them for the clinical input of our employed and volunteer doctors.

(1) My Role

6. I have worked at Medical Justice as Casework Manager since July 2009. I have held this position since then, save in respect of a short period of time, I stepped in as Acting Director (maternity cover) from December 2015 to January 2017.

7. As the Head of Casework for Medical Justice, I am engaged in policy work on behalf of the organisation alongside our policy manager and, sometimes, our Director. This includes attending stakeholder meetings with the Home Office, working on consultation responses to new policies, and engaging with the independent inspectorates whose remit include investigating matters concerning immigration detention and enforcement, particularly Her Majesty's Inspector of Prison ("HMIP") and the Independent Chief Inspector of Borders and Immigration ("ICIBI"). We have also provided written and oral representations to inquiries and reviews commissioned by the Home Office into immigration detention and the treatment of vulnerable people in detention. My colleagues and I have also given evidence before Parliamentary committees in inquiries into immigration detention, including the Home Affairs Select Committee.

(2) Work of Casework Team

8. The casework team consists 4 case workers and myself. We are responsible for deciding which referrals to accept, staying in touch with those clients during their time in immigration detention, arranging assessments by our clinicians, liaising with the healthcare unit in IRCs about detainees' care, referring clients to legal representatives and other relevant organisations and also referring them to community services for treatment, therapy and other

support on release from detention. Visits are arranged with people in detention only following referral (which I describe further below) and where it appears to us on the information provided to us that there may be issues which require medical assessment and assistance.

9. My colleague, Dr. Rachel Bingham, is Medical Justice's clinical advisor and oversees the doctors who are employed by or volunteer for Medical Justice. Her statement explains the clinical expertise available at Medical Justice, the training we provide for our volunteer doctors and the clinical assessment process for Medico-Legal Reports ("MLRs"').

10. Our casework remit covers 3 groups of people in detention:

    a. The first group is those who report having been subjected to torture or ill-treatment and have physical or psychological signs of that ill-treatment and who need this to be documented in an MLR for it to be considered as part of a legal case (generally an asylum or immigration case or one related to their continued detention). It is our experience that the majority of people who we see in detention are later released and may go on to be granted refugee status.
    b. The second group is those who have a clinical problem and require an assessment of their treatment and support. Our clinicians frequently draft letters outlining such significant medical concerns, the treatment that is required, and assess how they relate to whether someone is fit to fly, or whether and the extent to which someone is adversely affected by continued immigration detention.
    c. The third group is those who allege that they were assaulted or had excessive force used on them in detention or during an attempted removal. This area of work is particularly challenging. As explained by Dr. Bingham in her witness statement, our ability to document evidence of use of force depends on the incident being reported to us via a referral almost immediately after it has occurred, and our being able to arrange to see a detainee very shortly after force had been used. Otherwise the physical signs of excessive force or assault may have faded by the time we are able to arrange for a clinical assessment albeit there may have been some last mental symptoms.

11. Whilst we do not provide legal advice (and we are not registered with the Office of Immigration Service Commissioner to do so), it is an integral part of our casework function to be able to broadly identify whether there are legal issues arising in respect of the client's

detention, treatment in detention, or associated issues pertaining to their immigration case, so that we can make appropriate referrals for legal advice and representation.

(3) Referrals to Medical Justice

12. Medical Justice receives referrals through our online referral form or by telephone from solicitors, befrienders, other NGOs, and detainees themselves. Occasionally healthcare staff in detention will refer a client to us because of their concerns. Clients may be referred to us at any point in their immigration detention.

13. When a new referral is received, a Medical Justice caseworker will make initial contact with the detained person to gather additional relevant information not apparent on the referral form and to check the information put in the referral. We take basic details from the detainees of any trauma history, and information about their immigration history and any ongoing legal case.

14. People in detention do not always have all of their past immigration documents with them: this may be because they were detained without notice and did not have their documents with them; or they had not been provided with their immigration documents by previous legal representatives; or they had not kept hold of their past papers. People also will not have ready access to medical records in the detention centre; this needs to be requested from the healthcare unit specifically. If we accept a referral, we normally will take further steps to obtain immigration documents through the clients' legal representatives in the first instance, and request their medical notes from IRC healthcare.

15. We have extremely limited capacity and do not have the resources to realistically see all the referrals that we receive or would like to accept. We aim to provide assistance to the majority of people referred to us in one form or another but can only prepare MLRs for a small proportion of referred individuals. Since its inception, it has arranged for more than 1,500 reports concerning people in immigration detention, and assisted thousands more.

16. We decide which referrals to accept at our casework meetings, which currently take place three times a week There are three key considerations as to when we would be able to accept a referral to provide an individual with assistance: (1) whether the person has a level of medical need; (2) whether medical evidence will be significant and relevant for an individual

in their legal case and (3) whether we have an appropriate clinician available to provide an assessment.

17. In prioritising referrals, we take into account the availability of support from another agency, such as Freedom from Torture or the Helen Bamber Foundation, the detained person's current health and level of vulnerability and whether an intervention from us is likely to make a difference to their situation. We also prioritise those referrals where removal action is imminent and medical evidence has a role to play in whether removal should be enforced; or where the individual's health has deteriorated to a point of requiring urgent clinical input. If a client is unrepresented, we will assist with a referral to a solicitor (if they want this) or signpost them to the Detention Duty Advice (DDA) Scheme, the scheme set up by the Home Office with the Legal Aid Agency to make provision of 30-minute free advice slots for people in detention who wish to obtain legal advice and assistance.

18. Once we decide that a medical assessment is appropriate, I will arrange for one of our volunteer doctors with the right kind of specialism to visit the client and conduct a clinical assessment. Sometimes we arrange telephone assessments or produce a preliminary report on the basis of a review of the records. Where we accept the referral and produce an MLR or a clinical letter, we have a rigorous peer review process for doing so, as explained in Dr. Bingham's witness statement. With the client's consent, we often will send the report to healthcare if there are urgent clinical recommendations, unless the client's legal representatives send the report onwards themselves. We cannot offer treatment or therapy but we do endeavour to assist detainees to ensure that clinical recommendations are followed through such as by liaising with the IRC healthcare unit and referring to health services after release if appropriate.

(4) Medical Justice's Database

19. Medical Justice maintains a bespoke database, which contains details of almost 8,000 clients who it has assisted since 2009. This includes more than 1,000 clients who have been held in Brook House IRC since 2009. Over the years, Medical Justice has drawn on this database to produce significant research on systemic issues relating to clinical and healthcare provisioning in the detention estate. The research has also identified flaws in the legal and policy framework and its application to the detention of vulnerable people. The results of this

research are directly relevant to the range of issues that this Article 3 Inquiry has set out to investigate at both a systemic and operational level. The research has been summarised in the witness statement of Emma Ginn and I would invite the Inquiry to consider that summary and the underlying research reports for the context to understanding how mistreatment happened at Brook House in 2017. My second witness statement contains the analysis that we undertook of our case load of detainees who were held at Brook House for the relevant period identified in the Terms of Reference. The case studies that have been reviewed are annexed to that statement.

B. POLICY CONTEXT: BACKGROUND

20. It is not possible to understand how and why mistreatment of the kind documented in the Panorama Programme occurred without understanding the policy context within which these clinical and casework issues arise and the Home Office's rationale behind the policies and its attitude and approach to their operation and implementation.

21. The physical, verbal and mental abuse and ill-treatment recorded by BBC Panorama's documentary, *Under-Cover: Britain's Immigration Secrets*, was undoubtedly horrific and shocking. The abuse captured in the BBC footage and the evidence that has emerged in the course of Phase 1 of the Inquiry clearly expose particular cultural and institutional problems at Brook House, but it is Medical Justice's experience that the defects in the policy framework and the institutional culture of racism and of dehumanising people in detention are closely linked, and did not only affect Brook House IRC or play out only during the narrowly defined relevant period between 1 April 2017 to 31 August 2017.

22. The Panorama documentary was not the first time that serious abuse and ill-treatment in immigration removal centres was captured on film and exposed to the public. Ms. Ginn has already addressed the history of repeated abuse scandals linked to IRCs. I emphasise the fact that only two years earlier in 2015, Chanel 4 had broadcasted two documentaries recording similar racism and disregard for people in detention as human beings at other IRCs. The first concerned Yarl's Wood IRC (*Undercover in the secretive immigration detention centre*[1]) and showed shocking attitudes of guards to female detainees, referring to them as "animals", "beasties" and "bitches", using racist and derogatory language about them, and suggesting

[1] Channel 4 (2015) 'Undercover in the secretive immigration detention centre'.

that they should be headbutted and beaten. Standards of health care filmed in the documentary were poor, and an incident of miscarriage was filmed on camera. Later that same year, another undercover documentary on Harmondsworth IRC (*Inside Harmondsworth*[2]) exposed the poor conditions in which men were forced to live, the despair of those trapped in the system, the fears of those who work there and the problems with outsourced contracts.

23. Structural deficiencies in both the detention policy framework and its operation in relation to vulnerable detainees have also been identified through the courts and have resulted in findings that the individual detainees suffered serious ill-treatment and abuse to the Article 3 threshold. Serious concerns have also been raised repeatedly by independent inspectorates and Home Office-appointed independent reviewers.

24. Although repeated criticisms of the arrangements and operation of safeguards for vulnerable detainees have been made and recommendations identified through the courts, the statutory, parliamentary and other reviews, and repeatedly exposed by undercover journalism and other media reports, it is our experience at Medical Justice that these lessons are seldom actually learnt by the Home Office and its contractors or reflected in improvements that can be evidenced as effective and sustainable.

25. The Adults at Risk ("AAR") statutory framework, implemented through section 59 of the Immigration Act 2016, was introduced as a response to the findings and recommendations made by Stephen Shaw in his first *Review into the Welfare in Detention of Vulnerable Persons* ("Shaw 1") (discussed further below). However, for reasons that I will elaborate on below, the AAR statutory and policy framework has not and cannot meet the systemic deficiencies both in practice and institutional culture, or created a humane system of immigration detention, at least not when (i) there is no statutory time limit to immigration detention for the vast majority of people (save in respect of pregnant women and unaccompanied children); (ii) immigration enforcement and detention policy operates under the rubric of a "hostile environment" policy, designed to perpetuate the divide between us and others; and (iii) when there is no penalty or sanctions for abuse and ill-treatment that has been exposed through the courts, independent oversight reports and the media. Senior civil servants who were responsible for oversight and operation of immigration enforcement and

[2] Channel 4 (2015) 'Inside Harmondsworth'.

detention system during the documentaries and court cases remain in post. Contractors who operated the IRCs criticised for ill-treatment to the Article 3 threshold repeatedly saw the renewal of their contracts at the IRC or are given new contracts at other IRCs with no apparent scrutiny over their conduct. As explained below, changes at a policy level in guidance or Detention Service Orders (DSO's) or in action plans, will not begin to address the conditions that caused or contributed to the abuse at Brook House in 2017. Instead, what is required is fundamental change to the legal framework and safeguards as well as concentrated measures to the ingrained institutional culture of disinterest in the rights and welfare of detainees within the Home Office and which governs its relationship with its contractors.

(1) <u>Policy History for the Adults at Risk Statutory Framework</u>

26. For more than 20 years, Home Office policy has recognised that those who have suffered a past history of torture or other forms of ill-treatment are particularly vulnerable to harm if they are detained or remain in detention. This was clearly acknowledged in the 1998 Government White Paper, "Fairer Faster Firmer": *"the need to exercise particular care in the consideration of physical and mental health when deciding to detain"*, in particular *"[e]vidence of a history of torture should weigh strongly in favour of temporary admission or temporary release whilst an individual's asylum claim is being considered"*.

27. Until the AAR framework was implemented through the Immigration Act 2016 ("IA 2016"), the safeguards intended to ensure vulnerable people are identified promptly and are not normally subject to immigration detention were largely contained in executive policy. The Detention Centre Rules ("DCR") 2001 were the exception, implemented through section 153 of the Immigration and Asylum Act 1999.

28. The primary executive policy on detention was Chapter 38 of the Operational Enforcement Manual (OEM 38), which was replaced in 2008 by Chapter 55 of the Enforcement Instructions and Guidance (EIG 55). Both OEM 38 and EIG 55.10 operated a strong presumption against the detention of listed categories of persons considered by the Home Office to be unsuitable for detention save in *"very exceptional circumstances"*. EIG 55.10, as operated prior to August 2010, stated as follows:

55.10 Persons considered unsuitable for detention

Certain persons are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration accommodation or prisons. Others are unsuitable for immigration detention accommodation because their detention requires particular security, care and control.

…

The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons:

- *unaccompanied children and young persons under the age of 18;*
- *the elderly, especially where significant or constant supervision is required which cannot be satisfactorily managed within detention;*
- *pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this;*
- *those suffering from serious medical conditions or the mentally ill*
- *those where there is independent evidence that they have been tortured;*
- *people with serious disabilities which cannot be satisfactorily managed within detention;*
- *persons identified by the Competent Authorities as victims of trafficking*

29. In August 2010, the Home Office amended EIG 55.10 in respect of those with a. serious medical condition or mental illness as follows:

> *The following are normally considered suitable for detention in only very exceptional circumstances…*
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> - *those suffering from serious medical conditions <u>which cannot be satisfactorily managed within detention</u>;*
> - *those suffering serious mental illness <u>which cannot be satisfactorily managed within detention (in CCD cases, please contact the specialist Mentally Disordered Offender Team). In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act</u>…*
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> (emphasis added)

30. This amendment to EIG 55.10 was regressive and diluted the previous strong presumption against detention by treating those with a mental illness as suitable for detention unless they could show their conditions could not be *"satisfactorily managed"* in detention. It was also applied erroneously in a significant number of cases and overall resulted in individuals with serious mental ill-health being detained for prolonged periods of time. During their detention they suffered a deterioration in their mental ill-health, increased self-harming owing to a lack of treatment, and in some cases, lost mental capacity to make decisions for themselves.

Strong presumption of liberty – Very Exceptional Circumstances required for detention

31. Both EIG 55.10 and its predecessor, OEM Chapter 38, accepted that a person who fell within one of the identified categories was inherently vulnerable to harm in detention and should not be detained other than in "very exceptional circumstances". This strong presumption against detention recognised that these categories of people are at an increased risk of adverse impact of detention and it would not be appropriate to wait for evidence of harm to materialise before releasing the person from detention. This approach was corroborated by an established body of medical and other literature which found that immigration detention had a negative impact on the mental health of immigration detainees, particularly those who had pre-existing trauma or pre-existing mental and physical health problems. This clinical research was comprehensively and systematically reviewed by Professor Mary Bosworth for Shaw 1 and, more recently by von Werthern et al in their systematic review.[3] The Royal College of Psychiatrists ("RCPsych") has also issued several position statements on the subject matter, which I understand Professor Cornelius Katona, who chairs the college's Working Group on the Mental Health of Asylum Seekers and Refugees, discusses in his witness statement. I would invite the Inquiry to consider Professor Bosworth's literature review and Professor Katona's evidence on the subject-matter as they form important contextual information and clinical underpinning for understanding the approach that should be taken in policy formulation concerning the use of immigration detention.

32. The courts have also consistently interpreted the requirement that detention of vulnerable detainees should only be in *"very exceptional circumstances"* as requiring a *"high hurdle"* to be overcome before the strong presumption against detention can be displaced in respect of people who are otherwise considered unsuitable for detention.[4] Thus, mere immigration factors, such as having entered the UK illegally, having overstayed or refusing to leave voluntarily could not on their own constitute *"very exceptional circumstances"*. Otherwise, the policy would be devoid of meaning.[5]

33. The courts also held that *"very exceptional circumstances"* could not be justified by reference to a person's own well-being, such as to prevent suicide attempts.[6] The sorts of

[3] Von Werthern et al (December 2018) The impact of immigration detention on mental health: a systematic review.
[4] *R (Das) v SSHD* [2014] EWCA Civ 45 at [68].
[5] Rix LJ at [34] in *R (AM) v SSHD* [2012] EWCA Civ 521, affirmed in the Court of Appeal's judgment in *R (Das) v SSHD* [2014] EWCA Civ 45 at [68].
[6] *R (AA) (Nigeria)* [2010] EWHC 2265 (Admin) at [40].

cases where the high hurdle would be overcome and detention could be justified involved persons who posed high risks of serious harm to the public (such as someone with violent past offending and current risks of killing someone) or where removal was imminent.[7] Unless *"very exceptional circumstances"* could be established by the Home Office, detainees falling within the categories under EIG 55.10 had to be released from immigration detention on a proper application of the Home Office's policy,

Safeguards under the Detention Centre Rules 2001

34. EIG 55.10 was designed to operate alongside the DCRs, which came into force in April 2001. The DCRs only apply once a person is detained in an IRC; they do not apply in prison or in a short-term holding facility (although a modified version of the DCRs were implemented for STHFs in July 2018). The DCRs are similarly underpinned by acceptance of the need to identify those who are particularly vulnerable to harm in detention, although they are only triggered once a person is detained under immigration powers. Rule 3 requires *"due recognition"* to be given to *"the need for awareness of the particular anxieties to which detained persons may be subject."*

35. Two key oft-cited provisions are Rules 34 and 35. They are important for being the two provisions specifically directed at enabling prompt identification of vulnerable people on their being detained, so as to inform lawful decision-making regarding their ongoing detention as well as their treatment in detention.

36. Rule 34, entitled "Medical examination upon admission and thereafter", requires that "*Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) or (10)) within 24 hours of his admission to the detention centre.*

37. Rule 35, entitled "Special illnesses and conditions (including torture claims)", contains three limbs which are as follows:

> *35.—(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.*

[7] *R (Das) v Secretary of State for the Home Department* [2014] EWCA Civ 45.

(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.

(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.

38. A medical practitioner is defined under Rule 33(1) as a general practitioner and a fully registered person within the meaning of the Medical Act 1983 who holds a licence to practise.

39. The purpose of the Rule 34 medical examination is not only to *"identify any immediate and significant mental or physical health needs, the presence of a communicable disease"* but also to identify *"whether the individual may have been the victim of torture."* Early identification is key, hence the 24-hour turnaround from when a person arrives at an IRC. This is also clear from the Detention Services Operating Manual (September 2011) at para 15. In effect, Rule 34 medical examinations have a dual purpose, not only of identifying immediate medical needs, but also to facilitate the medical practitioner to alert Home Office decision makers of matters highly relevant to decision-making concerning detention and immigration enforcement.

40. Where the Rule 34 examination identifies *concerns* or *suspicions* of likely harm to continued detention or conditions of detention of the sorts identified under the three limbs of Rule 35, the doctor has an obligation to send a Rule 35 report to the Home Office to the attention of officers responsible for making decisions relating to detention as well as to those immigration caseworkers considering the immigration case. In this way, the Rules 34 and 35 process operate as an enhanced screening process. They do not require a diagnosis in order to be used.

41. Once the Rule 35 report is in the hands of the Home Office, the procedures for handling and assessing the Rule 35 report are governed by policy under the Detention Services Order ("DSO") 09/2016 *Detention centre Rule 35 and Short-term Holding Facility Rule 32*, which provides that the Home Office should review and respond to the Rule 35 report within two working days of receipt.

42. The connection between the detention policy and Rules 34/35 was emphasised in a statement by Lord Filkin, under-secretary for the Home Office, in 2002 in the context of torture cases:

> *…We made it clear in our 1998 White Paper, Fairer, Faster and Firmer that evidence of a history of torture should weigh strongly in favour of temporary admission or temporary release when deciding whether to detain while an individual's asylum claim is being considered. That remains the case. The instructions to staff authorising detention are clear on that. Independent evidence that a person has a history of torture is one of the factors that must be taken into account when deciding whether to detain and would normally render the person concerned unsuitable for detention other than in exceptional circumstances. Such evidence may emerge only after the detention has been authorised… If that happens, the evidence will be considered to see whether it is appropriate for the detention to continue.*
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> *We reinforced that in the Detention Centre Rules 2001. Rule 35(3) specifically provides for the medical practitioner at the removal centre to report on the case of any detained person who he is concerned may have been the victim of torture. There are systems in place to ensure that such information is passed on to those responsible for deciding whether to maintain detention and to those responsible for considering the individual's asylum application…*[8]

43. In *D and K v SSHD* [2006] EWHC 980 (Admin) the court considered challenges to immigration detention brought by two asylum seekers which alleged that there were systemic failings in the operation of rule 34 DCR at Oakington IRC, which was used for the Detained Fast Track process ("DFT"). The court held that the *"combined effect"* of the DCRs, the statement of Lord Filkin referred to above, OEM 38 (which operated at the time) and provisions of the Detention Services Operating Standards Manual was that rule 34 DCR was an important part of the safeguards to ensure that vulnerable individuals were not detained in breach of the policy. Further, a rule 35(3) report was itself capable of meeting the requirement for independent evidence of torture in OEM 38.

44. The judge held that Rules 34/35 and Lord Filkin's statement displaced *"any notion that in some way there is… an overriding burden on the detainee always himself to come up with the relevant 'independent evidence [of torture]'"*. There was an obligation *"on the detaining authorities… to provide the medical attendance which may in turn… lead to a report capable of being independent evidence of torture"*. The court rejected the contention that the Home Office could rely on the presence of lawyers or welfare groups at Oakington to contend that the burden lies with detainees to obtain relevant evidence. Parliament intended, through the

[8] Lord Filkin Hansard HL Deb 15 July 2002: Column 1060 - http://www.publications.parliament.uk/pa/ld200102/ldhansrd/vo020715/text/20715-20.htm

DCR, to introduce strong safeguards against the inappropriate detention of vulnerable groups and placed the onus on the Home Office to ensure that these safeguards are effective.

(2) <u>Defects in the system of safeguards for vulnerable detainees</u>

45. Despite the judgment in the *D and K* case, Medical Justice and other governmental and non-governmental organisations have consistently identified ongoing systemic failure in the operation of Rules 34 and 35 DCRs and in the application of the detention policy under OEM 38 / EIG 55.10 properly.

46. Similar criticisms of the Home Office's application of its detention policies in respect of vulnerable persons came from all quarters, including HMIP, ICIBI, the IMBs, the Home Affairs Select Committee, the UN Committee against Torture as well as many non-governmental organisations. The Home Office also, in consequence, commissioned several independent reviews into immigration detention and conditions of detention for vulnerable people, which made similar findings, discussed below.

47. The flaws in the Rule 35 process have historically been a primary focus for Medical Justice and other NGOs. This is because it is the only available *statutory* safeguard to prevent detention, or at least secure prompt release of vulnerable detainees. However, this focus did not mean that we thought the rest of the immigration detention system worked. We have always been concerned about the *"culture of disbelief"* within the Home Office and among its contractors (including healthcare professionals) coupled with *"hostile environment"* policies which led to an *"us versus them"* approach to decision-making. We just felt that if the statutory safeguards approved by Parliament were dysfunctional in achieving protection for vulnerable people against the disproportionate impact of immigration detention then it was unlikely that our concerns about the wider practices in the immigration detention system as a whole were secure any real change.

48. Moreover, information and documentation related to the Rule 35 process was easier to access – Rule 35 reports and Home Office responses to them are normally provided to the person and their legal representatives and uploaded onto medical records. By contrast, documentation concerning ACDT, the use of segregation or removal from association under Rules 40 / 42 DCRs or use of force incidents are seldom provided to the detained person or included in medical or Home Office records when requested through subject access request.

Many of those documents are held by contractors at the relevant IRC, and not readily available or provided. Therefore, we face significant hurdles in corroborating their accounts without independent evidence.

Systemic defects in the operation of the Rules 34 and 35 safeguard

49. Medical Justice has had long-standing concerns about the failure to ensure that Rule 34 medical examinations by a doctor took place within 24 hours of a person's arrival at an IRCs. Too often, the health screening, carried out usually by a nurse or nursing assistant, was mistaken to be a Rule 34 medical examination, which needs to be carried out by a medical practitioner (i.e. a GP, not a nurse). The health screening is typically a pro forma (with some variations amongst the different IRCs), with yes or no tick boxes and does not entail a physical and mental state examination, which Rule 34 requires.

50. Where an appointment with a GP did take place within the first 24 hours of detention, it was our experience that that consultation usually focused on identifying any immediate health needs that require medical input, rather than on identifying vulnerability to suffering harm while in detention, even though that is a key purpose of the Rule 34 examination. The routine failure to ensure that Rule 34 examinations were undertaken effectively was of obvious concern to us given its important role as an early trigger for a Rule 35 report to alert the Home Office that the person may be someone who, under EIG 55.10 (and later AAR) policy, is at risk of harm from detention and is should not remain in detention.

51. Even when a detained person did disclose torture to a nurse at health screening, it did not necessarily result in a prompt Rule 35 report or at all. In Medical Justice's experience, a practice developed where increasingly Rule 35 assessments were only triggered if a client requested such an assessment. Medical records for our clients often referred to a person in detention *"applying"* for a Rule 35, even though the rule did not require such a request. Of course, if the need for a Rule 35 was not identified at the point of entry into the IRC through the health screening or Rule 34 processes, then people should be able to ask for consideration of such an assessment. However, the routine need for people in detention to do so demonstrated the ineffectiveness of Rule 34. People often only knew to make a request after some time in detention, and after they had accessed legal advice and assistance, or learnt through word of mouth about the Rule 35 process. In our experience, detained people are not told of the safeguards, how they operate and how they can access them. The delay to

accessing a Rule 35 assessment means that people who are potentially vulnerable to harm in detention were exposed to higher risk of deterioration before their situation was drawn to the attention of the detaining authorities so that their suitability for detention could be considered properly.

52. When Rule 35 reports were produced, the reports tended to record physical scarring rather than involve a full examination and assessment or recording of any related concerns as to the mental state of the detainee arising out of their ill-treatment. A body map was sometimes but not always completed to record visible scars. Concerns about whether a person may be a torture survivor largely depended on scarring, when torture could be psychological or leave no physical scars. The reports also rarely considered or commented on impact of detention on the detainee's health.

53. Templates for Rule 35 reports operating prior to the Adults at Risk policy allowed doctors to use the same pro forma to identify more than one limb of Rule 35, so that a doctor may express concerns that a person may have been a torture victim and that detention was likely to be injurious to the detainee's health. But still, as the Rule 35 statistics below show, the vast majority were Rule 35(3) reports, and seldom about detention causing likely injury to health or suicide risks.

54. Another long-standing problem was that doctors routinely failed to review medical notes or include vital patient information in Rule 35 reports. For example, records may indicate a person has been on ACDT but that would not be mentioned in the Rule 35 report. There might also be records that the person has reported trauma symptoms. Both are obviously relevant to the GP's consideration but are too often left out of the report, with GPs not addressing the question of impact of detention at all or properly given their assessment omits key information of clinical importance.

55. Moreover, even when reports are made, the quality of the Home Office response tended to be poor and dismissive of the report's conclusions, focusing on immigration factors to seek to justify continued detention and misapplying the "very exceptional circumstances" threshold for displacing the strong presumption against detention of a person whose vulnerabilities had been documented in the Rule 35 report.

Engagement with Home Office

56. Since the 2006 *D and K* judgment, Medical Justice and other NGOs attempted to engage in constructive discussions with the Home Office on ways to improve the operation of the Rules 34 and 35 process so that they could better achieve their objectives. We pressed hard for the Home Office to implement an oversight mechanism to monitor the operation of the Rule 35 process but were met with significant resistance on this, with the Home Office claiming that the HMIP would be able to pick up any non-compliance and there was no need for a dedicated examination of the process. That approach was obviously inadequate as the HMIP was only ever going to be able to look at a snapshot sample of Rule 35s at a particular IRC and would not be able to systematically monitor how the safeguard was generally operating (or not) and over time.

57. Following concerned pressure, the Home Office did agree in 2006 to conduct a one-off audit of the operation of Rule 35, but those results were never published. In 2010, when pressed, the Home Office said the data collected had been lost. The Home Office agreed to a second Audit, which was published in 2011 and found that one-third of Rule 35 reports were not considered by the Home Office and responded to within the 48-hour time limit specified in policy, and a third were ignored altogether. The Audit concluded that the process required closer scrutiny and performance monitoring, and recommended a further audit after six months, but to our knowledge, this third audit never took place. Nor was any real improvement of substance brought about further to the 2011 Audit, especially concerning the quality of Rule 35 reports and the effectiveness of Rule 35 reports resulting in release.

Medical Justice's *The Second Torture* report

58. It was in the face of the persistent and abysmal record of failures in the Rule 35 process, and the Home Office's refusal to engage in constructive dialogue on improvements to the safeguard that Medical Justice published its report *the Second Torture* in 2012. That report relied on the following data sources: (1) review of the available literature and reported cases; (2) questionnaires completed by the 50 clients who had formerly been detained; (3) an analysis of the Home Office (SAR) files (4); IRC healthcare records; and (5) medico-legal

reports for the 50 cases documenting evidence at least *"consistent"* with the account of torture.[9]

59. The individuals which formed the cohort case studies were held in detention between May 2010 and May 2011 and had an MLR or medical letter produced for them by Medical Justice clinicians. All 50 cases were of individuals who alleged to be victims of torture and had medical evidence from a Medical Justice volunteer clinician, which was at least *"consistent"* with their accounts. In some cases, their allegations of torture had been found to be credible by either the Home Office or Immigration Judges, whilst in others they had not been found to be credible or their claims are still being determined.

60. However, only one of the individuals was released through the Rule 35 process; all but two were released subsequently from detention. Two others who had been removed from the UK then experienced further torture and returned to the UK subsequently. Failures were identified at every stage of the Rule 35 process, including (1) health screening failing to elicit a history of torture and prompt a Rule 35 assessment; (2) Rule 34 medical examinations not being completed, or completed partially with either no physical or mental state examination, and therefore not triggering Rule 35 reports; (3) Rule 35 reports failing to identify a significant number of torture survivors, body maps not completed documenting scarring, reports being completed by nurses, and reporting failing to consider impact of detention on the person's health; (4) the Home Office failing to respond to Rule 35 reports at all or within prescribed timeframes. When responses were provided, the Home Office disputing the credibility of the account despite the medical evidence and maintaining detention without considering the evidence or impact of detention on the detainee's health adequately or at all. The "very exceptional circumstances" strong presumption was not applied properly to secure the release of vulnerable people.

61. We provided our research report to the Home Office and indicated that we intended to bring judicial review proceedings to challenge these systemic failings. In response, the Home Office agreed to meet with Medical Justice and other stakeholders to discuss how improvements might be made. This was done mainly through the medical sub-group of the

[9] Between May 2010 and May 2011, Medical Justice clinicians wrote 98 medico-legal reports for clients in immigration detention documenting evidence of past torture. Great efforts were taken to trace and secure the consent of all 98 individuals but for various reasons, 48 people could not be reached or did not give consent to be included in the study.

Detention Users Group. Unfortunately, much of the proposals were on how to improve the Rule 35 templates, with little investigation into the fundamental flaws around the quality of Rule 35 reports and the Home Office's unsatisfactory responses to the reports.

EO and Ors v SSHD [2013] EWHC 1236 (Admin)

62. Around the same time in 2012, a number of Medical Justice clients lodged judicial review proceedings (the *EO* cases) to challenge the systemic failings in the operation of Rule 35 and the independent evidence of torture policy.[10] In the *EO* judgment, Mr Justice Burnett described Medical Justice's *The Second Torture* report and other evidence provided by Medical Justice to the Court as *"disturbing"*.[11]

63. In defence of the claim, the Home Office sought to suggest (for the first time) that a primary reason why individuals were not being identified as victims of torture under Rule 35 was because "torture" for the purposes of EIG 55.0 and Rule 35 was to be defined by reference to article 1 of the United Nations Convention against Torture and Other Cruel, Inhuman and Degrading Treatment ("UNCAT"). At around the same time, the Home Office revised its asylum policy instructions to reflect this position.

64. We were surprised by the Home Office's characterisation of its apparent long-standing interpretation of what "torture" meant for the purposes of EIG 55.10 and Rule 35(3). The Home Office had never raised this in the numerous meetings or correspondence in previous years as an explanation for why the Rule 35 process had consistently failed to properly to identify people with a history of past torture or other forms of serious ill-treatment. Its asserted position on what "torture" meant in *EO* also directly contradicted evidence it filed from a senior civil servant, Simon Barrett, in *D and K* several years earlier. In that evidence, Mr. Barrett said (at para 8 of his witness statement):

> *Torture, for these purposes [article 3 ECHR] constitutes deliberate inhuman treatment, causing very serious and cruel suffering. Acute mental suffering without any physical element can constitute torture. However, in order for ill treatment to constitute torture, the level of suffering has to be significant.* ***It need not be inflicted by public officials****... and need not be for a 1951 Convention reason."* (emphasis added)

[10] *EO and Others, supra.*
[11] *EO*, para 3.

65. The problem with the UNCAT definition of torture was that it only recognised torture as severe harm inflicted by state agents, those under the control of the state or with the acquiescence of the state. Such a narrow definition excluded those people who suffered from severe ill-treatment inflicted by non-state actors, often in the context of interpersonal violence, tribal disputes, domestic / family abuse, trafficking and slavery. Evidence filed by the claimants, including from the late Helen Bamber and Professor Katona, explained in detail why the identity of the perpetrator was not relevant to the way in which victims of severe harm experienced detention and was not relevant to their therapeutic needs

66. The Court accepted this and held that for the purposes of EIG 55.10 and Rule 35(3), given their aim was to safeguard against the disproportionate impact of detention on vulnerable groups, "torture" must encompass *"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."* (para 82). There was "*no significant difference between the therapeutic needs of victims of torture in the UNCAT sense, or in the wider sense"* (para 81).

67. Following the *EO* judgment, the Home Office nevertheless continued to apply the UNCAT definition in the revised policy as if the judgment had no effect. It was only in response to a pre-action letter sent by Medical Justice in June 2013 that the Home Office agreed to suspend the use of the UNCAT definition *"for the purposes of the Rule 35 policy and detention policy more generally".* Subsequently, in August 2013, the Rule 35 Process policy was amended in line with the *EO* judgment. The definition was not incorporated into the relevant Detention Services Order (DSO 07/2012) but on 7 and 8 August 2013 emails were sent to Home Office caseworkers and IRC doctors which clarified the position.[12]

Detention Action v SSHD [2014] EHWC 2245 (Admin)

68. However, the operation of the Rule 35 safeguard did not improve. Failings in the Rule 35 process were exposed in further litigation brought by Detention Action to challenge the unfair

[12] See: Home Office (January 2015) Guidance provided for Home Office caseworkers and Immigration Removal Centre doctors on Rule 35 (FOI release)

operation of the DFT process. In that context, the Rule 35 process not only served to identify vulnerable people who were unsuitable for detention, it was key to identifying those that the Home Office accepted were not suitable for the fast track process because their vulnerabilities may impair their ability to fairly advance their claim; this may be either because their claim is too complex and require further time to investigate (in particular to obtain medical evidence), or they are unwell and unable to effectively engage in the asylum process in detention. The failures detailed in evidence from Medical Justice, Freedom from Torture and the Helen Bamber Foundation showed continued persistent failings in the Rule 35 process for individuals in the DFT. The failings include poor quality reports, delays in Home Office responses to the reports, and formulaic and resistant nature of the response to the reports by the Home Office. Very few Rule 35 reports led to removal from the DFT and release from immigration detention. The collective evidence before Mr. Justice Ouseley led him to conclude in a judgment handed down in July 2014 that *"Rule 35(3) reports are not the effective safeguard they are supposed to be"* and *"do not work either by themselves or with Rule 34 to remove from the DFT those with independent evidence of torture or whose case is no longer suitable for fair determination no the quick DFT timetable, as a result of evidence of torture."*[13]

69. Following the *Detention Action* judicial review, the Home Office held a series of 'remedial' meetings with stakeholders, including Medical Justice, Freedom from Torture, Helen Bamber Foundation, Detention Action as well as Home Office contractors. These meetings were aimed at seeking solutions for the failings in the DFT identified by Mr. Justice Ouseley in that case, although the focus was on Rule 35(3) and not on the other two limbs of Rule 35. At one of the meetings, the Home Office shared the results of a "dip sample" of 26 Rule 35 cases which showed doctors not including sufficient information to explain their concerns about the individual but also showed Home Office caseworkers failing to seek further information from the doctors as required under the DSO 07/2012, and instead rejecting the Rule 35 report as independent evidence of torture and of the person being unsuitable for detention. The dip sample confirmed what Medical Justice and other NGOs had suspected for many years, that a Rule 35 report seldom led to release of the detained person under EIG 55.10. Although the Home Office appeared to be more engaged in these meetings, the

[13] *Detention Action v SSHD,* para 133.

meetings did not result in reforms for real change, and were suspended further to the *JM and Ors* litigation (discussed below) and the suspension of the DFT.

JM and Ors v SSHD [2015] EWHC 2331 (Admin)

70. Medical Justice also contributed evidence in support of four individual challenges brought to the DFT in 2015 (*JM and Ors*), further to the *Detention Action* judgment. Each of the four cases showed, on their facts and circumstances, that they had suffered horrific past torture and severe ill-treatment ranging from rape, cigarette burns, beatings and broken limbs. Each had Rule 35 reports documenting their accounts of torture and trauma symptoms including flashbacks, poor sleep, self-harming, and tearfulness. Yet none of them were removed from the DFT or released from immigration detention on account of the Rule 35 reports, which was still defective as a safeguard against detention and systemic the unfairness in DFT process.

71. These individual claims were ultimately conceded, with the Home Office accepting that *"[t]he safeguards in the DFT including screening and Rule 35 of the Detention Centre Rules 2001 did not operate sufficiently effectively to prevent an unacceptable risk of vulnerable or potentially vulnerable individuals, whose claims required further investigation, being processed in the DFT."*[14] As a result of the litigation, the then-Immigration Minister James Brokenshire announced the suspension of the DFT on 2 July 2015. It has not since been reintroduced although there is a very real concern that a fast track process will be re-introduced under the current Nationality and Borders bill before Parliament.

"Satisfactory management" of seriously ill detainees

72. The amendment of EIG 55.10 to introduce a threshold of "satisfactory management" was highly problematic. By a letter of 11 October 2010, the Immigration Law Practitioners' Association ("ILPA") wrote to the Home Office expressing concern that the changes had been made without an Equality Impact Assessment (EIA), significantly widened the Home Office's powers to detain vulnerable groups and increased the risk of individuals being detained unlawfully or in breach of their ECHR rights, particularly the mentally unwell. The Home Office responded on 20 December 2010, denying that there had been any change in

[14] *JM and Others v SSHD* [2015] EWHC 2331 (Admin) at para 65.

policy and dismissing the concerns, but committed to undertake an EIA *"when we are in a position to do so."*

73. Around that time, a number of individuals, some of whom were Medical Justice clients, challenged their detention on the basis that it breached the Home Office's policy on the detention of the mentally ill and exposed individuals to treatment in breach of Article 3 ECHR. In five cases, the Administrative Court made unprecedented findings that the detention of mentally ill individuals was inhuman and/or degrading in breach of article 3 ECHR.[15] In all five cases, the detainees' health deteriorated in detention and the deterioration was not identified until they were very unwell and, in all but one of the cases, required inpatient hospital treatment, which is what brought the detention to an end. *BA*, *S* and *MD* were Medical Justice clients. *HA* and *D* were detained at Brook House IRC. Three out of those five cases (*S, BA*, *HA*) concerned former foreign national offenders (FNOs) facing deportation. Medical Justice contributed evidence in four of the five cases (BA, HA, S and MD). I understand that Professor Katona has annexed to his witness statements summaries of these cases (and two later cases). I refer to those summaries and will only highlight the cases where relevant to my discussion of policy development in respect of the detention of vulnerable people.

74. In *R (BA) v SSHD* [2011] EWHC 2848, the claimant was hospitalised under the Mental Health Act 1983 ("MHA") whilst serving a custodial sentence. His treating clinical team considered that his mental state would deteriorate to *"dangerous levels"* were he to be re-detained in prison. He deteriorated when he was briefly returned to prison and had to be re-hospitalised. Despite these known clinical concerns, BA was transferred to an IRC on completion of the custodial part of his sentence. It was abundantly clear from the medical records at Harmondsworth IRC that he was extremely unwell; he appeared disorientated, and had stopped drinking and eating. An IRC psychiatrist advised that he needed to be re-referred to hospital for assessment and treatment, and an IRC doctor considered him unfit for prolonged detention because he could not be treated successfully in that environment. There was a real risk that he could die or his internal organs could shut down if he did not receive appropriate psychiatric treatment. The healthcare staff were so concerned that they began to

[15] *R (S) v SSHD* [2011] EWHC 2120 (Admin), *R (BA) v SSHD* [2011] EWHC 2748 (Admin), *R (HA) v SSHD* [2012] EWHC 979(Admin), *R (D) v SSHD* [2012] EWHC 2501 (Admin), *R (MD) v SSHD* [2014] EWHC 2249 (Admin).

formulate an end of life care plan for BA. Yet detention was maintained at successive detention reviews by the Home Office, relying on the risk of absconding and re-offending owing to his conviction for drug smuggling. BA was detained for a little more than six months,[16] after which he was transferred for urgent treatment under section 48 MHA.

75. The Home Office sought to justify his continued detention by contending that the phrase in the EIG 55.10 – *"those suffering from serious mental illness which cannot be satisfactorily managed in detention"* – only applied at the point at which a detainee was currently and obviously suffering from a condition that could not be managed in detention (as opposed to applying when a detention decision was made in respect of a person whose mental illness *might not be capable of* satisfactory management in detention). The judge rejected this submission, calling the Home Office's interpretation of the policy *"laissez faire"*[17] and problematic as it permitted the Home Office to detain someone who is potentially unsuitable for detention and to forget about him, leading to risks that the detainee's condition will not be monitored, and to risks of detention to a point where the illness cannot be managed. The judge held that the correct approach required a preventative approach: even if a detained person was well at the time of detention, it was necessary to assess whether the condition might not be capable of satisfactory management. It required the Home Office to confront this issue at the outset and to make plans for the detainee's welfare if the decision is to detain, and to be alert, in detention reviews, for signs of deterioration which may tilt the balance of factors against detention. The judge described BA's detention and treatment in detention as *"a deplorable failure"* and attributable to a complete absence of any monitoring of BA's condition in the early stages of his detention. The subsequent combination of *"bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare"* was unacceptable and reflected a *"callous indifference"* to BA's plight.[18]

76. A year later, in *R (HA) v SSHD* [2012] EWHC 979 (Admin), the Court ruled that the failure identified by ILPA in 2010 to conduct an EIA prior to introducing an amendment to EIG 55.10 was unlawful. HA's case exemplified how the "satisfactory management" threshold resulted in extremely unwell people being kept in detention for a prolonged period of time and suffering a significant deterioration in their mental health. HA displayed unusual and

[16] 1 February to 6 August 2011.
[17] *BA v SSHD*, para 184.
[18] *BA v SSHD,* para 237.

paranoid behaviour whilst in immigration detention, which included filling his drinking cup with toilet water, drinking directly out of the toilet bowl and washing his face and hands with water from the toilet. He slept on the floor with a single sheet covering him near the toilet area and refused food and fluids, believing that this was tampered with and poisoned. HA remained detained for more than a year, during which he was put on ACDT, moved between different IRCs, including Brook House, and segregated as an apparent means of managing his disturbed behaviour.

77. A Rule 35(1) raised at Brook House had confirmed that detention was likely to be injuriously to his health, and healthcare had taken a view that he required a hospital transfer. But the Home Office maintained his detention. The Home Office also contended that HA's self-neglect justified detention so that he could receive the necessary medical attention and care. When HA was finally hospitalised, he was diagnosed with paranoid schizophrenia and given anti-psychotic medication. Although the hospital advised the Home Office that a return to an IRC would cause a significant deterioration in his mental health, the Home Office did it anyway. He was only released from immigration detention by an order of the High Court in the course of judicial review proceedings issued on his behalf.

78. The court held that authorisation of HA's continued detention further to the Rule 35 report was unlawful. The delay in transferring him to hospital for treatment was also *"manifestly unreasonable."*[19] The Court found that HA had suffered degrading treatment in breach of Article 3 ECHR, including at Brook House, not only because his mental health had deteriorated significantly whilst in detention, but also because he was subjected to prolonged periods of time in isolation in segregation, and to the use of force on several occasions. HA also suffered self-neglect and he was denied access to appropriate medical treatment to alleviate his mental illness for a prolonged period of more than five months.[20] The return to detention was also in breach of Article 3 ECHR as both inhuman and degrading treatment.

79. The Home Office denied that the introduction of the threshold of *"satisfactory management"* of mentally ill detainees led to such ill-treatment or that it was a policy change, only a clarification of an existing policy. This was not accepted by the Judge, who found that in any event that the change / clarification breached the Home Office's equalities duties. Initially

[19] *HA v SSHD*, para 171.
[20] *HA v SSHD*, para 181.

the Home Office sought to appeal the court's judgment, and Medical Justice and Mind were going to jointly intervene, but shortly before the appeal hearing, the Home Office withdrew the appeal and confirmed the commitment to carry out an EIA.

80. Shortly after the *HA* judgment, another High Court judge found a breach of Article 3 ECHR in respect of another detainee held at Brook House and Harmondsworth. In *R (D) v SSHD* [2012] EWHC 2501 (Admin), the Home Office was heavily criticised for depriving D of any psychiatric input or access to anti-psychotic drugs for a period of more than nine months even though the Home Office knew that this medication was needed to manage D's paranoid schizophrenia. The Home Office was also aware of clinical concerns that the IRC environment was not conducive to his mental health. Whilst in detention, D experienced auditory hallucinations and felt suicidal. There were repeated references to a need for assessment in his medical records, but this did not take place at either Brook House or Harmondsworth. He was eventually granted immigration bail in April 2012, after being detained for more than a year.

81. The court found that D's mental ill-health could not have been satisfactorily managed at either Brook House or Harmondsworth, and although he received fortnightly psychiatric input at Colnbrook, he had deteriorated to the point of losing capacity to instruct lawyers and that ought to have indicated that he could not be satisfactorily managed in the IRC even with that psychiatric input. The court found a breach of Article 3 in respect of D's time at Brook House and Harmondsworth, where the absence of proper psychiatric treatment caused or exacerbated his mental suffering. In particular, the court considered that D's ill-treatment was *"premeditated"* in the sense that *"those with responsibility for the well-being of detainees in the two institutions knew that D had a history of mental illness and persisted in a medical regime for him which involved neglect (particularly in relation to the taking of anti-psychotic medication and denial of access to a psychiatrist) and recourse to what were in effect disciplinary sanctions under Rules 40 and 42 which were unsuitable for a person with his condition."*[21]

82. These cases were stark illustrations of the concerns that Medical Justice and others had about the consequences of the application of the *"satisfactory management"* threshold. At least

[21] *D v SSHD*, para 183.

two of the cases concerned the ill-treatment of detainees at Brook House. But importantly, the cases also showed that the factors contributing to Article 3 breaches were not limited to the way in which a particular IRC was set up (in D and HA, two IRCs were involved), or to contractors at a particular IRC or to a "bad apple" immigration official. These cases showed defects at the policy level (both in its formulation and its operation), at the institutional level (both within the Home Office decision-making and at the IRC), and at the day to day level (in the "laissez faire" and even "callous" response to urgent and severe mental ill-health). However, and despite this series of unprecedented court judgments finding that the policy and its misapplication resulted in a number of detainees suffering ill-treatment in breach of Article 3, the Home Office took no meaningful steps to remedy the situation.

83. Instead of promptly carrying out an EIA as it was required to do and had committed to do in settling the appeal in *HA*, the Home Office decided in 2014 to commission the Tavistock Institute to undertake a review into how mental health was dealt with in immigration detention and how improvements could be made to improve the well-being of detainees and to reduce the number of cases that end up in legal challenge. Medical Justice participated in that review, contributing written evidence and attending a stakeholder workshop. A discussion on the findings of the Tavistock review is set out below.

84. Separately, on 21 January 2014, the Home Office announced a limited consultation on EIG 55.10, which focussed on mental health, with a close date for responses of 21 March 2014. The questions posed in this limited consultation sought answers on equality issues arising from a situation where persons suffering from mental illness may be detained, asked for evidence that showed that detaining mentally ill persons would have a disproportionate impact on them and invited views on whether, and how the policy could be reformulated to address concerns about the "satisfactory management" threshold. Responses from stakeholders such as ILPA and HMIP sought to press upon the Home Office the importance of the strong presumption that mentally ill persons will not be detained save in very exceptional circumstances, and proper consideration be given to alternative means for addressing concerns about absconding that would not easily displace the presumption. The outcome of the consultation was never published, and no change to the policy arose from the consultation.

85. In September 2014, NHS England took over responsibility for healthcare commissioning and arrangements at IRCs and short-term holding facilities. There were hopes, at the time, that the transfer could lead to substantial improvements in the long term in the provision of healthcare for detainees at IRCs. However that has not been Medical Justice's experience, at least not immediately. About a year later, the service specifications were reviewed and consulted on and the level of service provision improved to an extent. We understand that there was further investment particularly into mental health care in IRCs. However, the core concerns as to the role of IRC healthcare remain, particularly (i) the significant recurring problems in the failure of healthcare to play their part as the safeguard against the continued detention of vulnerable people, as identified by Dr. Bingham in her witness statement, (ii) the failure to identify and assess trauma-related symptoms and mental health problems; and (iii) the significant limitations to effective mental health treatment in detention. Those issues are not ones that can be addressed by the change of identity in the commissioner and are underlined by a failure to appreciate the particular role that healthcare plays in the immigration detention context (as opposed to in prisons), in identifying those who are unsuitable for detention and should be released:

86. ***First***, healthcare in immigration detention falls within the Health and Justice branch of NHS England, and is thus commissioned by the same people who commission prison healthcare. In turn, much of the understanding and guidance applying to healthcare in prisons have been applied without modification to immigration detention.

87. Whilst the two are both detention contexts, the population held in the two environments is different and the basis upon which they are held in the two environments is also fundamentally different. The majority of the prison population are people subject to a custodial sentence and cannot be released other than at the end of their custodial sentence or when they are granted early release or parole. By contrast, the detained population at IRCs are held there are the discretion of the Home Office, in a system that ought to operate a presumption against detention and a policy of using detention as a last resort where all other alternatives have been considered. Whereas prisoners who are mentally unwell will normally need to be managed within the prison environment (save in cases where a hospital transfer under the MHA is justified), immigration detainees do not *have* to be detained if detention has caused or exacerbated a deterioration in their mental health.

88. The language of service specification initially produced for IRCs repeatedly referred to detainees as prisoners and pointed to the need to have provision to deal with "health-related drivers of offending behaviour", which was inapt and inaccurate for the IRC context, given that many immigration detainees had no criminal offending history.

89. Similarly the prison-based ACDT processes for managing risks of suicide and self-harm have been applied to IRCs. In prison, ACDT is a management mechanism for suicide and self-harm risks because prisoners cannot be released. By contrast, in the immigration detention context, managing risk to self (in the form of ACDT) is not limited only to ensuring no actual harm is caused whilst the person is subject to detention, but should also prompt IRC staff (including healthcare professionals) and the Home Office to ask whether the person should be in detention at all.

90. ***Second***, transfer of responsibility to NHS England did not mean that the healthcare provided in IRCs is equivalent to that available in the community. That has not been our experience. By and large NHS England has made arrangements for healthcare provision in IRCs through public procurement and frequently from private contractors. Therefore, the standard of health was and continues to be unavoidably dependant on the contractor commissioned by NHS England to provide the actual care in the IRCs. Initially when healthcare was first transferred to NHS England, the same contractors were kept on to continue provide healthcare in their relevant IRCs without proper scrutiny of their track record. I was told by my colleague Emma Ginn that an NHS commissioner for healthcare for the area that includes Yarl's Wood once said to her that they felt lucky that G4S Health was in place at Yarl's Wood given their expertise. This was just before the Channel 4 documentary filmed undercover in 2015 showing abuse and racism being rife within that IRC and pregnant and other vulnerable women being unable to access adequate healthcare. Yet G4S Health continued to operate at Yarl's Wood until 30 August 2019 and at Brook House and Tinsley House until 30 August 2021.

91. G4S Health is now no longer operating in the IRC context further to the Panorama documentary but it would be naïve to think that they were the only problematic contractor in the context of IRC healthcare. The Practice PLC, for example, which now provides healthcare at Brook House and Tinsley House IRCs, were the provider at the Heathrow IRCs when BA and on S were subject to Article 3 ill-treatment in 2011 / 2012. There is no publicly

available information to show how these private contractors' past track record was properly scrutinised, or whether and the extent to which they were required to demonstrate sufficient improvements to their systems, procedures, and operation to assure us that the kind of abuse captured on footage in the BBC Panorama programme and in the Channel 4 undercover exposes would not be repeated.

92. ***Third***, and although NHS England amended the service specification over a year later, it was initially modelled on the prison service specification, and did not initially reference, promote or make provision for the operation of the Rule 35 process, its role in the immigration detention context, and the obligation on healthcare staff (particularly GPs) to complete a report where there are concerns that a person may fall within one of the recognised categories of vulnerabilities. There was also nothing indicating a proper understanding of the immigration detention regime, how detention was discretionary and meant to be a last resort generally, and more so where it concerned vulnerable groups who should only be detained in "very exceptional circumstances."

93. For example, in the context of mental illness, the service specification stated that people would be held in detention until they are able to be transferred to a hospital for treatment and that they would be returned to prison once discharged from hospital. This is not applicable to the immigration detention context and as the *HA* case illustrates, on discharge from hospital, the Home Office needed to consider whether the detention power could and should be exercised given the risk of Article 3 ill-treatment where his mental illness had already seriously deteriorated in detention.

94. Furthermore, safeguards such as health screening and initial medical examination under Rule 34 DCRs have an additional purpose to identify concerns about suitability for continued detention in the light of the person's vulnerabilities.

95. Moreover, the standard of healthcare provision referred to in the service specification did not match what was required under the Home Office's own policies. There was a lack of detail about the services available in IRCs. For example in relation to mental health, it was said that the services must be safe, high quality and integrated, but the specification did not say at which level – primary, secondary, tertiary, or what on-site provision of mental health staff there would be, what provision for in-reach services would be contracted, or how the level of staffing would be determined. This was addressed in detail in a later revised service

specification. No reference was made to a key consideration for healthcare staff, which was whether mental ill-health could be satisfactorily managed within the IRC, and the factors that would inform that, including importantly, whether the necessary treatment was available. PTSD was unfortunately referred to as a "common" condition when the Royal College of Psychiatrists had made clear that it was not a condition that could normally be satisfactorily managed in detention. No guidance was given on how to deal with conditions that could not be satisfactorily managed in detention. No consideration as given to the adverse impact of detention itself on mental health.

Tavistock Institute's Mental Health Review (2015)

96. The Tavistock Institute was aware of the transfer of healthcare responsibility to NHS England when it conducted the Mental Health Review, but as their Review of Mental Health Issues in IRCs was published on 9 February 2015,[22] less than six months after responsibility had transferred, they were not in a position to assess whether that change had made any material difference to the standard of healthcare and treatment of the mentally ill at IRCs.

97. The Tavistock report nevertheless made a number of critical findings about mental health policy and care in immigration detention, including:

a. The underlying defensive dynamic between policy makers, managers, detention centre custody staff, healthcare staff and caseworkers (3.4), which makes it difficult to change the organisational culture in the IRCs. The provision of training, more staff, different providers and other inputs, cannot alter this and will only be incorporated into the problematic defensive culture. (3.9)
b. Mutual antagonism and suspicion existed as between the Home Office and some NGOs, official oversight bodies and voluntary organisations operating in the sector; (3.5)
c. Detention itself can create highly stressful situations for detainees and staff alike, (3.6) but caseworkers, sub-contractors, and solicitors often disagree over the appropriate response to the impact of detention on vulnerable detainees, thus feeding the detainees' sense of powerlessness, hopelessness and fear of the future; (3.7)
d. Home Office detention centre policies and procedures needed to be better aligned to the identification and management of mental health issues. (4.4) The current provision of

[22] The Tavistock Institute (2015) Review of Mental Health Issues in Immigration Removal Centres.

training on mental health awareness and appropriate treatment was limited; Home Office staff lacked the skills necessary to be able to identify existing mental health issues in detainees; (4.1)

e. Healthcare screening needed to be more alive to a person's previous mental health condition and any history that is available in order to provide better psychiatric oversight at the start of the detention process. (4.2) Screening should not take place at night and should be in the presence of interpreters; (4.5)

f. Better understanding and training on the complex issues affecting the emotional well-being of detainees was needed to combat the "culture of disbelief" which affected how staff assessed health complaints, especially about self-harm, which were too often seen as attention seeking behaviour; (4.5)

g. Healthcare staff may be compromised by being employed by an outsourced agency in the absence of any unified standard of care that is to be expected in the detention context; (4.5)

98. The report made recommendations including for better training for detention centre staff in order to identify mental health issues promptly and prevent flaws in medication and delayed care; better communication between custodial staff and healthcare staff, and in relation to concerns about the pervasive *"culture of disbelief"* and better working relationships between the Home Office and stakeholders, including NGOs.

99. The Tavistock review recommendations were muted against the backdrop of unprecedented findings by the courts of detention conditions causing Article 3 ill-treatment in a succession of cases. They did not suggest the kind of radical change we felt was urgently needed in order to prevent a repeat of the ill-treatment identified in the court judgments. This was not surprising considering it was not an independent review and was overseen by a steering group from the Home Office. Nevertheless, some of the recommendations were practical and would have brought about, at a minimum, some necessary improvements to the conditions and treatment of detainees with mental ill-health, albeit not enough.

100. It was therefore extremely disappointing that instead of implementing those recommendations, the Home Office announced on 9 February 2015 yet a further review, to be led by Stephen Shaw, into the welfare in detention of vulnerable persons. It was said that

the Shaw Review would serve as a response to the recommendations made by the Tavistock Institute,[23] even though what was needed and indeed had been pressing for some time was some actual and practical change on the ground, rather than another review, and further delay whilst the defects within the policy and system continued to operate, to the detriment of detainees. There was still no published EIA and the satisfactory management policy remained unchanged.

101. Whilst, as discussed further below, we considered that the first review completed by Mr. Shaw to have made some significant strides in pressing for reform, we felt at the time that this announcement was a mechanism to deflect attention from the Tavistock review and the damning findings of Article 3 breaches in respect of immigration detainees and to push down track addressing the fundamental problems.

Parliamentary Joint Inquiry into Use of Immigration Detention in UK

102. Shortly after the announcement of the Shaw review, the All-Party Parliamentary Group ("APPG") on Refugees and the AAPG on Migration published a cross-party report into its *Joint Inquiry into the Use of Immigration Detention in the United Kingdom* in March 2015.[24] The inquiry had been formed in July 2014 following a number of high profile incidents within IRCs and amid plans to increase the size of the detention estate. This report found that the *"enforcement-focused"* culture within the Home Office led to too many instances of unnecessary detention in breach of official guidance. The Parliamentarians involved in the inquiry came from across the political spectrum, and whilst they had different views as a panel on immigration policy in general, they were *"all united in the view that the current system of immigration detention is not working and must be substantially changed."*

103. In the report's foreword, Sarah Teather MP, chair of the inquiry, described a moment *"when the audience in the room gasped"* when receiving personal testimony from people suffering from mental health conditions who were detained for prolonged periods of time. The foreword went on to state:

> *The UK is an outlier in not having a limit of how long we can detain people under immigration powers. We are also an outlier on the scale of our immigration detention*

[23] Home Office (2015) Announcement of Home Secretary re independent review of welfare in detention (Shaw 1).
[24] APPG on Migration and APPG on Refugees (2015) Report of the Joint Inquiry into the Use of Immigration Detention in the United Kingdom.

estate. We detain a lot of people, some for a very long time, all with huge uncertainty, and we have very limited processes for individuals to challenge that detention.

Every few months there is a fresh news report about poor treatment of individuals in the detention estate. These reports shine a light briefly on the inmates of immigration detention, but the interest is fleeting, and little seems to change for those who languish there, hidden from public view.

Crucially, this panel believes that little will change by tinkering with the pastoral care or improving the facilities. We believe the problems that beset our immigration detention estate occur quite simply because we detain far too many people unnecessarily and for far too long. The current system is expensive, ineffective and unjust.

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104. The inquiry panel called for a *"very radical shift in current thinking"* about immigration detention and for *"wholescale change in culture, towards community models of engagement and better caseworking and decision making"* and considered there to be no reason why the UK could not achieve this when other countries have managed to do so.

105. The findings and recommendations made included:

a. a need for a much wider range of alternatives to detention, and move to community-based resolutions because detention was being used disproportionately frequently, resulting in too many instances of detention.
b. a need for a time limit of 28 days on the length of time anyone can be held in immigration detention, but that should not become a default period. Decisions to detain should be "very rare" and detention should e for the shortest possible time and only to effect removal.
c. introduction of a robust system for reviewing the decision to detain early in the period of detention, for example by the implementation of automatic bail hearings, a statutory presumption that detention is to be used exceptionally and for the shortest possible time, or judicial oversight, either in person or on papers.
d. The Home Office needs to undertake a literature review to collate recommendations for improvement of the immigration and asylum systems, including case-working and the use of detention, that have been made in successive reports, drawing out common themes with a view to analysing what progress has been made against these recommendations.
e. IRCs should not be prisons or prison-like settings.

f. Detainees need to have proper and effective access to the internet.

g. Better access to legal representation was needed.

h. Detainees should only be transferred between IRCs when absolutely necessary and legal representatives informed because frequent moves are disruptive and distressing for detainees and their family and friends.

i. Health screening was inadequate and there was a long waiting period to see a doctor. This meant that mental health illnesses were not picked up quickly.

j. It was difficult for detainees to receive appropriate mental health treatment even after trying to commit suicide. Detainees who had attempted suicide or who were self-harming were treated with a lack of urgency. The process of "suicide watch" was also itself "distressing and dehumanising."

k. Healthcare professional did not have, but needed, the resources and training to be able to identify and treat mental health issues, especially those which are likely to be more common among the IRC population.

l. The Home Office did not recognise symptoms of mental illness such as depression, schizophrenia, PTSD, personality disorder, or at risk patients, self-harming behaviour, suicidal ideation and general anxiety. This meant, according to NICE guidelines, that the patients were without full and proper assessments and treatment plans. There was, instead, a culture of disbelief as to whether a detainee's odd behaviour was manipulative or was genuinely symptomatic of mental ill-health.

m. Evidence received from health professionals showed it was not possible to treat mental health conditions in IRCS and the Home Office policy that individuals suffering from serious mental conditions can be managed in detention put the health of detainees at serious risk. Individuals with mental health conditions should only be detained under very exceptional circumstances and should not require an additional criteria of satisfactory management.

n. Rule 35 Reports were failing to protect vulnerable detainees for whom continued detention is detrimental to their health, or who are victims of torture. In too many cases GPs were either simply passing on the details of claims made by detainees rather than giving a clinical opinion or Home Office staff are failing to act on the evidence they receive".

o. Home Office caseworkers were also failing to act on the evidence they did receive. Caseworkers should be properly trained in how to respond to Rule 35 reports, so that responses are in accordance with Home Office policy.

p. Screening processes needed to be improved before a decision to detain is taken so as to ensure that victims of trafficking were not detained for immigration purposes and the Home office caseworkers understood the National Referral Mechanism and its importance.

106. The Home Secretary did not respond to the findings of the Parliamentary joint inquiry, save to state that the Government did not intend to take any steps to introduce a time limit to immigration detention. Otherwise, the then Immigration Minister James Brokenshire's letter to the Chair of the inquiry, dated 24 March 2015, sought to defer making any commitments to reform and, instead, stated that the recommendations would be fed into the Shaw Review.

VC: Exposure of lacuna in safeguard for those suffering from severe mental illness or lack mental capacity

107. An area that neither the Parliamentary inquiry nor the Tavistock review grappled with was the treatment of people who are detained but may lack mental capacity owing to their severe mental illness. This was exposed in a court judgment concerning VC, a man with severe illness, who was held at Brook House IRC from December 2014 to September 2015.[25] He also spent time in Morton Hall, Haslar and Dover IRCs. His mental health severally deteriorated at Brook House to the point that he lacked mental capacity and was eventually transferred after 10 months of detention to a psychiatric hospital. I understand that a more detailed discussion of VC's case is contained in the witness statements of Naomi Blackwell, formerly of Gatwick Detainee Welfare Group, who acted as his advocate, and Hamish Arnott of Bhatt Murphy Solicitors, who acted for VC. The significance for these purposes is that whist reviews were taking place vulnerable detainees such as VC were suffering treatment later accepted by the Home Office itself to be inhuman and degrading in breach of Article 3 ECHR. Moreover, the Court of Appeal found a wholesale failure on the part of the Home Office to ensure arrangements were in place to identify and safeguard people with severe

[25] VC was detained under immigration powers from 11 June 2014 to 28 September 2015, with detention at Brook House from 23 December 2014 until his release. Judicial review proceedings were issued on 30 April 2015. The Court of Appeal judgment was handed down on 2 February 2018 ([2018] EWCA Civ 57.

mental ill-health and mental incapacity in detention. The absence of any measures to support them to understand their rights and access legal remedies for their treatment was unlawful and discriminatory contrary to the Equality Act 2010. The Court directed the Home Secretary to take urgent steps to remedy the serious systemic lacuna but this did not happen.

108. Indeed, a year and a half later, in late July 2019, the Court of Appeal handed down a further judgment in the cases of *ASK and MDA v SSHD* [2019] EWCA Civ 1239, both Medical Justice clients, repeating the same directions for urgent remedial steps to be taken.

109. These three cases are not anomalies. I have done a review of our casework for the relevant period in 2017 under investigation by the Inquiry. There were 11 cases of individuals (including MDA) who we had concerns may lack capacity to make decisions relating to their immigration case and detention/release. Three of the individuals were at Brook House. Six cases were assessed by Medical Justice clinicians to lack capacity or with strong suspicions they may lack capacity. In three cases we could not undertake a medical assessment because the individual was not communicating with us. In one other the client's solicitor managed to In four of the cases, our casework database data showed that the detainee was transferred to hospital for treatment under section 48 MHA 1983, and three were released into the community with intensive support care packages. We do not know the outcomes for the other detainees.

110. These and other cases concerning incapacitated detainee exposed a serious gap in the structure of the detention safeguards, and showed that the Rule 35 process was not designed to and was not able to address this particular lacuna. Nor was Rule 45(4) DCR, which imposes a duty on detention centre officers to inform the healthcare team of any concern they have about the physical or mental health of a person in detention, but does not impose any consequential duty on healthcare to notify these concerns to the Home Office. There was no mechanism in the detention context that would ensure the provision of an advocate to assist the person who may be incapacitated. This is in contrast with the provision of an independent advocates in the context of the Mental Health Act 1983 and the Mental Capacity Act 2005.

111. It is Medical Justice's view that at a minimum, the system must make provision for independent advocacy so that, at least, the detainee can be facilitated to make representations about their detention, the conditions in which they are held and the treatment (or lack thereof)

with which they are provided. It is Medical Justice's view that a person who lacks mental capacity should not be detained, especially if their incapacity is connected with or caused by severe mental illness. We recognise that there will be some who lack mental capacity not connected with a mental illness, for example where a person has suffered a brain damage or a learning disability. However, IRCs are not set up to meet the needs and protect the rights of people with such disabilities. The Royal College of Psychiatrists have also stated the same in its Position Statement 03/17 (November 2017).

112. Yet, as discussed further below, even five years on from the experience that VC had at Brook House, which included the failure of the Rule 35 process to secure release and inadequate medical treatment, repeated forced segregation without recourse to mental treatment or advocacy assistance, there has been no real change.

C. Adults at Risk Statutory Framework (Section 59 of the Immigration Act 2016)

113. The Adults at Risk ("AAR") statutory framework was the Government's response to the findings made by Stephen Shaw in his first report, *"Review into the Welfare in detention of Vulnerable Persons"*, published on 14 January 2016.[26] ("Shaw 1")

(1) Shaw Review into the Welfare of Immigration Detainees

114. In announcing the review, the then-Home Secretary Theresa May stated that:

> *... The purpose of this wider-ranging review is to consider the appropriateness, and application, of current policies and practices concerning the health and wellbeing of vulnerable people in immigration detention, and those being escorted in the UK. I am committed to considering any emerging findings made by the review and to taking action where appropriate.*

115. Mr. Shaw's overall conclusion was that the safeguards for vulnerable people in detention, operated under EIG 55 and the DCRs 2001 were insufficient to protect them and that *"there is too much detention; detention is not a particularly effective means of ensuring that those with no right to remain do in fact leave the UK; and many practices and processes associated with detention are in urgent need of reform."*[27] In all, Mr. Shaw made 64 recommendations for change, additions and improvements to the existing detention policy framework for

[26] Shaw. S (January 2016) Review into the Welfare in Detention of Vulnerable Persons (a report to the Home Office)
[27] Section 11.1.

handling vulnerable detainees. All recommendations were directed at effecting change at the systems, policy and operational levels.

116. The central findings included that:

a. individuals do not already need to be suffering physical or emotional harm, damage or injury to be considered vulnerable to harm in detention. It is the *potential* or *likelihood* of suffering such effects that make someone vulnerable: at §4.8;

b. There is merit to a list of identified categories of vulnerable people who should be afforded the protective benefit of a strong presumption against detention so that they are not detained save in very exceptional circumstances (the formulation under EIG 55.10): §4.18. But this list should expressly include additional categories, such as victims of sexual or gender-based violence; those with a diagnosis of post-traumatic stress disorder (PTSD); those with learning difficulties; transsexual people: §4.19-4.45. A "catch-all" category of *"persons otherwise identified as being sufficiently vulnerable that their continued detention would be injurious to their welfare"* should be added to ensure *"individual and holistic"* identification of those who do not fall within the identified categories but who may nevertheless be vulnerable to harm given the known adverse effects of detention which cannot always be predicted. This *"reflect[s] the dynamic nature of vulnerability"*: §4.5.1 (Recommendation 16).

c. The qualification against detention - that the mental illness *"cannot be satisfactorily managed"* –should be removed. The detention of the seriously mentally ill is *"an affront to civilised values"* because their treatment and care in detention does not and cannot equate to good psychiatric practice (whether or not it is satisfactorily managed) and: §§4.35-4.36.

d. The Home Office should introduce a single gatekeeper for detention to ensure consistent application of the criteria under EIG 55.10, to carry out risk assessments prior to detention and to maintain strategic oversight of the detained population so as to ensure, more systematically and consistently, that those who should not be in detention are not detained, and that individuals' shifting circumstances and suitability for detention are acted upon swiftly and appropriately: §§4.90-4.91.

e. A review of case law on immigration detention, by Jeremy Johnson QC (now a High Court judge in the Administrative Court), found that *"…the nature of the findings and the pattern of findings as between the different cases (taken together with some*

observations made in cases where no Article 3 breach has been found) do tend to suggest that these cases may be symptomatic of underlying systemic failings (as opposed to being wholly attributable to individual failings on the part of the clinicians or public servants who were involved in the particular cases).”[28]

f. Shaw concluded that a clinical literature review of the effects of detention on the mental health of detainees undertaken by Professor Mary Bosworth “*incontrovertibly demonstrates”*[29] that detention *“in and of itself”* has a negative impact per se on detainees’ mental health, that impact increases the longer detention continues and is enduring after release. Asylum seekers, victims of torture, children and women are particularly vulnerable to adverse mental health outcomes in detention.[30]

117. Mr. Shaw’s findings confirmed concerns that Medical Justice had previously raised repeatedly with the Home Office.

118. Mr Shaw considered a dip sample of rule 35 reports and observed that they were of *“variable quality in terms of information provided by the medical practitioner, and in the overwhelming majority of cases it was difficult to deduce whether the GP believed that torture had actually occurred.”*: §4.99. The data showed a high volume of Rule 35(3) reports rather than Rule 35(1) and (2)s and most Rule 35(3) reports documented the physical effects of torture rather than mental health issues relating to abuse. Releases rates as a result of a Rule 35 report were under 20% of the total number of reports done.

119. Mr. Shaw noted the “sense of frustration” amongst NGOs (including Medical Justice), lawyers, and professional organisations (e.g., ILPA and the BMA) about the continued inefficacy of the Rule 35 safeguard, and its dysfunction in ensuring that vulnerable detainees are properly identified and released from immigration detention. The BMA in particular noted a lack of knowledge and appropriate training and confidence on the part of some GPs in completing Rule 35 assessments, leading to reports of insufficient quality to enable the Home Office to reach decisions. But the BMA added that the problem with the Rule 35 process could not be explained by inadequate GP training, but also arose from reports being disregarded as being unsatisfactory by the Home Office for reasons including the erroneous

[28] Shaw 1, p296.
[29] Sections 8.7- 8.11 of Shaw 1; section 11.4.
[30] Section 8.9.

perception that the GP's view was not independent. The rejection of a Rule 35(3) could have a profound effect on the doctor-patient relationship and impact on patients' willingness to access or cooperate with healthcare services.

120. Mr. Shaw concluded at §4.118 that:

> *"…It is abundantly clear to me… that rule 35 does not do what it is intended to do – that is, to protect vulnerable people who find themselves in detention. The Home Office's approach has been to focus on whether forms can be made clearer or more user-friendly, and on better training for medical staff. Both of these might help, but they will not fundamentally change the issue at hand, which is – and I put this bluntly – that the Home Office does not trust the mechanisms it has created to support its own policy."*

121. But he did not consider that further audits of Rule 35s, an amendment to the pro forma used for Rule 35 assessments or more training for GPs would improve the safeguard sufficiently. He said at §4.120 that

> *Fundamental to the issue at hand is the lack of trust placed in GPs to provide independent advice. Home Office guidance (DSO 17/2012) requires a 'person who is vocationally trained as a general practitioner and fully registered within the meaning of the Medical Act 1983' to complete a report under rule 35. It is wholly unacceptable for the Home Office then to dismiss that report on the grounds that it is insufficiently informed or insufficiently independent. The Home Office cannot have it both ways.*

122. He recommended that *"the Home Office immediately consider an alternative to the current rule 35 mechanism"* and that this should apply to immigration detainees held in prisons as well as those in IRCs. (Recommendation 21)

Government Response to Shaw Review

123. The Government responded to Shaw 1 on 14 January 2016, *"accept[ing] the broad thrust of his recommendations"*. It stated that it would introduce a new "adults at risk" concept into decision-making on immigration detention that retains the clear presumption against detention of vulnerable people and seeks to "strengthen" the approach to safeguarding those whose care and support needs make it particularly likely that they would suffer disproportionate detriment from being detained, and will therefore be considered generally unsuitable for immigration detention unless there is compelling evidence that other factors

which relate to immigration abuse and the integrity of the immigration system of such significance as to outweigh the vulnerability factors.[31] No details were given at this stage.

124. On 1 March 2016 the Government published a further statement,[32] repeating an intention that fewer vulnerable people will be detained, and that, where detention becomes necessary, it will be for a shorter period and that there will be improved oversight of the cases by a new vulnerable persons team. Again, the statement did not come with details of what the new framework would look like.

125. Medical Justice was invited to attend a meeting of the Strategic Engagement Group (SEG), which consisted of a small number of NGOs, the UNHCR and the International Organisation for Migration which met quarterly with the Home Office to discuss asylum -related issues. The May 2016 meeting was with the Immigration Minister James Brokenshire MP. The Minister reassured the group that the AAR policy, which had yet to be published, would increase safeguards for vulnerable people subject to immigration detention.

(2) <u>Adults at Risk Statutory Guidance and Casework policies</u>

126. The Government formalised its proposed AAR policy by introducing an amendment to the 2016 Immigration Bill (now section 59 of the Immigration Act 2016), which required the Home Secretary to issue guidance setting out the circumstances in which an individual will be considered particularly vulnerable to harm in detention and the circumstances in which the detention of such individuals may be justified. [33] This would be the first time that policy guidance on the detention of vulnerable persons is placed on a statutory footing. It would work alongside an *"enhanced gatekeeper role"* so that *"we fully expect to see fewer people being detained, for shorter periods."* The intention was to implement a *"different, and better, way of assessment of the circumstances that apply in any given case of a vulnerable person …"* The statutory provision came into force on 12 July 2016, section 59 was brought into force.

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[31] Brokenshire.J (January 2016) Ministerial statement responding to the 2016 Shaw report
[32] Gov UK (March 2016) Further response to Shaw: Detaining individuals for the purposes of immigration control – consideration of risk issues .
[33] See Lord Keen (2016) HL Deb 1 February 2016 vol 768 (Immigration Bill), Lord Keen (2016) HL Deb 10 May 2016 vol 771 (Immigration Bill), May. T (2016) HC Deb 18 April 2016 vol 608 (Immigration Detention).

Adults at Risk Policy

127. An Adult at Risk is defined as someone who has either self-reported an indicator of risk or who has *"medical or other professional evidence, or observational evidence, which indicates that an individual is suffering from a condition, or has experienced a traumatic event (such as … torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention – whether or not the individual has highlighted this themselves with the highest level (Level 3) of professional evidence."*: paras 7 and 8 of the statutory guidance.

128. Para 11 identifies indicators of risk, which include if someone is a victim of torture, suffers from a mental health condition, has PTSD or a learning disability. On the basis of the available evidence, the Home Office will reach a view on whether a particular individual should be regarded as being "at risk", and if so considered, *"the presumption will be that the individual <u>will not be detained</u>."*: para 8 (emphasis supplied).

129. The statutory guidance removed the list of category-based vulnerabilities and removed the threshold of not detaining save in very exceptional circumstances, even though Shaw 1 had recommended retaining that structure and extending the categories of vulnerable people. Instead, in its place was the introduction of the concept of "levels" of risk, which ranked self-reporting as Level 1 (to be given limited weight). Level 2 risk is classified as where there is professional evidence (e.g. from a doctor) of risk. Risks are only ranked Level 3 if there is additionally, evidence that a period of detention would likely to cause harm, such as by increasing the severity of symptoms. Only then is "significant weight" to be afforded to that evidence: para 9. Individuals *"with a completed Medico Legal Report from reputable providers will be regarded as meeting level 3 evidence, provided the report meets the required standards"*: para 11. A Rule 35(1) is also considered Level 3 risk evidence.

130. Although the AAR statutory guidance stated that there would be a clear presumption against detention of adults at risk, the guidance also went on to state (at para 14) that the strength of the presumption depended on the "level" of risk, and the immigration control factors present: Whether immigration control factors outweigh the presumption depends on the assessed level of risk. According to the AAR casework guidance, in Level 2 risk cases, if the person had

been non-compliant with immigration control factors and removal could take place in a reasonable timeframe, that may be sufficient to outweigh the presumption against detention. Even in Level 3 risk cases, the casework guidance permits the presumption to be outweigh by "public protection" concerns, said to be situations where a person has a 4+ year custodial sentence or a fixed imminent date of removal.

(3) Medical Justice's concerns with the Adults at Risk policy

131. Medical Justice engaged with the Home Office over various drafts of the AAR statutory guidance, and met with Ian Cheeseman of the Removals, Enforcement and Detention Policy Team, and Della Mcvay, his supervisor, on an early draft of the statutory guidance in June 2016. This was the only real opportunity to meet to discuss the draft guidance with the Home Office. However, and as has become typical of our engagement with the Home Office, we received no response to our feedback. The Home Office did not allow much time in subsequent drafts for opportunities for feedback. The second draft was then published just before Parliamentary summer recess so that not only could we not properly engage the Minister and civil servants on our concerns, neither could MPs who had to approve the statutory guidance. The undertone to this approach strongly suggests a lack of desire to know what stakeholders and MPs actually thought of the guidance.

132. On 22 August 2016, one week after the summer recess, regulations providing for the Statutory Guidance to come into effect on 12 September 2016, were laid before Parliament.[34] A day later, a third version of the AAR Risk Statutory Guidance was published.[35] Few changes were made between the drafts, which was itself also indicative of the fact that our and other stakeholders' feedback was not taken on board, but with no discussion or explanation.

133. Our primary concern was that the AAR statutory guidance as proposed by the Government did not reflect the commitments it had made to Parliament about strengthening safeguards for vulnerable people. This was evident in three main ways:

[34] The Immigration (Guidance on Detention of Vulnerable Persons) Regulations 2016 (SI 2016/847)
[35] Home Office Immigration Act 2016: Guidance on adults at risk in immigration detention (first published in 2016)

a. It sought to revert to an UNCAT definition of torture, limiting the application of torture to ill-treatment by state actors and those operating with the acquiescence of the state, even though this had already been found to be unlawful in *EO* (discussed above);

b. The new "levels" of risk concept introduces a new requirement of evidence not only of the indicator of vulnerability but additionally of likely harm of continued detention. This requires the doctor to express a view on prognosis and give artificial estimates of when deterioration is likely to occur. Only those with evidence of likely harm of continued detention would be treated as Level 3 AAR. Those with Level 2 evidence (that is independent indication of risk but no evidence of likely harm) could see the presumption against detention outweighed by factors related to non-compliance with immigration enforcement or reasonable timescales for removal. This was not previously required under EIG 55.10, and in effect lowered the "very exceptional circumstances" threshold required to displace the presumption against detention for anyone not treated as Level 3.

c. Furthermore, although the *"satisfactory management"* threshold was removed from the AAR policy when it replaced EIG 55.10 in September 2016, in requiring evidence of likely harm in detention and when deterioration is likely to happen, the threshold had been retained, albeit not overtly, and still to the significant detriment of vulnerable people likely to be harmed by being detained or kept in continued detention.

Medical Justice and 7 Ors v SSHD [2017] EWHC 2461 (Admin)

134. Medical Justice challenged the adoption in the AAR statutory guidance of a restrictive definition of torture based on UNCAT. It was quite unbelievable that this was still contentious in the light of the *EO* judgment four years earlier. We again produced evidence to show how a narrow "torture" definition excluded from identification and protection many who were subject to ill-treatment by non-state actors and had previously protected under EIG 55.10. The narrow definition in particular undermined the ability of the Rule 35(3) mechanism to identify to the Home Office the full spectrum of people who are likely to be vulnerable to harm in detention. This was illustrated by examples from our casework.

135. The Home Office sought to contend that other mechanisms – such as Rule 35(1) and IS.91 RA Part C - were capable of identifying vulnerable people who did not fall within the narrow torture definition. But this argument was rejected by Mr. Justice Ouseley in *R (Medical Justice and 7 Ors) v SSHD* [2017] 4 WLR 198, handed down in October 2017. An earlier

injunction, granted in December 2016 suspended the application for the unlawful narrow definition pending the litigation so it was not applied at Brook House or other IRCs during the relevant period of the Inquiry's Terms of Reference.

136. In the judgment, Ouseley J found that:

a. The AAR statutory and caseworker guidance and DSOs related to the Rule 35 process are intended to operate as a consistent and coherent whole for the purposes of identifying what constitutes indicators of harm, levels of evidence of vulnerability to harm and how to weigh the risk of detention against the strength of countervailing factors warranting detention despite an individual's particular vulnerability to harm.[36]

b. Rule 35(3) reports are an important indicator of unsuitability for detention.[37] The torture definition applicable to Rule 35(3) was authoritatively decided in *EO*. The Home Office could not seek to alter the meaning of a statutory instrument by issuing policy statements whether expressly or by necessary implication.[38]

c. The problem with the narrow definition adopted was that it excluded certain individuals whose experiences of the infliction of severe pain and suffering may make them particularly vulnerable to harm in detention, where it was not caused by state actors or at the acquiescence of the state.[39] As explained in *EO*, there was *"no rational or evidence base"* to draw a distinction between torture victims based on who inflicted the harm.[40]

d. The alternative mechanisms of Rule 35(1) or IS91 RA Part C are not substitutes for the Rule 35(3) safeguard.[41]

e. Rule 35(1) has a different focus, and operates a *"significantly higher threshold"* than is required for a Rule 35(3) report and is required for the consideration of risk following self-declaration. It is also not aimed at the particular question of vulnerability to harm in detention though it will cut across it.

f. IS91 RA Part C is not a substitute because it does not form part of a mechanism that requires the Home Office, on receipt, to consider the question of a person's suitability for detention, weighing up countervailing factors.

[36] See [129] of the judgment.
[37] Ibid.
[38] Ibid, at [126].
[39] Ibid, at [154].
[40] Ibid at [123], [162].
[41] Paragraphs 166-167 of the judgment.

137. Following judgment, the Home Office was ordered to take steps to review and reissue the AAR Statutory Guidance within a reasonable period of time. This was done in March 2018 but again included another unlawful version of the torture definition which required detainees to demonstrate powerlessness to resist in order to be treated as a victim of torture for the purposes of the AAR statutory framework. Further to another challenge brought by Medical Justice (CO/2382/2018), the Home Office agreed to further amend the definition.

No Change to Rule 35 DCR

138. Despite Shaw's call for radical reform of the Rule 35 safeguard. The only change made was to the templates relating to Rule 35 which were separated out for each of the three limbs of Rule 35 and made significantly more complex . I understand there was also training for doctors working in IRCs.

139. Medical Justice had provided a joint response with the Helen Bamber Foundation on similar draft templates and the training material in 2015 expressing concerns about the following:

a. The templates and slides suggested that doctors were expected to document torture in detail. This approach went beyond what was required under Rule 35(3), which only required doctors to have *"concerns"* that a person may have been a victim of torture to complete a report to send to the Home Office. Whilst guidance was useful to ensure better quality Rule 35 reports, the level of detail apparently demanded from medical practitioners was unnecessarily onerous and time-consuming. This risked creating an obstacle to reports being completed, and inadvertently raised expectations of a Rule 35 being more akin to an MLR rather than a report recording concerns and indicators of vulnerabilities to trigger the protection of the strong presumption against detention. There was also a risk that doctors would wrongly think that specific medical evidence would be needed to corroborate the detainee's account before completing a Rule 35(3) report, when no such requirement existed.
b. In respect of the Rule 35(1) template, we were again concerned by the high level of detail required in order to establish whether a person's health was "likely to be injuriously affected by continued detention or any conditions of detention" as well as the requirement on the doctor to make reasoned prognoses, timescales for deterioration and the ongoing effect of detention. An exact prognosis was not required under Rule

35(1) in order to report on whether a detainee was likely to be injuriously affected by continued detention. It also did not direct doctors to take account of the absence of social care and specialist medical treatment available in detention as factors going to the question of likely injurious harm.

c. As for Rule 35(2), given its purpose of reporting suspicions of suicidal ideation, the absence of any reference to mental health assessments seemed to us to be a serious omission. The template also did not link up with the ACDT process, which was the default way to manage self-harm and suicide risk in IRCs.

d. The requirement that doctors express an additional view as to the impact of detention was of serious concern, went beyond what was required under Rule 35 and also contradicted long-standing recognition that detention was likely to be inherently harmful to victims of torture or other forms of serious ill treatment as well as to those with pre-existing mental ill-health and suicidal risks.

140. We also had concerns about draft templates for Home Office responses to Rule 35. The response templates appeared to direct caseworkers to expect very specific detailed information being available about the effects of detention within a specific period time, and expect doctors would be in a position to give precise views as to prognosis, likely timescales for deterioration and harm caused by continued detention, when these well exceed what is asked of the doctor under the Rule 35 process. This was problematic given long-standing concerns about the Home Office's dismissive approach to doctors' opinion about the suitability for detention.

141. The HMIP and other independent oversight bodies had also raised concerns about continued delays in getting a Rule 35 report due to *"long waiting times for GP appointments and delays in Home Office processing of reports."*[42] The response templates did not address these problems, and in our view, increased the risk of continued poor Rule 35 responses given the unrealistic expectations as to what information a Rule 35 report ought to contain.

[42] See HMIP (January 2017) Report on an unannounced inspection of Brook House IRC: 31 October - 11 November 2016.

142. The Home Office continued to refuse to formalise a process for auditing the Rule 35 process. When adopting new templates and making changes to practice, we considered such audits to be essential to assessing the outcomes and quality of the Rule 35 report and responses in order to know whether actual improvements had been made. The sort of information that needs to be captured includes (1) outcomes for each report, that is whether the Rule 35 report led to release, whether detention was maintained and the reasons for maintaining detention; (2) the numbers of individuals requesting Rule 35 reports for whom the doctor declined to report and the reasons why; (3) where the concerns expressed in the Rule 35 reports were accepted but detention was maintained explanation of what those circumstances were; (4) where reports were rejected for providing unclear or insufficient information, whether further information was sought from the doctor, and what the outcome of the reviewed decision was upon receipt of additional information.

143. We received no response to our feedback, and as has been our consistent experience of other consultations, our responses appeared to have little impact on the text of the draft templates as they were implemented virtually as drafted. No commitment was given by the Home Office to carry out periodic audits of the Rule 35 process. In September 2019 the Home Office did decide to centralise the team that responds to Rule 35 reports after conducting a pilot of this change. We requested the evaluation of the pilot under the FOIA but the request for disclosure was rejected. The only publicly available audit touching on Rule 35 is the annual ICIBI report on adults at risk, but there are limitations to the effectiveness of that given what the ICIBI has itself identified, that is that recommendations arising from the identification of problems are not always accepted by the Home Office and even if they are, the response is vague, non-specific and there are seldom timescales for implementation of any change...

Medical Justice's Monitoring of Rule 35

144. The Home Office does publish some limited statistics on the operation of the Rule 35 process as part of its quarterly statistics. Medical Justice has, since 2013, made routine requests under the Freedom of Information Act for data related to Rule 35, including the number of reports by type and by IRC and the numbers of releases by type and by IRC broken down by month and the numbers of detainees to whom to Rule 35 reports relate, to supplement the published

information but a complete picture and what is required is substantial analysis of the content of the Rule 35 reports and responses from the Home Office has never been made available.

145. Data we have taken from the quarterly statistics and information obtained from FOIA requests consistently show the following consistent trends regarding the Rule 35 process:

146. **Rule 35(1) / Rule 35(2) not used at all or under-used**: Data from our FOIAs show that in every quarter from 2013 – 2019 (7 years), very few Rule 35(1) reports and even fewer Rule 35(2) reports across all of the detention centres. In 2017, for example, a total of 2759 Rule 35 reports were completed across all IRCs, of which only 94 (3.4%) were Rule 35(1) reports and 7 (0.3%) were Rule 35(2) reports, the rest (2658, 96.3%) were Rule 35(3) reports. These proportions were no different in the previous two years 2015 and 2016. See Table 1 below.

Table 1: Breakdown of Rule 35 reports across IRCs from 2015-2017 and release rates

Type of R35	**2015**	**2016**	**2017**
Rule 35(1) (% of all R35s)	83 (3.1%)	85 (3.2%)	94 (3.4%)
Rule 35(2) (% of all R35s)	13 (0.5%)	6 (0.2%)	7 (0.3%)
Rule 35(3) (% of all R35s)	2554 (96.4%)	2594 (96.6%)	2658 (96.3%)
Total R35s	2650	2685	2759
R35(1) releases (% of reports)	35 (42.2%)	32 (37.6%)	64 (68.1%)
R35(2) releases (% of reports)	323.1%)	1 (16.7%)	0 (0%)
R35(3) releases (% of reports)	392 (15.3%)	910 (35.1%)	481 (18/1%)
Total R35 releases	430	943	545
% released because of Rule 35	16.2%	35.1%	19.8%

147. At Brook House, no Rule 35(2) reports were raised at all for the three years, 2015 – 2017. Only 2 Rule 35(1) reports were raised in 2015, 11 in 2016 and 8 in 2017. Nearly all Rule 35

reports were under the third limb. Even where a Rule 35(1) report was raised, the person did not always get released. In 2017, for example, only 2 out of 8 detained persons with a Rule 35(1) report were released as a result of a report stating that they were likely to be injuriously harmed by detention. (See Table 2 below).

148. During the two quarters of 2017 (April to September 2017) covering the relevant period for the Inquiry, the breakdown of Rule 35 reports (Table 2 below) showed that only one of five people who received a Rule 35(1) report were released as a result of the Home Office being informed that their health was likely to be injuriously harmed by continued detention.

Table 2: Breakdown of Rule 35 reports at Brook House for 2017

Type of R35	**Q1 (Jan-Mar 2017)**	**Q2 (April – June 2017)**	**Q3 (July– Sept 2017)**	**Q4 (Oct-Dec 2017)**
Rule 35(1)	2	3	2	1
Rule 35(2)	0	0	0	0
Rule 35(3)	105	65	54	90
Total R35s	107	68	56	91
Detainees to which R35 related (% of detainees at Brook House)	106	67 (5.5%)	56 (5.5%)	91
Total detainees at BH for the period	1252	1200	1004	806
R35(1) releases (% of reports)	0 (0%)	1 (33%)	0 (0%)	1 (100%)
R35(3) releases (% of reports)	13 (12.4%)	14 (21.5%)	4(7.4%)	13 (14.4%)
Total releases	13	15	4	14
% released following R35(1)/(3) per quarter	12.3%	22%	7.1%	15.4%
% released because of R35 for the relevant period (Q2 & Q3)		15.3%		

149. The very low release rates for Rule 35(1) are quite hard to understand on the face of it, given the Home Office's own policy treats Rule 35(1) reports as Level 3 (the highest level) evidence of risk.[43] Its AAR casework policy states that it would really only be in cases where there was an immediate and fixed removal date or the public protection factors were really so serious (such as the example of someone posing a high risk of murder) that the strongest of presumptions in favour of liberty could be displaced.

150. It is alarming that no Rule 35(2) was raised at Brook House for the whole of 2017 given the evidence before the Inquiry as to the high levels of self-harm and the frequent use of ACDT and removal from association and E Wing in response to self-harm and suicidal risks.

151. Data from the FOIAs suggest that this failure to use the Rule 35(2) safeguard is a long-standing and indeed ongoing problem at Brook House. This is evident from Table 3 below, which shows the same pattern in 2018 and 2019. The data also shows very few Rule 35(1) reports in either year. Release rates for Rule 35(3)s have also consistently been low with some improvement in 2016 in respect of release rates which inexplicably has not been sustained.

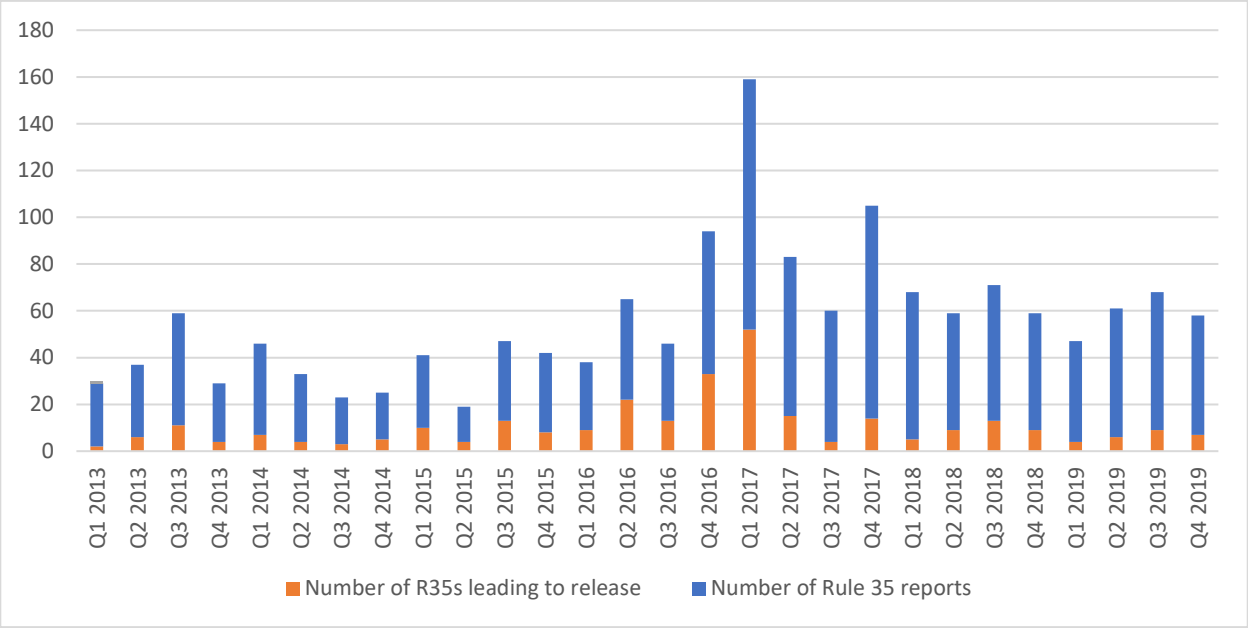
Table 3: Breakdown of Rule 35 reports at Brook House from 2016-2019

Type of R35	**2016**	**2017**	**2018**	**2019**
Rule 35(1)	11	8	2	1
Rule 35(2)	0	0	0	0
Rule 35(3)	155	314	197	90
Total R35s	166	322	199	91
Total detainees at BH for the period	3455	4262	3135	806
R35(1) releases (% of reports)	5 (45.5%)	2 (25%)	1 (50%)	1 (100%)
R35(3) releases (% of reports)	72 (46.5%)	84 (26.8%)	35 (17.8%)	13 (14.4%)
Total releases	77	86	36	14

[43] Home Office (November 2021) Adults at risk in immigration detention.

% released following R35(1)/(3)	46.4%	26.7%	18.1%	15.4%

152. **Rule 35(3) reports do not result in release from immigration detention**: As the data in Table 1 above show, the vast majority of Rule 35(3) reports do not lead to release across all IRCs. The average rate of release across 2015-2017 was about 23%. At Brook House, a little over a quarter of detainees with Rule 35(3) reports (84 of 314, 26.8%) were released as a result of such a report. This is also illustrated pictorially in the graph below which shows just how small a proportion of people in detention who receive a Rule 35 report are released.



153. The Home Office has sought to assert in the past contended that the Rule 35 data may not always represent the same number of detainees and some detainees may receive more than one Rule 35 report. However, the duplication is not all that significant even according to the Home Office's own data. For example, in Brook House in 2017, 320 detained persons had Rule 35 reports and 322 reports were produced. Similarly, in 2016, 158 detained persons had Rule 35 reports and 166 reports were produced. Thus, duplication cannot really provide a material explanation for the significantly low release rates for Rule 35 reports.

154. Under the previous EIG 55.10 policy, the decision to maintain detention more often arose from a decision not to accept the Rule 35(3) report (often erroneously in our view) as independent evidence of torture. Under the previous policy there was no additional

requirement to show likely harm if detained or held in continued detention, and thus the critical issue was whether the Home Office accepted the Rule 35(3) report and the clinical view of the doctor contained within as satisfactory evidence of a concern that a person may have been a victim of torture. Since the implementation of the AAR statutory framework, we started to see in our casework an increase in the number of decisions not to release further to a Rule 35(3) based on immigration factors which under the previous policy would never have constituted "very exceptional circumstances." This is illustrated by the case studies set out in my second witness statement in respect of detainees held at Brook House during the Inquiry's relevant period when the AAR policy applied.

D. Policy Reform of the Adults at Risk Policy

155. The AAR policy did not improve and strengthen protections for vulnerable detainees, as intended, but rather, as explained from our experience, carried over dysfunctions in the Rules 34 and 35 safeguards, even compounding them through increased complexity, the weakening of the "very exceptional circumstances" threshold safeguard by replacing it with a balancing exercise that allows immigration factors to override vulnerability to risk of harm in detention.

(1) Medical Justice Briefings on Failures of the AAR Policy post-2017

156. In 2018 and 2019, we published two reports highlighting our concerns to explain why we were of the view that the AAR policy framework has failed to effectively identify and protect vulnerable people from suffering harm in detention.

157. In *Putting Adults at Risk* (2018), we identified four key ways in which the AAR policy failed to fulfil the statutory purpose of being more protective of vulnerable people than the previous IG 55.10, led to more vulnerable people being detained for longer and did not provide the safeguards needed to avoid future Article 3 breaches:

a. **The policy failed to identify vulnerable people** because there remained no considered approach to screening for vulnerabilities prior to a decision is made to detain. The Detention Gatekeeper Team was created to meet a recommendation in Shaw 1 for pre-detention screening of vulnerabilities. But the gatekeeper relies solely on internal information for the decision to detain. The problem is that the information held by the Home Office may be out of date, incomplete or there may not be any significant

information available, such is the case with people who are detained on arrival to the UK. Even where there is current medical evidence available, for example because reports had been adduced in immigration appeals, these do not appear to be considered (or accessed) by the gatekeeper team and therefore the often-valuable information about vulnerabilities in the reports are ignored. Even where relevant medical evidence is considered by the gatekeeper team, our experience was that the Home Office would proceed to make a decision to detain anyway, but seek to justify this notwithstanding acceptance that the person is an AAR level 2.

b. **The policy increases the evidential burden on individuals** to show proof that they are likely to be harmed by detention, after how long, and to what extent. The Home Office wrongly treats the levels of evidence as a measure of the risk of deterioration to the individual rather than as evidence of pre-existing vulnerability. There appears to be no acknowledgment that the vulnerability itself, if established, is evidence of likely harm in its own right.

c. **The policy increases the threshold for release from detention**. We analysed 100 rule 35 reports and responses of people referred to Medical Justice between March and October 2017 (across IRCs). 97% of the cases were accepted as AARs but in 95% of cases, detention was maintained. Only 2% of the cases were assessed as Level 3 despite many more reports noting trauma-related symptoms. In 14% of cases, detention was maintained even though an IRC doctor specifically stated that the detainee's health was deteriorating in detention. Heavy reliance was placed in Home Office responses on immigration factors such as overstaying, absconding, illegal working, late asylum claims, past offending (but not considered high risk to the public). These factors would not have sufficed to overcome the high hurdle of "very exceptional circumstances" under the old policy yet appeared to outweigh the presumption against detention under the AAR policy.

d. **There was a systemic lack of follow up of vulnerable detainees who end up in detention.** Where a person was identified to be an AAR by the gatekeeper but detained anyway, there was no follow-up once they are detained to monitor whether their situation had changed, or they had suffered a deterioration which meant they were no longer suitable to remain in detention.

158. This report was followed up a year later with *Failure to Protect* (2020), which was a collection of case studies where the AAR policy failed in the ways that the earlier report identified. We analysed the failures by reference to more detailed case studies, including two from Brook House (Daniela and Jack) in a way that we had not been in a position to do in 2018. The case studies showed that the move away from a category-based approach to protecting vulnerable detainees to the evaluative balancing exercise promoted by the AAR policy reduced safeguards against the risk of and actual harm suffered by detainees in detention.

(2) Stephen Shaw's Follow Up Review (2018)

159. In September 2017, Mr. Shaw was asked to commence a follow-up report to assess whether and to what extent the Home Office had adopted recommendations in Shaw 1, and what impact this had in practice. The start of the review coincided with revelations by the BBC Panorama programme of the appalling misconduct of detention centre staff at Brook House. In a report published in April 2018 ("Shaw 2"),[44] Mr. Shaw made the following key findings:

160. **Adults at Risk (general):** it is *"not clear"* that the Adults at Risk policy has cut the number of vulnerable people in detention and many NGOs and detention centre managers think it has made things worse. During IRC visits, Mr. Shaw found many people who should not be there. The number of AAR in detention was just under 44% of the detained population as at February 2018. There were significantly higher than expected numbers of AAR Level 2 remaining in detention. (§2.102-2.120). But the policy was still a *"work in progress"* and should not be abandoned without further attempts to make it work;

161. **Healthcare**: There were some improvements in IRC healthcare but still "significant concerns" about current levels of demand and provision (§1.28). In every IRC, the demand was significant and patient dissatisfaction "considerable" (§3.4). Whilst NHS England commissioning was an improvement on custodial sub-contracting, there was little evidence of best practice and lessons learned sharing. This risked fragmented contracting leading to "silo mentality" (§§3.5, 3.58-3.86) Mr. Shaw expressed dissatisfaction at the way medication was dispensed and the lack of consistent and proper medication reviews. (§§3.109-3.11)

[44] Shaw. S (2018) Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons (a follow up report to the Home Office)

162. There is a high level of medical need in detention, with 46% of detainees stating that they had a long-term condition, 22% suffering depression, 49% requiring medication. Mental health provision remained inadequate. Although the most common mental health condition at Brook House, for example, was PTSD, there was a lack of trauma therapists and community-equivalent counselling. (§3.40). There continued to be delays to referrals and transfers to mental health hospitals where there is such acute need. (§§3.154, 126-127).

163. **Detention environment and staff culture**: Cells were filthy, singling out Brook House where clinical rooms required attention and had blood splatter on walls. Staff were *"desensitised"* to unacceptable conditions with only half of staff interviewed said they would report inappropriate behaviour or know how to do so. (§§3.105-107, 3.33, 3.146)

164. **Rule 35**: The dysfunctions of the Rule 35 process had not changed. Release rates were still declining, and they were routinely rejected for small errors, and lacked confidence of both GPs and Home Office caseworkers. (§2.139) The demand for Rule 35 assessments impacted on healthcare staff capacity. Continued readiness of the Home Office to dismiss Rule 35 reports damaged patient relationships. (§2.139, 3.36, 2.149).

165. **Prevention of suicide / self-harm**: There remains a lack of properly understanding of the specific vulnerabilities of those in immigration detention to understand the increase in the number of self-inflicted deaths. (§§5.28, 5.31) Very few steps were taken to investigate and understand "near misses" / attempted suicides to learn lessons. (§5.32-5.33) There were very high numbers of ACDTs opened, and an over-reliance on detention staff to operate constant watch. Mr. Shaw pointed out that if a detainee is on constant watch, there must be "serious questions" asked about the justification for their continued detention. (§5.19) The relationship between ACDT and the AAR policy also needed to be clarified, as currently ACDT does not trigger a review of AAR risk level. (§5.26)

166. **Detention decision-making**: Almost all of the safeguards against excessive use of detention are internal, such as the case progression panels, and the gatekeeper mechanism. There remains a need for "robust *independent* oversight". The gatekeeping function did not function well because it did not involve representations from detainees or legal representatives and was without clinical input. (§§4.8, 4.15)

167. **Staff culture and oversight**: The *Panorama* revelations of detainees being abused at Brook House show that the systems of recruitment, training, whistleblowing and complaints were in place but manifestly failed to prevent abuses of the kind revealed by the BBC. (§§6.28-6.29) Existing independent oversight from HMIP, PPO and IMB did not prevent Brook House abuses. (§§6.44-6.45)

168. **Alternatives to detention**: The "hostile environment" policy (reframed as "compliant environment" policy) does not fit well alongside alternative to detention for ex-offenders who cannot be removed from the country. Despite a previous recommendation in Shaw 1 to consider the need for a time limit to detention, the Home Office's agreement to carry out such a review has not been developed as a full policy proposal, and needs to be.

169. Mr. Shaw made 44 new recommendations in this second report which included:

a. Amending the AAR policy so that anyone at AAR Level 3 should be subject to showing 'exceptional circumstances' for detention.
b. Consideration should be given to sub-diving AAR Level 2 so that the presumption against detention for those in the upper division should be strengthened. The Home Office should consider the merits of the UNHCR Vulnerability Screening Tool.
c. New arrangements are needed for the consideration of Rule 35 reports. This should include referrals to a new body – which could be within the Home Office but separate from the caseworker responsible for detention decisions.
d. All relevant Home Office staff should be trained in making assessments of vulnerability within the parameters of the Adults at Risk policy.
e. The Home Office should roll out the use of body worn cameras to all IRCs and robustly monitor their use.

170. In response to Shaw 2, the Home Secretary announced several immediate measures, including increasing the amount of data published on immigration detention and asking the ICIBI to report annually on "whether and how the Adults at Risk policy is making a difference."

(3) ICIBI annual reports on AAR policy

171. Since Shaw 2, the ICIBI has carried out two annual inspections of AAR in immigration detention. The first,[45]published in April 2020 covered the period from November 2018 to May 2019, and the second,[46]published in October 2021, covered the period from July 2020 to March 2021. Both reports identify concerns about the AAR statutory framework that echo what Medical Justice has been saying, and also highlight how little change has been brought about by the introduction of the AAR statutory framework in 2016. The same recurring thematic deficiencies in the system are flagged up by the ICIBI, again revealing how lessons simply have not been learnt and genuine efforts to bring about positive change remain lacking.

172. The first report highlighted:

a. the limited data and information from the Home Office on quality of decisions to detain or impact of detention on specific groups, making it difficult to properly assess the progress of the AAR policy (§3.27, 5.100);
b. Key intervention mechanisms, on which the AAR relies, are undermined by a lack of genuine empowerment. Decision-making either rests elsewhere or issues of release are complicated by limited facilities or support (§3.25);
c. The detention gatekeeper is a weak screening tool, as decision-makers have no direct contact with the persons referred and are reliant on referral forms of variable quality with inconsistent understanding of vulnerability. (§§3.7, 6.34) Decision-makers and referrers also have no professional medical knowledge which risks hidden disabilities going undiscovered (§3.8);
d. Where vulnerabilities are identified by the gatekeeper, insufficient information is passed onto the IRCs (§6.72);
e. There remain continued delays in carrying out Rule 34 medical examinations. The safeguard does not effectively function as second line of assurance for those not screened out by the gate keeper.
f. Release rates for Rule 35 reports continue to be low (less than 25%), with consistency and quality still being problematic and the impact of continued detention still not commented on (§§8.172-8.174). Where information is lacking, the Home Office seldom

[45] ICIBI (2020) Annual inspection of 'Adults at Risk in Immigration Detention' November 2018 – May 2019.
[46] ICIBI (2021) Second annual inspection of 'Adults at risk in Immigration Detention' July 2020 – March 2021.

takes steps to seek clarification (§8.178), and provides little feedback to healthcare on Rule 35 reports (8.177);

g. Case progression panels lack independent oversight, are plagued by poor preparation, lack of rigour, with AAR issues appearing to be an afterthought further to consideration of immigration factors. Panels wrongly applied a presumption of detention for FNOs. Where panels are recommending release, these are frequently rejected by Home Office caseworkers without reason (§§3.18, 8.117, 8.141);
h. There is a disconnect between the AAR policies and what is operated on the ground in IRCs, with custodial staff reliant on their contractor internal policies (§8.14);
i. Home Office decision-making indicates that caseworkers do not understand clinical information about vulnerabilities (§8.18).

173. The ICIBI made 8 key recommendations in his first report, including:

a. Continued implementation of recommendations from previous reviews and reports relating to vulnerability and the management of non-detained and detained persons, ensuring that this work is properly prioritised, resourced and coordinated, with an overall Action Plan setting out actions, responsibilities, delivery dates, intended outcomes and review/evaluation mechanisms;
b. Review the various definitions and indicators of risk and vulnerability used throughout Home Office guidance, processes and forms (not solely related to AAR guidance) and in the DCRs and DSOs, and (with input from relevant experts) ensure that they are clear, consistent and comprehensive, and that all staff (Home Office, supplier and IRC/ prison) are fully trained to understand and comply with them.
c. Review where the authority not to detain/to release should sit, and at what level/grade, at each of the three key stages of detention: prior to admission to an IRC; during the admission process; and once a person has been in detention for more than 24 hours and is into the cycle of reviews.
d. Better and up to date information needs to be provided to the gatekeeper, and better communications and information sharing is needed between the gate keeper, detention engagement team, IRC staff, healthcare and Home Office case workers, this being essential for a thorough understanding and assurance that the AAR policy is effective and consistently applied;

e. Training and consistent guidance required to ensure that the safeguard mechanisms under the AAR function properly across the Home Office, IRC staff, healthcare, case progression panels, gate keepers and detention engagement teams.

174. The second ICIBI report concluded that little progress had been made in the 18 months between the two reports, with:
   a. contractors still relying on internal processes and guidance disconnected from the AAR policy;
   b. data keeping and analysis was poor;
   c. the gatekeeper was not working as an effective detention screening mechanism. Even though Shaw 2 recommended a vulnerability-focussed screening tool, this was still absent with decision-making more focused on immigration processes;
   d. there was a sharp increase in self-harming between August to September 2020, and an increase in detainees being subject to Vulnerable Persons Care Plans. But there was a disconnect between the VPCPs and ACDTs in IRCs and no improvement to the Rule 35 process;
   e. detention case progression panels continued to produce poor quality discussion that lack rigour and pay no proper considerations to alternatives to detention;
   f. there was also little evidence that case owners understand vulnerability as a dynamic concept that may fluctuate and therefore require monitoring and review.

175. 11 substantial recommendations were made in respect of case working, detention decision-making, Rule 35, and other safeguard mechanisms necessary for the effective operation of the AAR policy. Despite contrary evidence, the Home Office's response rejected any suggestion that the AAR policy prioritises immigration factors over vulnerability, or that the policy did not already adequately and appropriately focus on the identification and management of vulnerable people in detention. But it accepted certain operational recommendations on training and improvement of internal safeguards such as IS91 RA Part C, the case progression panels, training for doctors, healthcare and detention decision-makers.

176. In Medical Justice's view the problems run deeper and are the predictable result of the way the Adults at Risk policy is designed, most obviously the requirement to produce specific evidence of likely harm caused by detention in order to benefit from a strong presumption

against detention and the weight afforded to even relatively minor immigration factors. These structural problems are compounded by what appears to be a lack of interest by the Home Office in uncovering and acting on vulnerability and what appears to be a perception by the Home Office that any mechanism that identifies large numbers of people as vulnerable is therefore flawed and needs to be limited in some way so as to only identify a small number of 'most vulnerable'.

(4) Home Office Proposals for Reform

177. In 2019, the Home Office made some proposals for reform of the AAR, which, in our view, do not adequately address the recommendations made by Mr Shaw following his second report, the ongoing concerns raised by the ICIBI in the light of his AAR reports or the court rulings on the deficits in the legal protections for those with serious mental illness.

DSO 04/2020 on Mental Vulnerability and Detention (DSO 04/2020)

178. The first of the proposed reforms purported to address the unlawful discrimination made by the Court of Appeal in *VC* against those who suffer from severe mental illnesses and may lack mental capacity. A draft DSO was circulated by Ian Cheeseman on behalf of the Home Office for consultation in September 2019 among a small number of stakeholders but rather surprisingly, it initially excluded other organisations that held obvious expertise on the topic, including the Royal College of Psychiatrists, Mind, and the BMA from consultation. It was only when concerns were raised about this that these organisations were included.

179. The timetable for the consultation was also truncated. We were only given 3 weeks to respond. The draft was not well-received by the stakeholders invited to respond. In our response dated 27 September 2019), we highlighted a series of problems, including:

    a. the glaring absence of any provision for independent advocacy for those with mental incapacity and disability in IRCs even though this was a core reason that the Court of Appeal found the Home Office in breach of its equality duties in respect of *VC*, having left him in segregation with deteriorating mental ill health with no ability to make representations on his own behalf about his detention or conditions of detention. This was raised with the Home Office in a joint letter from several NGOs including Medical Justice;

b. the high threshold set for referral for identification of individuals suspected of having serious mental illness and mental incapacity. We considered it vital that all detention centre staff should be trained in identifying these signs and that there be prompt referrals made about any concerns about mental illness or mental incapacity to a named and trained designated person within the IRC who makes the decision on onward referrals and assessments of mental health and capacity;
c. The absence of an adequate mechanism by which suspicion of mental incapacity, when identified, trigger a review of suitability of detention, with the detainee having access to support from an independent advocate;
d. The use of the language of "management" throughout the DSO wrongly suggests that issues concerning mental incapacity do not engage reviews of decision-making on immigration and enforcement matters;
e. The interchangeable use of the terms "mental disorder", "mental disability" and "mental capacity" suggest that the authors of the draft policy lacked sufficient understanding on of the subject matter, and a clear idea of what the DSO is seeking to address;
f. The lack of any clear pathway setting out the expectations following a finding of mental capacity issues, including in respect of detention and removal action;
g. the absence of an adequate procedure for recording concerns, remedial action and monitoring decisions concerning detainees who lack mental capacity;

180. The Home Office held a short meeting with stakeholders on 8 October 2019 to discuss our responses. Then we heard nothing further about the DSO for several months until a further draft with some tweaks was circulated in late January 2020 which split the issue of mental health and disability from mental capacity so that two DSOs would be produced. This was discussed at a further stakeholder meeting in February 2020. The concern for Medical Justice and others remained the disjunct between the DSO and provision of independent advocacy. It was difficult to see how real change could take place if people in detention were still solely reliant on detention centre staff to identify potential concerns to healthcare and the Home Office, when a root cause of the systemic gap was that these issues were not being identified by staff. In any event, they are not independent or advocates for detainees. There is an obvious conflict of interest, and they have no training in the role. It was only after further pressure from the stakeholders, including Medical Justice, that the Home Office agreed at a meeting in May 2020 that it would consider the provision of independent advocates.

181. The DSO on Mental Vulnerabilities and Immigration Detention 4/2020 was published in July 2020, with the Home Office deciding in the end to produce only one DSO (rather than splitting the two). The fundamental concern about independent advocacy has not been addressed in the DSO with no explanation

182. The problem remains that those who lack mental capacity to make decisions relating to their detention or immigration position are not identified. Where symptoms of mental illness are recognised, they are referred to the healthcare team and should receive assessment and treatment. They may receive an assessment of their capacity to make decisions relating to their medical care, but, in our experience, the Healthcare teams in IRCs do not view it as their responsibility to assess capacity to make decisions in any other areas or to identify concerns in relation to this, and there is no mechanism to trigger for this to happen. If someone was identified as lacking capacity to make such decisions, there is still no process in place to enable them to access independent advocacy to advance their interests. The possibility of legal representatives is insufficient to meet the obligation. That argument had been rejected by the Court of Appeal in *VC*. It ignores the fact that those lacking capacity to make decisions about their detention or immigration case are often unable to seek out legal advice and representation.

Reforms of AAR policy

183. In August 2020, we received another invitation for consultation from Ian Cheeseman, this time regarding a range of AAR policy reforms. There were three key areas of reform proposed including: (a) the introduction of quality standards for external medical evidence in AAR; (b) change to the framework on detention of potential victims of trafficking, and (c) reforms to AAR safeguards including a change to the approach to assessing immigration factors concerning Levels 2 and 3 AARs, and expanding the range of health professionals who may be authorised the carry out Rule 35 assessments.

184. I understand that the Inquiry has already received evidence from Sile Reynolds on behalf of Freedom from Torture concerning these reforms, therefore I will seek not to duplicate what has already been said in evidence.

185. Medical Justice provided a response to these reform proposals in October 2020, drawing the Home Office's attention to the defects in the proposals as follows. The first two changes were introduced in May 2021; the others have not been implemented yet but it is possible they may be in 2022.

Quality Standards for external medical evidence in AAR

186. The Home Office has suggested that in the last few years they have received "multiples of thousands" of medical reports which fall below expected professional standards and that they see evidence of an "industrial" and "strategic" approach to the production of these reports. The ICIBI considered these alleged concerns and recommended the Home Office undertake a thorough investigations into these allegations before proposing fundamental changes to its approach to MLRs (see recommendation in ICIBI's second AAR report, October 2021).

187. The Home Office appeared not to have followed through on that recommendation of the ICIBI and when asked, were unwilling or unable to provide stakeholders with evidence of the nature or scope of this alleged problem. The lack of evidence in the Home Office's decision-making on immigration enforcement issues is something about which both the Public Accounts Committee and National Audit Office have recently expressed serious concerns. Instead, the Home Office has proceeded with proposals to add a list of 'quality standards for external medical evidence' under the AAR policy.

188. We expressed grave concerns about the scope, intention and nature of the proposed standards, particularly as the Home Office had produced no evidence to suggest a general and wide-spread problem of experts not performing to expected standards and had provided no explanation as to why problems with individual experts could not be dealt with by way of a complaint to the expert's relevant professional standards bodies. We were also concerned at the suggestion that the Home Office proposed to be the regulator of the MLR quality standards without any explanation as to why the standards already set by regulatory bodies were not sufficient, or as to the basis of the Home Office's expertise to do so and without recognising the conflicts of interests.

189. Under the proposed changes, any medical evidence that does not comply with the quality standards would be disregarded. We consider that this fetters discretion of caseworkers and

may inappropriately disadvantage vulnerable and disabled individuals rather than addressing any suspected fraudulent behaviour.

190. The quality standards also appear to increase the standard of proof for professional medical evidence under the AAR policy, which goes against the stated intention and purpose of the policy. The threshold of proof for evidence of vulnerability has been and should continue to be kept consistent with that in Rule 35 of a "concern" or "suspicion" in order to ensure that vulnerable people are proactively protected from harm. The proposed standards also appear to exclude evidence from detainees who do not have a legal representative.

191. Despite these concerns, the Home Office nevertheless implemented the new quality standards for MLRs on 25 May 2021 in an amendment to the AAR Casework Guidance. The MLR standards incorporated into the AAR Casework Guidance apply to any medical report commissioned by an immigration advisor or solicitor and purport to:

a. require that the assessment *"must have been conducted face to face with the detained individual in person"* save in *"exceptional circumstances."* Failure to meet this standard *"may contribute to the report being given limited weight"*.
b. require the expert to *"state the limitations (if any) attached to forming opinions through"* telephone or video assessments and the evidential weight is said to be dependent on this explanation.
c. require concerns that a medical expert has to be raised with the on-site healthcare team, the failure of which *"may lead to the report being considered with limited weight."* The failure to consider the availability of primary care in IRCs and secondary care being accessible is said to mean that the report *"may not have accurately considered the impact of detention on the individual's health"* and affected the evaluation of *"impact/harm of detention"* and thus the report would be accorded *"limited weight."*
d. require a *"statement of assurance"* that the report has been prepared and completed in line with the purported Home Office-imposed standards.
e. an MLR which does not meet the purported standards set out in the guidance could result in the downgrading of an Adult at Risk from Level 3 to Level 2 or to Level 1, and be treated as no more than a person's self-declaration of a risk factor.

192. We are deeply concerned that the MLR quality standards undermine the statutory purpose of the AAR policy and conflicts with the AAR statutory guidance, which has not been amended (and any amendment would require Parliamentary approval). Notably,

a. the AAR statutory guidance (which has not been amended) had not stipulated specific standards be met before an MLR can be accepted as Level 3 evidence of risk. As was stated by Ouseley J in *Medical Justice*, the statutory guidance stands on its own as the basis for considering whether a person is an adult at risk and at what level of risk. The casework guidance cannot add additional requirements that are not required by the statutory guidance.
b. the MLR standards undermine the protection to be afforded to adults at risk as it permits the downgrading of expert clinical evidence, most often, of a person's deterioration in detention and likely further deterioration if he remains detained, which, on the face of the AAR statutory guidance, would clearly and ordinarily constitute Level 3 evidence of risk. That is not to say that the Defendant cannot decide in a given case that less weight should be afforded to an MLR, but there must be good objective reasons for downgrading the evidential weight of the report, balanced against the expertise of the author, the subject matter of the report and the quality of its analysis.
c. it entrenches the practice of effectively asking whether serious mental illness can be satisfactorily managed in immigration detention despite Mr. Shaw's categorical rejection of this approach and its removal from the AAR guidance, at least in principle.

193. We have amended our processes to ensure that our MLRs comply with the standards. We have therefore only encountered relatively few cases where medical evidence has fallen foul of the standards. However, this is not particularly reassuring because the standards are most likely to cause problems when a detained person obtains a report from a clinician who does not belong to an organisation such a s Medical Justice and who may not be aware of the standards, for example if the detained person has a clinician in the community. Our casework shows that, in the handful of cases we have seen, the MLR standards have been operated as a tick-box exercise such that if one apparent standard is not met, it would automatically downgrade the weight that an MLR should be given irrespective of the cogency of the report for the purposes of considering whether an individual is an AAR, the level of risk evidence and the strength of the presumption against detention.

194. This is illustrated by a recent case of a Medical Justice client, AK, who is an Indian national and Tamil with a history of detention and torture by Indian police, including by beating, cigarette burns, water boarding, rape and sexual assault. The Home Office accepted that he was a victim of torture on account of a Rule 35(3) report. AK adduced, with the assistance of his solicitors, additional medical evidence that he was not only at risk of deterioration in detention, he had actually suffered a significant deterioration in his mental health in detention. He had become so unwell that he was extremely distressed, confused and struggled to talk about his past trauma. His solicitors expressed concerns that he was not fit to be interviewed, and they could not even take a witness statement from him whilst he remained in detention, concerned that it was likely to cause further re-traumatisation. Medical evidence obtained by AK's solicitors in the form of an MLR from an experienced consultant psychiatrist, supported these concerns. The psychiatrist assessed AK as suffering from PTSD and Severe Depressive Episode and was likely to suffer further harm if he remained in detention. A month later our clinical advisor, Dr. Rachel Bingham assessed him and was so concerned about him after the assessment that she urgently informed the IRC healthcare of her serious concerns about his high suicide risk. There was no contraindicative evidence from IRC healthcare.

195. Although the consultant psychiatrist's MLR and Dr. Bingham's letter would appear, on their face, to clearly constitute professional evidence of the highest level such that the strongest presumption against detention ought to apply to AK, the Home Office refused to recognise him as an AAR Level 3 on the basis that the evidence did not meet the purported standards for MLRs and also refused to release him from immigration detention. The reasons given for rejecting the expert psychiatrist's report were that it failed to set out the limitation of remote assessments, to raise concerns about AK's mental health with the IRC healthcare immediately, to consider the availability of primary healthcare in detention and the absence of a statement of assurance that the MLR met the purported standards set out in the casework guidance. The Home Office however did not dispute the clinical conclusions drawn by the expert about the nature of AK's mental illness and his high vulnerabilities to harm. The decision to maintain AK's detention took a "tick-box" approach, disregarding undisputed evidence that he had actually suffered from harm by being detained. This resulted in AK remaining in detention for several more weeks before he was released from immigration detention after judicial review proceedings were issued.

196. AK's case illustrates how the MLR quality standards do not actually seek to protect detainees from continued detention where the evidence points to Level 3 risk, but instead sanction the dilution of protection for the most vulnerable of detainees on technical breaches of artificial standards set down by the Home Office, which bear no semblance with existing, professional regulatory standards.

Changes to the policy framework on detention of Potential Victims of Trafficking (PVoT)

197. Previously the detention of victims of trafficking with a positive reasonable grounds decision from the national Referrals Mechanism was dealt with in a separate policy. That policy was removed and victims of trafficking brought 'fully within the Adults at Risk Policy'. This effectively removed the presumption that a positive Reasonable Grounds decision in the NRM is adequate professional evidence of modern slavery to justify accepting the person is likely to be at risk in immigration detention. Subsequent to this change, a positive Reasonable Grounds decision now only counts as level 2 evidence under the AAR policy. The presumption for release can therefore easily be outweighed by immigration factors. In response to concerns raised by the Parliamentary Scrutiny committee the Home Office accepted that the policy change would mean that more victims of trafficking would be detained and for longer than they otherwise would have been.

New levels of AAR

198. Under the existing AAR policy, an AAR is defined as including someone who self-declares as being so. Such self-declaration is treated as the lowest level - "level 1" AAR – evidence of risk, but nevertheless still means a person is acknowledged to be an AAR. The Home Office AAR reform proposal sought to remove self-declaration as indicative of risk, and instead suggested that unless there is professional evidence of a risk indicator, the person would not be classified as an adult at risk at all. This proposal was purported to reflect a recommendation in Shaw 2 of splitting level 2 evidence into sub-categories. But that is wrong. Mr. Shaw championed acting on the account of the individual. He did not recommend that those who have self-declared an indicator of vulnerability should be excluded from the protection of the AAR policy. He was addressing a different problem, the surprisingly low release rates for those who have AAR Level 2 risk professional evidence. The low release rates showed that the AAR safeguard was not functioning properly if adults at risk with Level

2 evidence could not normally secure release from detention as a result, in circumstances where the previous EIG 55.10 policy would have done.

New assessment of risk to predict future harm

199. Instead of reflecting levels of evidence, the intention is that Level 1,2 and 3 would instead reflect levels of risk of deterioration in detention. The continued move to requiring professional evidence capable of confirming and predicting future harm would, in Medical Justice's view, allow the Home Office to continue to adopt a "wait and see" attitude to delaying proper consideration of the question of release or continued detention until actual evidence of deterioration has already occurred. It is extremely difficult to accurately predict who will deteriorate in detention and within what timeframe. Therefore, requiring professional evidence of making detailed prognoses about deterioration in detention, would, in Medical Justice's view, increase the risk that vulnerable detainees would be left to actually deteriorate and suffer harm before they are removed from the harmful detained environment. This would entrench the already flawed approach of the Home Office, when responding to a Rule 35 report, in expecting there to be evidence of actual and current deterioration in a person's health, rather than a risk that, given the person's vulnerabilities, harm could be assumed to arise. The Home Office's proposal appears to entirely disregard clear clinical literature, reviewed by Professor Bosworth, von Werthern, Professor Katona and the Royal College of Psychiatrists, establishing that people with a history of ill-treatment or pre-existing mental or physical ill-health were likely to suffer harm in detention, instead requiring for the harm to have actually been realised.

Role of the doctor in risk assessments

200. We have serious concerns about the envisaged changes to the role of doctors under the policy. Levels of risk under the proposed policy would be determined by the relative risk of harm in detention which would be set by the examining doctor for the purposes of reviewing detention, or potentially the doctor would determine the level of risk- level 1,2 and 3, themselves. We are concerned that the perceived role of doctors goes beyond normal clinical assessments and crosses into custodial decision making. We are concerned that the change to the doctor's role under the AAR policy could damage the doctor-patient relationship, put vulnerable detainees at risk and potentially compromise the ethical obligations of doctors working in this setting. It also requires a level of competency and expertise that is not

available in IRC s and is likely to create yet more complexity and confusion for a task that was intended be a speedy screening out of those unsuitable for detention. The failure of doctors to make any or any proper assessment of risk of harm under the system as operated since 2016 is powerful evidence that this proposed reform, if implemented, will similarly fail to remedy the problem and is likely to perpetuate the deficiencies still further.

201. We believe it is crucial that this Inquiry should scrutinise these proposals if effective lessons are to be learned and any real reform of the AAR policy and practice is finally to be achieved.

E. Conclusion

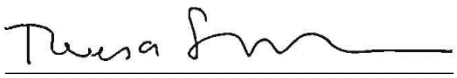
202. Whilst Medical Justice is conscious that the Terms of Reference are limited in time and to Brook House, it is important to put the structural and operational problems in 2017 in Brook House in context by reference to how those safeguards were operating in previous and subsequent years. Whilst there is no doubt that what was exposed on BBC Panorama was shocking and unacceptable abuse of vulnerable detainees, it did not just happen overnight from April to August 2017. As has already been discussed above, many of the problems with the structural safeguards and their operation, as exposed by the BBC, are not new. The problems with the Rule 35 process not achieving its objective have been raised repeatedly with the Home Office over many years, as discussed above, and continues to be raised with them. As Emma Ginn's witness statement explains, Medical Justice and other NGOs and independent oversight bodies have also pointed to the risk of harm caused to vulnerable detainees concerning the laissez faire use of segregation and the inability of IRC healthcare to manage mentally ill detainees. The institutional culture, racism and dehumanising attitudes toward vulnerable detainees, as documented by the BBC, sadly are not limited to Brook House, as is evident from documentaries about Yarl's Wood, Oakington and Harmondsworth.

203. The inertia and intransigence in bringing about real change is what is concerning; that reflects a higher-level problem with the institutional culture at the Home Office – and not just at the IRC level – where abuse and wrong-doing, when exposed, has not lead to fundamental change in approach to immigration enforcement and detention policy and practice. Without this protection of vulnerable people from harm in detention and at risk of inhuman and degrading treatment will remain intrinsic to the system as it was in 2017 and since.

Statement of Truth

I believe that the facts stated in this statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.



Theresa Schleicher

Date: 28 January 2022

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