Friday 10th March 2023

Medical Justice Submission to the Committee for the Prevention of Torture

Contents

About Medical Justice

Medical Justice is the only charity in the UK to provide independent volunteer clinicians to attend all the Immigration Removal Centres (IRCs) across the UK to medically assess people held in detention. Our clinicians assess the physical and mental health of clients in detention and write medico-legal reports documenting physical injuries and scarring attributed to torture or other serious mistreatment, serious medical conditions, serious mental disorder and mental capacity also often related to a history of torture or other serious mistreatment and trauma. We assess the impact of detention, continued detention and the conditions of detention on any identified physical or mental disorder as well as identify and assess injuries and mistreatment sustained during attempted removal. Our casework also includes assessing fitness to fly/removal, challenging instances of medical mistreatment and assisting people in detention and upon release to access the healthcare and the support services they need. We receive between 600 and 1,000 referrals from people held in detention each year and have gathered a sizeable, unique and growing medical evidence base. Drawing on this evidence base we have published a number of reports documenting systemic and wide ranging failure in detention policy, safeguards and practice giving rise to serious human rights issues concerning the misuse of the powers of administrative detention, the use of force and to conditions that expose those detained, particularly those with a history of torture and/or other serious ill- treatment and/or trauma to further treatment in breach of Article 3 ECHR (inhuman and/or degrading treatment) or Article 8 ECHR (physical and/or moral integrity and/or denial of human dignity).

We assist our clients to access competent legal advice and representation to ensure that the strength of the expert medical evidence and its implication for the legality of detention and treatment in detention is properly deployed. In legal challenges, lawyers utilise evidence from our casework and our research into systemic failures in healthcare provision, the harm caused by the absence of effective safeguards, and the adverse effect of immigration detention itself, in terms of its indefinite nature and constant threat of removal, on the health of people in detention. Our evidence is also utilised by statutory bodies and non-governmental organisations seeking to support change in policy and practice by the state authority (the Home Office) responsible for immigration detention.

Evidence from our casework informs our research, policy work and strategic litigation with the aim of identifying the limits of legal protection for fundamental rights, and with the aim of securing lasting change in reducing, if not ending administrative detention for immigration purposes, in particular, for those with a history of torture and/or other serious ill-treatment, trauma or other significant vulnerability. Medical Justice believes the only way to ultimately eradicate endemic healthcare failures in immigration detention is to end the use of immigration detention, a position supported by the British Medical Association (BMA), amongst others.

Introduction

Immigration detention is the practice of detaining people who seek asylum or those with an unsettled immigration status for administrative purposes. It is not part of any criminal sentence. Detention decisions are made administratively by caseworkers employed by the Home Office applying legal principles and government policy with no prior judicial authorisation. It is recognised as an exceptional and draconian power.

In the UK, immigration detention is indefinite; there is no upper time limit on how long someone can be detained under immigration powers. Individuals do not know in advance how long they will be held in detention.

There is a well-established and wide-ranging consensus in research showing that the rates of mental illness within immigration detention are high.[1] It is recognised, including by the Home Office itself, that survivors of torture, trafficking, trauma, and those with mental health conditions such as Post Traumatic Stress Disorder (PTSD) and depression are particularly vulnerable to suffering harm when detained. People seeking asylum are known to have a higher incidence of these vulnerabilities[2]; their detention is therefore a clear and long-standing concern.[3]

Legislation and policy require that a person's vulnerability is considered as part of all immigration detention decisions and in principle provides for safeguards to identify and protect vulnerable people from detention or continued detention. This is a key element to ensuring that the detention is lawful. This requirement was put on a statutory footing with section 59 of the Immigration Act 2016[4] and the Adults at Risk Statutory Guidance[5] aimed at addressing whether (a) a person would be particularly vulnerable to harm if they were detained or were to remain in detention, and (b) if the person is identified as being particularly vulnerable to harm in those circumstances, whether they should be detained or remain in detention. An Adults at Risk policy was also introduced and is referred to below as the AAR policy.[6]

It is Medical Justice's experience that the existing legal protections, policy and safeguards are ineffective and fundamentally flawed. The consequence is that many vulnerable people – including those with a history of torture or other serious mistreat and trauma, including those seeking asylum – are neither identified nor promptly routed out of the detention system, and instead are subjected to prolonged detention, unnecessary suffering and in some cases irrevocable harm.

There are well established and long-standing concerns that have been identified and evidenced in numerous reports by statutory and parliamentary bodies, independent investigations and reviews including by the Prison and Probation Ombudsman, Stephen Shaw[7], His Majesty's Chief Inspector of Prison[8], the Independent Monitoring [9], the Joint Committee on Human Rights[10], the Home Affairs Select Committee[11] and the Independent Chief Inspector of Boarders and Immigration[12]. The Statutory Inquiry under the Inquiries Act 2005 into mistreatment and abuse in breach of Article 3 ECHR at Brook House IRC exposed by undercover reporting [13] was instituted in November 2019

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

[2] See for example Royal College of Psychiatrists (2021) Detention of people with mental disorders in immigration removal centres (IRCs): Position Statement, 7-8.

[3] Medical Justice (2007) Beyond Comprehension and Decency.

[4] Immigration Act 2016 s 59

[5] Adults at Risk in Immigration Detention laid before parliament on 21 July 2016 and last updated on 16 March 2022.

[6] Immigration Act 2016: Guidance on adults at risk in immigration detention

[7] Stephen Shaw (July 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.

[8] For example, see HMIP (23 September 2022) Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons (30 May – 16 June 2022).

[9] For example, see IMB (May 2021) Annual Report of the Independent Monitoring Board at Brook House IRC For reporting year 1 January - 31 December 2020.

[10] Joint Committee on Human Rights (2018) Inquiry into Immigration Detention.

[11] House of Commons Home Affairs Committee (March 2019) Immigration detention: Fourteenth Inquiry Report of Session 2017-2019.

[12] For example, see ICIBI (12 January 2023) Third annual inspection of Adults at Risk Immigration Detention June to September 2022.

[13] "Undercover: Britain's Immigration Secrets", BBC Panorama, 03 September 2017.

following judicial review proceeding[14]. The Brook House Inquiry heard extensive evidence of continuing systemic and institutional failures by both the government and its private contractors (G4S), misuse of force, racism and dehumanization over 10 weeks in 2021-2022 and is imminently due to report. Despite this and of particular concern is that the government has plans and is in the process of expanding the immigration detention estate. It has recently announced plans to reopen and expand Campsfield House IRC and Haslar IRC, increasing the detention capacity by 1,000 places (a 33% increase). In addition, the Home Office opened new Short Term Holding Facilities (STHF) at HMP Morton Hall and at Manston (a former military barracks). At Manston, there is capacity for 1,600 places, 600 of which are planned to be part of a new residential holding room, under the new STHF (Amendment) Rules 2022. The new STHF (Amendment) Rules extended the length of time that people can be held in such facilities from 24 to 96[15] hours (with a further power to extend the period in exceptional circumstances); this follows evidence of STHF Rules 2018.[16]

This all comes with the reintroduction of a detained fast track asylum appeals procedure (DFT)[17] (previously declared unlawful, unfair and unjust[18]) and a 'detain and deport' model in the Illegal Migration Bill (first published on 7 March 2023)[19], the 2022 planned investment of over half a billion pounds into expanding detention[20], and reports of "tens of thousands" of people who could be deported to Rwanda[21]; all of which would require an increase in detention capacity.

Such an expansion marks a significant change in overall detention policy in place since 2016 and reverses the Home Office's commitment to reduce the use of detention in response to the recommendations of the highly critical first review into the welfare in detention of vulnerable persons provided by Stephen Shaw in January 2016. Following publication of Stephen Shaw's review, the government announced that it intended to *"reduce the number of those detained, and the duration of detention before removal"*.[22] It also completely disregards the consensus in clinical research and other recorded evidence from many sources about the serious harm that immigration detention continues to cause.

Our submission

Our submission will draw on Medical Justice's extensive casework experience, recent research, as well as evidence from the ICIBI and HMCIP as well as from the Brook House Inquiry[23], the first of its kind into the mistreatment and abuse of those detained under immigration powers and the conditions of detention.

Undercover reporting by BBC Panorama revealed widespread abuse at Brook House IRC, both verbal and physical, of detained persons including undercover footage of a vulnerable detained person being choked, with a threat to kill him, demeaned and threatened by other officers with further violence after attempting suicide.

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[14] R*(MA and BB) v Secretary of State for the Home Department* [2019] EWHC 1502.
[15] Rule 6A(1) of the STHF (Amendment) Rules 2022.
[16] HM Chief Inspector of Prisons (2022) Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston; Peter Walker (3 Nov 2022) Manston asylum centre not operating legally, concedes minister, The Guardian.
[17] S27of the Nationality and Borders Act 2022.
[18] *Lord Chancellor v Detention Action* EWCA Civ *and R (on the application of) Detention Action v Secretary of State for the Home Department* [2015] EWCA Civ 840.
[19] Illegal Migration Bill 2023
[20] https://www.gov.uk/government/speeches/pm-speech-on-action-to-tackle-illegal-migration-14-april-2022
[21] https://www.theguardian.com/uk-news/2022/apr/14/tens-of-thousands-of-asylum-seekers-could-be-sent-to-rwanda-says-boris-johnson
[22] https://questions-statements.parliament.uk/written-statements/detail/2016-01-14/HCWS470
[23] The Brook House Inquiry

The Inquiry eventually held public hearings over 46 days in two phases, 23 November 2021 to 10 December 2021, and 21 February 2022 to 6 April 2022. Central to the Inquiry's Terms of Reference was the extent to which any Home Office policies or practices, or clinical care issues within detention, caused or contributed to any identified mistreatment. Medical Justice was a designated core participant (CP) to the Inquiry due to our extensive first-hand experience of the policy and practices concerning detention and safeguarding of those with vulnerability, as well as its understanding of the adequacy of the healthcare provision at the IRC.

Our submission will look at the following issues:

1. The impact of detention on health
2. The limitations on effective medical treatment that can be provided in immigration detention settings
3. Systemic defects in detention clinical safeguards
4. Prisonisation/criminalisation, institutional culture of dehumanisation, and racism
5. Use of Force and Segregation
6. Prolonged cell confinement of immigration detainees held in mainstream prisons
7. Lack of accountability, oversight and institutional culture of impunity
8. Recent developments
    a. The UK's plans to remove asylum seekers to Rwanda
    b. Harmondsworth power outage
    c. Manston
    d. Quasi-detention and accommodation centres
    e. Nationality and Borders Act 2022
    f. Illegal Migration Bill 2023

1. The impact of detention on health

The high rates of mental illness within immigration detention and the harmful impact that being in detention has on people's mental health, are widely evidenced.[24]

The data from a recent systematic review conducted by Irina Verhülsdonk, Mona Shahab and Marc Molendijk (2021) suggests that "immigration detention independently and adversely affects the mental health of refugees and migrants".[25] The study, including four separate studies of people in immigration detention in the UK, shows the extent of this issue: three quarters of people in immigration detention experienced depression, more than half experienced anxiety and almost half experienced symptoms of PTSD. The prevalence of all three mental disorders was around twice as high in detained refugees and migrants compared to non-detained refugees and migrants.[26]

This study corroborates previous research, which has consistently found immigration detention to have an adverse effect on mental health. Professor Mary Bosworth's literature review for Stephen's Shaw's 2016 report to the Home Office on the Welfare in Detention of Vulnerable Persons set out this consensus. She summarises that "literature from across all the different bodies of work and jurisdictions consistently finds evidence of a negative impact of detention on the mental health of detainees".[27]

The severity of the mental health symptoms in detention has been found to correlate with the length of time spent in detention.[28]

People in detention have described a range of factors contributing to this including fear for their safety, criminalisation, experiences of physical and verbal abuse and in particular its indeterminate nature. All of these contribute to experiences of loss of agency, entrapment, and feelings of hopelessness.[29]

The Royal College of Psychiatrists published a detailed position statement in 2021 summarising the current research concerning the adverse impact of immigration detention.[30] The statement states that detained people with pre-existing vulnerabilities such as mental health issues or survivors of torture and other forms of cruel or inhumane treatment, including sexual violence and gender-based violence, were at particular risk of harm as a result of detention. The position statement concludes that IRCs were likely to precipitate a significant deterioration of mental health in most cases.

There is a particular focus in the position statement on survivors of torture, highlighting the research evidence of how "a history of torture alone predisposes an individual to a greater risk of harm,

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

[25] Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis. BJPsych Open 7(6) 1.

[26] Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis. BJPsych Open 7(6) 5.

[27] Bosworth M. (2016) Appendix 5: The Mental Health Literature Survey Sub-Review. Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office.

[28] M von Werthern, K Robjant, Z Chui et al. (2018) The Impact of Immigration Detention on Mental Health: A Systematic Review, BMC Psychiatry 18: 382.

[29] See Annex I to Duncan Lewis Closing Submissions - Witness comments on indefinite detention, DL0000260; and Annex 5 to Duncan Lewis Closing Submissions - Instances of racist language in disclosure, DL0000264.

[30] Royal College Psychiatrists Position statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, (April 2021) 18.

including deterioration in mental health and increased risk of anxiety, depression and PTSD, than would be experienced in the general detained population".[31]

2. The limitations on effective treatment that can be provided in immigration detention settings

Immigration detention is not an appropriate setting for effective mental health treatment. Our clinicians repeatedly observe clients whose mental health deteriorates in immigration detention, even when provided with some treatment. The barriers to successfully treating mental illness are outlined in the above-mentioned position statement by the Royal College of Psychiatrists, which addressed the impact of detention on specific conditions. Factors intrinsic to detention include the subjective lack of safety experienced by many detained people, the inability to make plans due to the uncertainty of release of removal, fear of removal and the highly emotionally charged environment.

Management of complex mental health conditions may require specialist therapies. Whilst IRCs have primary care, a mental health team and the ability to make psychiatric referrals, they do not have access to specialist services. For example, in the community, there are separate, specialist teams for people in mental health crisis, people with psychosis, and people with PTSD. Many specialist psychological therapies are also not available in detention.

The unknown length of detention also limits the effectiveness of treatment and the psychological interventions that might be possible, whilst someone is held in an IRC. Evidence-based psychological therapies have a recommended duration, which is usually planned in advance with the therapist alongside planned review points at which the duration might be changed. In the IRC setting, the duration of treatment is likely to be determined by the person's legal situation, and planning for longer-term treatments is likely to be difficult or impossible.

The Royal College of Psychiatrists position statement also clearly indicates the significant limitations to successful treatment in immigration detention for people with a mental disorder. Psychotropic medication alone is unlikely to achieve good outcomes without a broader multi-model therapeutic approach. As detention prevents community rehabilitation, it is a barrier to achieving recovery and impedes rehabilitation in functional and social aspects of mental health.[32]

The Royal College of Psychiatrists states: *"Crucially, a background context of basic physical and emotional security, including an assurance of safety and freedom from harm, is a key factor in recovery from most if not all mental disorders. Many people with a mental disorder will not even be able to engage in specialist psychological treatment without this."*[33] Detention centres are not therapeutic environments, they cannot provide a sense of physical or emotional stability. Moreover, requesting mental healthcare and disclosing symptoms require the individual to have trust in available services.

The detention setting is not conducive to encourage the disclosure of symptoms. People in immigration detention often do not trust healthcare staff as they are perceived to be part of the Home Office, the body holding them in detention. People in detention may also worry about confidentiality between healthcare staff and the Home Office. The culture of disbelief that exists within detention settings further deters people from disclosing symptoms, as they feel disbelieved,

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[31] Royal College Psychiatrists Position statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, (April 2021) 13.
[32] Royal College Psychiatrists Position statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, (April 2021) 10.
[33] Royal College Psychiatrists Position statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, (April 2021) 8.

experience disinterest and lack of empathy.[34] People who have survived torture in their home country face additional barriers and often require additional assurances of their safety with authority figures in the UK.

The persistent mischaracterisation by healthcare staff of symptoms of serious mental illness as merely behavioural was illustrated by evidence to the Inquiry of one nurse referring to a detained person in the midst of suicidal crisis as "(having) a massive hissy fit on the floor".[35] Another attributed the distress of a detained person, who had jumped onto the suicide netting with a plate shard, to him having to do the washing-up.[36]

This echoes findings from the ICIBI's second annual review of the Adults at Risk policy, that healthcare and contractor staff in IRCs indicated that "they were suspicious about the motivation behind the self-harm and suicide attempts".[37] A similar trend was observed by Stephen Shaw in his second follow up review of UK immigration detention[38], and by the IMB in its 2020 report on Brook House IRC[39]. The IMB said the issues with staffing culture had not improved even with the handover of the contract to run Brook House from G4S to Serco, citing examples of staff expressing "desensitised" views about detainee and attitudes towards self-harm and food and fluids refusal, which 'lean towards a culture of disbelief'.[40]

The clinical impact of a culture of disbelief has been summarised by the British Medical Association: *"Most concerning for doctors working in IRCs is the risk that they become cynical and absorb the "culture of disbelief" - the assumption that individuals are lying or exaggerating for attention or to further their own aims - which pervades the immigration system. A frequent concern of the way that healthcare is provided in IRCs is that individuals complaining of physical or mental health problems are assumed to be lying about or exaggerating them in an attempt to manipulate or disrupt the system."*[41]

The lack of trust is particularly a concern where people have had adverse experiences of authority figures, have been tortured, or experienced trauma, as is the case for many detained people in UK IRCs. The Faculty of Forensic & Legal Medicine's *"Quality Standards for healthcare professionals working with victims of torture in detention"* states that:

"Experiences of loss of agency and powerlessness are key to the consequent risk of further harm in detention, rather than the specific identity of the perpetrators…It can thus be difficult for healthcare professionals in the detention setting, where they are likely to be viewed by the victims of torture as agents of the state, to engage in a trusting therapeutic relationship with victims of torture, and victims of torture may specifically avoid going to healthcare while in detention as they do not trust anyone in the detention setting to help them. Further, a key feature of post-traumatic stress disorder

[34] Day 11 transcript at time-marker 46:6-11. See also Dr Husein Oozeerally, 11 March 2022, 102-109
[35] TRN0000100_0008 [226-229]
[36] TRN0000005_007 [27-35]
[37] ICIBI (October 2021) Second annual inspection of 'Adults at risk in immigration detention' July 2020 – March 2021 para 9.22.
[38] Stephen Shaw (July 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.
[39] IMB (May 2021) Annual Report of the Independent Monitoring Board at Brook House IRC For reporting year 1 January - 31 December 2020.
[40] IMB (May 2021) Annual Report of the Independent Monitoring Board at Brook House IRC For reporting year 1 January - 31 December 2020 20-23.
[41] BMA (2017) 'Locked up, locked out: health and human rights in immigration detention' 56.

is avoidance of reminders of the trauma, which can contribute to avoidance of seeking healthcare and a general lack of help-seeking behaviour".[42]

Lack of training to identify and treat trauma-related symptoms

Refugee and asylum-seeking populations are at a heightened risk of PTSD[43], and there is a high rate of people with trauma related symptoms in detention.[44]

However, there is a specific lack of any or any adequate training relating to identifying PTSD and trauma-related symptoms. For those with PTSD, their symptoms are likely to be aggravated by the detention environment triggering reminders of the loss of agency and powerlessness that are strongly associated with traumatic events. However, as trauma focused therapy is not possible in detention settings, they will be unable to access treatment. On PTSD specifically, the Royal College of Psychiatrists position statement notes that trauma-focused therapy is not possible in detention settings.[45]

The lack of screening for PTSD by IRC healthcare staff is contrary to the approach recommended by the National Institute for Clinical Excellence (NICE) which gives guidelines on evidence-based recommendation for healthcare.[46] Without the ability to identify trauma symptoms and PTSD, vulnerable people in detention are deprived of key safeguards which seek to raise clinical indicators against continued detention so it can be promptly reviewed, and release considered. This includes Rule 35 in the Detention Centre Rules 2001 (DCR 2001), as explained below. If these safeguards are not operated effectively, people are exposed to an environment which risks worsening their symptoms and to detention which is unlawful due to being inconsistent with the AAR policy.

Of the 45 people analysed in Medical Justice's recent report *"Harmed not Heard"*[47], 76% either had symptoms of PTSD or a diagnosis of the condition by a Medical Justice clinician.[48] None of the individuals included in the case sample had evidence in their medical records that there was any screening for symptoms of PTSD by IRC healthcare staff.[49] None were identified as requiring a Rule 35(1) report to identify their risk of harm from detention.[50]

Evidence to the Brook House Inquiry confirmed this deficit to be longstanding and ongoing. Sandra Calver, the Head of Healthcare at Brook House IRC, accepted that, whilst PTSD was the prevailing mental health disorder amongst detained persons, her staff were not sufficiently trained in identifying trauma-related symptoms.[51]

Even where trauma-related and other serious mental health issues are identified, there is no specific therapy available, and detention is not reviewed promptly or at all by the Home Office. The Brook House Inquiry heard evidence that without appropriate secondary mental health care provision, such as trauma therapy, staff resorted to 'managing' serious ill-health by custodial risk management

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[42] Faculty of Forensic & Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention 5-6.
[43] Post-traumatic Stress Disorder, National Institute for Health and Care Excellence (2021).
[44] Royal College Psychiatrists Position statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, (April 2021) 7; Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis. BJPsych Open 7(6).
[45] Royal College Psychiatrists Position statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, (April 2021) 11.
[46] Post-traumatic Stress Disorder, National Institute for Health and Care Excellence (2021) para 1.1.9.
[47] Medical Justice Harmed not Heard (2022).
[48] Medical Justice Harmed not Heard (2022) 25.
[49] Medical Justice Harmed not Heard (2022) 25.
[50] Medical Justice Harmed not Heard (2022) 25.
[51] Sandra Calver, 1 March 2022, 186/6-16

tools including segregation and use of force to transfer to segregation. A Registered Mental Health (RMN) Nurse at Brook House, accepted that the forms of intervention used failed wholesale to address or mitigate the underlying mental distress and symptoms, focusing purely on risk management over therapeutic care.[52]

People in immigration detention should be provided with mental healthcare, however, the effectiveness of treatment is likely to be limited in most cases and certainly not equivalent to treatment in the community. Its function is limited to containment and not treatment to improve the condition contrary to the requirements of Article 3 ECHR.[53]

3. Systemic defects in detention and clinical safeguards for vulnerable people

Given the known adverse impact of immigration detention on health and the limitations of successfully treating mental illness in detention as outlined above, it has long been stated Home Office policy not to normally detain particularly vulnerable people, including those with pre-existing mental illnesses and survivors of torture. This was previously set out in the Enforcement Instruction and Guidance (EIG) chapter 55.10, which listed several categories of people presumed to be unsuitable for immigration detention because of their vulnerability to its adverse effects (including survivors of torture and 'the mentally ill') and stated that they could only be detained "in very exceptional circumstances."

Following the highly critical review by Steven Shaw in 2016, the policy was reformulated as the current 'AAR Policy'. The stated intention of the reform was to build on the previous protections, to improve safeguards for vulnerable people and to ensure fewer would be detained and for shorter periods.

The AAR policy is that vulnerable individuals or adults at particular risk of harm in detention should not normally be detained and can only be detained when 'immigration factors' outweigh their indicators of risk.

People in detention are required to provide evidence of their vulnerability in detention. There are three levels of evidence of risk. The first evidence level (Level 1) is a declaration by the detained person about their medical or other aspects of their history that would indicate they had an indicator of risk. The second evidence level (Level 2) is where a professional person provided information that the detained person had indicators of risk. The third evidence level (Level 3) is evidence from a professional that the person fell within the categories of risk and detention would be likely to cause them harm. The policy requires 'immigration control factors'[54] to be considered when taking a decision about whether the vulnerable person would be released. Only persons with Level 3 evidence of risk would have the greatest protection against continued detention.

Since vulnerable people do not necessarily have the means to produce evidence of their own vulnerability, the DCR 2001 provide for a mechanism of assessing any person entering detention and generating the evidence required to allow for those who are vulnerable due to a history of torture, trafficking, sexual violence, mental illness, disability or any other factor to be identified and promptly routed out of detention. From its inception there has been widespread criticisms of the AAR policy and extensive evidence of its ineffectiveness in facilitating identification and prompt release of vulnerable people in detention.

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[52] Karen Churcher, 10 March 2022, 56/1-25

[53] *Rooman v Belgium* (app.18052/11) 31 January 2019 [GC].

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

This mechanism is provided by Rule 34 and Rule 35 DCR 2001 and place a statutory obligation on IRC healthcare departments to identify vulnerability and communicate it to the Home Office. These are meant to work in tandem to identify vulnerable detained individuals promptly and trigger a review of their continued detention with a view to release.

Under Rule 34 DCR 2001, all people arriving at an IRC must be offered an appointment with a GP within 24 hours. At the appointment the doctor is required to undertake a mental state and physical examination of their patient.

At this consultation, or at any subsequent meeting, the GP has specific reporting obligations to the Home Office under Rule 35 DCR 2001 if the detained patient is identified as at risk in detention.

Rule 35 DCR 2001 requires GPs to formally report safeguarding concerns where they (1) consider someone's health is likely to be "injuriously affected" by detention; (2) suspect someone "may have suicidal intentions"; or (3) have concerns that someone "may have been a victim of torture".

The Rule 34 and 35 safeguards should, when operating together effectively, pre-empt and prevent a vulnerable person from being exposed to further risks of harm and deterioration in their health. This system is designed to bring such individuals promptly to the attention of the Home Office to review their suitability for continued detention.

However, in practice, the policy framework intended to protect those who are particularly vulnerable to harm in detention, has never worked effectively and continues to systemically fail to date. The ways in which the processes fails and some of the reasons behind it, as well as the consequences of there not being effective safeguards, was considered in detail by the evidence heard to the Brook House Inquiry.

Rule 34

Sandra Calver, the Head of Healthcare at Brook House IRC confirmed that Rule 34 examinations were only allocated 5 minutes in 2017[55], and even now only 10 minutes[56]. She stated that the defective operation of Rule 34 was the same "throughout all of the IRCs as well".[57]

Dr Hard, the independent clinical expert to the Inquiry, expressed surprise at the Rule 34 arrangements, which was at best "a very very cursory appointment", in which it was "impossible" to fulfil the requirements of a Rule 34 examination or to complete a Rule 35 report in the limited time allocated.[58] Due to this, the evidence of the clinical staff was that a practice had developed in which a follow-up GP appointment would be booked for people who disclose vulnerabilities which require a Rule 35 assessment.[59] These second GP appointments could take 2-4 weeks to be arranged[60], during which time the risk that such vulnerable persons will be exposed to harm increased and occurred.

[55] Sandra Calver, 1 March 2022, 207/4-7, 208/16-25 and 209/1-15
[56] Sandra Calver, 1 March 2022, 207/8-11
[57] Sandra Calver, 1 March 2022 209/1-6
[58] Dr Jake Hard, 28 March 2022, 19/1-25, 20/6-14
[59] Dr Husein Oozeerally, 11 March 2022, 18/18-25 and 19/1-15; Dr Saeed Chaudhary, 11 March 2022, 204/1-9
[60] Dr Husein Oozeerally, 11 March 2022, 20/9-12

Medical Justice's recent report *"Harmed Not Heard"* (2022) is based on an analysis of 45 cases from July to December 2021. Of those 45 people, barely half (51%) saw a GP within 24 hours of arrival at the IRC[61] as required by Rule 34 DCR 2001.

For those that did not have a Rule 34 GP appointment, the average time to see a GP from arrival in detention was 29 days.[62] The longest time between arrival in detention and an individual appointment with a GP was 65 days, followed by 64 and 62 days.

Rule 35

Rule 35(1) and (2)

Our casework experience and research show that the first two limbs of Rule 35 DCR 2001 are seldom used, not because detention was not injurious to health in most cases or there were not many suicide risk cases, but because those safeguards were simply not being utilised in practice. As indicated in the recent quarterly statistics, in the year ending September 2022, there were 35 Rule 35(1) reports, 24 Rule 35(2) reports and 1,551 Rule 35(3) reports.[63]

The findings in our report *"Harmed Not Heard"* (2022) show that 87% of the 45 people analysed had suicidal and/or self-harm thoughts recorded by a Medical Justice clinician. Everyone in this group were at increased risk of suicide in view of their mental health issues and were isolated from their usual sources of support in detention. Remaining in detention carried a high risk of further deterioration in their mental health and, with this, an associated increasing risk of disturbed behaviour, self-harm and suicide. 44% of the group had suicidal or self-harm thoughts or episodes recorded in their detention medical records by IRC healthcare staff, including references to the Assessment Care in Detention and Teamwork (ACDT) regime to reduce self-harm and manage suicide risk.

However, no individual in our sample of 45 people had a Rule 35(2) report completed by IRC healthcare staff, despite Rule 35(2) DCR 2001 requiring a report to be completed if they suspect that someone "may have suicidal intentions". The lack of such reports is a known long-standing issue and deeply concerning as the clinical threshold for reporting is low. It is particularly difficult to understand why no such safeguarding reports were completed in light of the information in the medical records suggesting a significant proportion of people needed active management of their suicide risk in detention and urgent review of whether they should continue to be detained under the AAR policy.

The ICIBI, in its second annual review of the AAR policy, published in 2021, suggested that a possible cause for the high numbers of ACDTs, non-existent use of Rule 35(2) and the absence of any action to seek the release of detainees on ACDT may be the underlying staff culture of disbelief around self-harm and the perception among detention centre staff that detainees were faking and seeking to use self-harm to avoid removal.[64]

Concerns of the lack of Rule 35(1) and (2) DCR 2001 reports were also raised in the evidence to the Brook House Inquiry. The evidence uncovered a systemic misunderstanding amongst healthcare staff over the correct interpretation and application of Rule 35 DCR 2001. Key healthcare witnesses,

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[61] Medical Justice was unable to access the medical records of one individual at the time of their arrival in detention and one person who was held under STHF Rules 2018 and so was required to have a different type of screening.

[62] This statistic is based on an assessment of the records of 19 people, since it was not possible to determine the timing for 2 individuals.

[63] Home Office and Immigration Enforcement Immigration Enforcement data: Q4 2022 (Published 23 February 2023).

[64] ICIBI (October 2021) Second annual inspection of 'Adults at risk in immigration detention' July 2020 – March 2021 para 9.22.

including Ms Calver[65] and Dr Husein Oozeerally[66] the lead G.P. at Brook House IRC, showed a lack of understanding of the relevant thresholds for Rule 35 reports. Dr Oozeerally had never completed a Rule 35(2) report on suicidal ideation in the whole time he had been at the IRC – he had worked there since 2014.

Although a letter (April 2021) was sent jointly from the Home Office and NHS England reminding healthcare units in all IRCs of their obligations under Rules 34 and 35 DCR 2001 in light of the evidence of systemic failure, there has been no tangible improvement. Indeed, the recent report from the ICIBI's inspection of the AAR policy, found that: *"From a total of 538 reports received by the Home Office between April and June 2022, 517 were R35(3) (torture), 10 were R35(2) (suicidal intention) and 11 were R35(1) (physical health). Doctors often perceived that mental health symptoms could be managed in detention, without the need to bring them to the attention of the Home Office via a R35(1) or R35(2) report, despite these being engaged."*[67]

The Rule 35(3) DCR 2001 report is the mechanism whereby those at risk of harm in detention is most often identified, despite these reports only applying to survivors of torture. In practice, this means that, whilst people with a history of torture are likely to be highly vulnerable in detention, other indicators of vulnerability in some other people who will be at risk of harm in detention fall outside this definition and are not identified.

Rule 35(3)

Rule 35(3) is the limb of Rule 35 DCR 2001 specifically designed to identify and safeguard torture survivors. Whilst this is used much more frequently than Rule 35(1) and Rule 35(2), evidence to the Brook House Inquiry showed that these reports were also of a very poor quality. Dr Hard confirmed that three quarters of the reports he reviewed contained no information on the impact of detention, despite this being required by the AAR policy. The reports also failed to identify the psychological sequalae of torture and other symptoms of trauma which should be a "red flag" to end detention.[68]

In our analysis of 45 cases from July to December 2021,[69] 34 individuals had a Rule 35(3) DCR 2001 report completed. 76% of the 34 Rule 35(3) DCR 2001 reports did not directly identify the patient as at risk of harm in detention and no one had a separate Rule 35(1) report - as they should have done - to identify the risk of harm to their health due to continued detention. There is a failure to directly address harm in a substantial majority of Rule 35(3) DCR 2001 reports and to complete a separate Rule 35(1) DCR 2001 report to address the risk of harm to health in detention. This is concerning given the clinical research consensus about the likely harmful effects of detention on torture survivors and the actual harm that our clients (and others) have suffered. Indeed, of the 45 people in our report *"Harmed Not Heard"*, 82% were identified as experiencing a deterioration in their mental health as a consequence of detention by the time they were assessed by a Medical Justice clinician. The failure to identify the risk of harm caused by detention, and subsequently the failure to communicate that to the Home Office, means that the Level of evidence provided by the Rule 35 report is downgraded and limited to Level 2 and seriously undermines the effectiveness of the AAR policy as a safeguard against continued harmful detention.

Rule 35 delays

Our casework experience shows that delays occur between the identification of the need for an assessment and the Rule 35 DCR 2001 appointment taking place. Our findings from *"Harmed not*

[65] Sandra Calver, 1 March 2022, 217-225

[66] Dr Husein Oozeerally, 11 March 2022, 59-60

[67] ICIBI (12 January 2023) Third annual inspection of Adults at Risk Immigration Detention June to September 2022 para 3.5.

[68] Dr Jake Hard, 28 March 2022, 38/4-7

[69] Medical Justice Harmed not Heard (2022).

Heard" show that of 26 people who had a Rule 35 DCR 2001 appointment, and for whom their medical records show what triggered the appointment[70] the average time between identification of need for an assessment and the appointment taking place was 25 days. The longest time it took for someone to have their Rule 35 DCR 2001 appointment after identification that this was indicated was 253 days.[71]

In principle this system is predicated upon a Rule 34 examination, a Rule 35 report and a review of detention being undertaken within 3-4 days of the arrival at an IRC.[72] The delays are unacceptable and of serious concern given the levels of vulnerability and the deterioration that can occur during the delay. It also indicates systemic failure with the safeguard clearly not functioning as intended, namely to promptly identify vulnerable individuals and enable an urgent review of their detention and consideration of the need for release. The Home Office has been and is well aware of these long- standing problems but has consistently failed to act to address them.

Home Office responses to Rule 35

The Home Office is required to respond to a Rule 35 DCR 2001 report within two working days after receipt. Its response reviews the individual's suitability for continued detention in line with the AAR policy, the stated purpose of which is to protect vulnerable people who may be at increased risk of harm in detention.

For someone to obtain Level 3 evidence, and therefore be afforded the strongest presumption against continued detention, the AAR policy requires evidence demonstrating "that the individual is at risk and that a period of detention would be likely to cause harm". The requirement for evidence replaced the presumption of harm on the previous category-based system in Chapter 55 EIG and which reflected the clinical consensus - a major failing in the AAR policy. It is difficult to evidence harm before it has occurred, therefore the AAR policy operates in such a way that the risk of harm (and in some cases actual harm) will occur before Level 3 evidence is obtained and the presumption can be applied.

In our report *"Harmed not Heard"*, of the 27 available Home Office response letters to clients who had a Rule 35 DCR 2001 report, 74% were assessed as Level 2 and 26% were assessed as Level 3. However, only one Rule 35 DCR 2001 report led to a release of the client.[73]

The national quarterly statistics show that in the year ending September 2022, 21 out of the 35 Rule 35(1) reports; 10 out of the 24 Rule 35(2) reports and 621 out of the 1,551 Rule 35(3) reports led to release from immigration detention. Medical Justice tends to see the people who are still in detention after a Rule 35 report because of the time it takes for someone to find out about our charity and get in touch. So, these statistics show that the cohort of people who remain detained despite a Rule 35 report include some very unwell and vulnerable people.

All 45 people analysed in our report *"Harmed not Heard"* were identified by Medical Justice clinicians as being at risk of harm in detention, including people with both mental health issues and risk of suicide. Yet this risk was not routinely identified through the IRC and Home Office mechanisms.

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[70] For 8 people out of 34 that attended a Rule 35 assessment, it is not known what triggered the appointment from the medical re cords.

[71] For this individual it was 119 days until the appointment was scheduled, but the person did not go to the appointment, and it was rescheduled twice resulting in the appointment taking place with a 253-day delay.

[72] Home Office DSO Detention services order 09/2016 Detention centre rule 35 and Shortterm Holding Facility rule 32 Version 7.0.

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

Our report findings show that Rule 35 DCR 2001 reports were not effectively providing the Level of evidence necessary to secure release. Whilst the assessments completed by Medical Justice clinicians show a disturbingly high level of vulnerability and found that these individuals were at risk of harm in detention, they were not identified properly or at all as such by the detention safeguarding systems.

Overall, the extensive evidence to the Brook House Inquiry confirmed that that the AAR policy and procedures designed to identify and protect clinically vulnerable persons at particular risk of harm in detention, by effecting their prompt identification and release, were systemically failing. Evidence from Dr Hard indicated that the entire system was "dysfunctional".[74] He described a "deprivation of safeguards" which contributed to the mistreatment of vulnerable detained persons.[75] Our casework indicates that these issues continue today, across the detention estate. This is also supported by the recent findings of the ICIBI referred to above.

A cause and/or significant contributor to the conditions that lead to ill-treatment and abuse at Brook House in 2017, the subject of the Brook House Inquiry, was the dysfunction of Rule 34/35 DCR 2001 and the AAR policy. Such failings are at the heart of why there was (and continues to be) such a high incidence of highly vulnerable people in immigration detention at risk of and suffering harm, contrary to the statutory intention in s59 of the Immigration Act 2016[76] [77] which cannot be managed and treated in detention. As Dr Hard said: *"Without these safeguards being used to their full force, at the earliest opportunity, then it appears that … the only consequence [is] that people are likely to come to more harm"*.[78] This is the context in which high levels of use and misuse of force, segregation and other inappropriate management tools are used by detention staff without the appropriate skills, training and resources in an environment which is wholly unsuitable for such vulnerable people to be held.

There was no indication that the situation has improved since 2017. The systemic conditions for mistreatment in Brook House IRC environment have continued and persist. The findings of the IMB 2020 report about Brook House IRC, found that the whole detained population was subject to inhumane treatment[79], and identified the same continuing failures that operated in 2017 with similarly high levels of vulnerable people deteriorating in detention, evidenced by high levels of self-harm and suicidal ideation with correspondingly increased use of force and segregation. The IMB raised concerns to the Immigration Minister under s 6 of the DCR 2001 that "*a series of issues are collectively and cumulatively having an unnecessary, severe and continuing impact on detainees, particularly those facing removal on charter flights, as well as across the detainee population as a whole. We believe that the cumulative effect of these concerns amounts to inhumane treatment".*[80]

Our casework experience and evidence to the Brook House Inquiry both show an ongoing failure to complete Rule 35 reports properly, despite the high prevalence of mental illness in detention.[81] Dr Sarah Bromley, the National Medical Director for Health in Justice for Practice Plus Group (PPG), the

[74] Dr Jake Hard, 28 March 2022, 72/17-19
[75] Dr Jake Hard, 28 March 2022, 178/20-25 and 179/ 7-9
[76] Immigration Act 2016 s 59
[77] Immigration Act 2016: Guidance on adults at risk in immigration detention
[78] Dr Jake Hard, 28 March 2022 54/24-25 and 55/1-3
[79] IMB (2021) Annual Report of the Independent Monitoring Board at Brook House IRC for reporting year 1 January 2020 – 31 December 2020.
[80] M. Molyneux and L. Lockhart-Mummery, Letter to Chris Philp MP, Minister for Immigration Compliance and the Courts, Home Office, 2 October 2020.
[81] Dr Rachel Bingham, 14 March 2022, 34/4-13

current healthcare contractor, said with reference to the safeguard in Rules 34 and 35 DCR 2001, "it is likely that it will continue to be breached, particularly as numbers ramp up in Brook House".[82]

4. Prisonisation/criminalisation, institutional culture of dehumanisation, and racism

The evidence to the Brook House Inquiry identified as a cause or contributory factor for the mistreatment and abuse was what the Inquiry institutional expert Professor Mary Bosworth termed 'prisonisation' which is at the centre of the functioning of the detention estate. 'Prisonisation' refers to the physical design of the IRC, as well as the policies, practices, and regimes that operated to embed an institutional culture of inappropriate use and misuse of force, desensitisation and dehumanisation. These conditions meant that IRC staff felt they were "actually working in an institution that was effectively a prison with people who were therefore criminal and dangerous".[83]

The Inquiry heard unanimous evidence of witnesses that Brook House IRC looked and felt like a prison. Built as a category B prison, it was intended originally to be used only as a 72-hour holding centre for individuals facing imminent removal but was extended far beyond its original purpose. The physical environment was manifestly prison-like: cell-like rooms with heavy security doors; a concrete yard; cramped overcrowded conditions, toilets within cells and limited space for association. This was also reflected in how the centre was run: extended lock-ins, night patrols, and limited opportunities for association/exercise. There was overall clear evidence that the IRC ran an impoverished, punitive regime, driven by cost-cutting measures and substandard conditions. The cells were filthy, many toilets were unscreened and unhygienic, there was inadequate ventilation with detained people held for prolonged periods in conditions many found to be humiliating and degrading.[84] This has not changed, and many other IRCs, including Colnbrook IRC, are also built to category B specifications. Actual prisons such as HMP Morton Hall, Haslar and Dover have also been used as IRCs.

Professor Bosworth stated that the use of prison-based measures was inappropriate: IRCs are not the same as prisons and should not be using a prison-based model.[85]

The Detention Custody Officer training programme and language was found to also be prison-based, with an emphasis on security and counterterrorism.[86] Professor Bosworth was "quite clear" in her live evidence that the prison-like conditions, practices, and operation of the regime at Brook House IRC contributed to the mistreatment of detained people: "if you lock people up in a building that looks like a prison, you tell those people and the people who are looking after them that they are criminals…there's a sort of symbolism to it….that kind of symbolism was reinforced in training materials, in the language".[87]

The Brook House Inquiry heard that 'prisonisation' informed the conditions for desensitisation to and dehumanisation of detained persons by staff at Brook House IRC. One result of this was the entrenched scepticism amongst staff concerning symptoms of serious mental illness. People in acute distress or self-harming were labelled as 'manipulative' or 'attention-seeking'.[88]

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[82] Sarah Bromley, 1 April 2022, 168/1-7
[83] Professor Mary Bosworth, 29 March 2022, 13/23-25, 14/1-2, 39/18-22 and 46/10-12
[84] *R (Hussein and Rahman) v Secretary of State for the Home Department* [2018] EWHC 213 (Admin).
[85] Professor Mary Bosworth, 29 March 2022, 107/4-7
[86] Professor Mary Bosworth, 29 March 2022, 37/22-25, 38/1-12 and 63/9-14
[87] Professor Mary Bosworth, 29 March 2022, 13/7-21
[88] See for example the refrain from a DCO about a detainee who was on constant watch for self-harm/suicide attempts: "hurting yourself, you're attention-seeking aren't you, you little prick", TRN0000097_0002

A key aspect of dehumanisation was racism. Professor Bosworth was clear that this was institutional[89], agreeing with Stephen Shaw's findings from his 2005 PPO report on Oakington IRC (now closed down) that the risk of racism and abusive practice was inherent in the IRC system[90]. Evidence of pervasive racism was identified amongst G4S staff by the Mubenga Inquest in 2013[91] and by undercover reporting at Yarl's Wood IRC in both 2004 and 2015.[92]

Despite previous findings of racism and warnings of the risk of a repeat by Stephen Shaw and others, it was evident that no effective steps had been taken by the Home Office or G4S to address these risks and that institutional racism was embedded in Brook House IRC.[93]

5. Use of Force and segregation

Medical Justice has consistently identified issues with the misuse of force and segregation in immigration detention. Our 2015 report *A Secret Punishment* highlighted how segregation is one of the most severe and dangerous sanctions that can be imposed on detainees - it's devastating impact on mental and physical health is widely recognised. Yet, there has been surprisingly little effective scrutiny of its widespread use in IRCs.

More recently, the evidence to the Brook House Inquiry has demonstrated how the unlawful and/or inappropriate use of coercive measures, such as restraint, the use of force and segregation was used as the default means to manage mentally unwell detained individuals including those who lack mental capacity. This was an important context for and contributed to the conditions leading to mistreatment and abuse at Brook House IRC.

Jon Collier, the Inquiry's Use of Force (UoF) expert, identified from the 43 Use of Force incidents he reviewed, recurrent concerns of force not being lawfully used as a last resort; lack of de-escalation attempts; inappropriate blanket use of Personal Protective Equipment (riot gear and shields); and, most critically, the inappropriate use of force on those with mental illness including force used to transfer people into segregation as well as for removal. There was an alarming pattern of excessive use of force on naked detained people as a result of a practice early morning no notice removals. An example captured on late disclosed body worn footage was of a man subject to prolonged unlawful control and restraint, whilst naked, to facilitate his charter flight removal. He was highly vulnerable, on constant observations. He was restrained supine on the ground, before being handcuffed in an impermissible sitting position and taken by unsafe and pain inducing carry technique for handover to escort officers. This technique was banned following review into the death of James Mubenga in 2015 but still used in Brook House in 2017. This man was also put into a waist a restraint belt, leg restraints, and rigid-bar hand-cuffs. Until addressed by the Inquiry expert this use of force and patently humiliating and degrading treatment was accepted to be lawful and no issues of concern were raised by any member of staff, manager or independent motioning body. Overall Mr Collier was of the view that what he was able to review was likely just the "tip of iceberg".

Mr Collier also agreed with Dr Brodie Patterson (another use of force expert in the Inquiry) that such prison and pain based techniques are particularly problematic for those in mental distress or whose capacity is compromised who may have impaired responses to the use of pain, and it risks

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[89] Professor Mary Bosworth, 29 March 2022, 97/10-13

[90] PPO (2005) *PPO Inquiry into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort*, 3-4.

[91] Report by Assistant Deputy Coroner Karon Monaghan QC under the Coroner's Rules 1984, Rule 43: Inquest into the Death of Jimmy Mubenga, 23 July 2013.

[92] 76 See Witness Statement of Emma Ginn, §14, BHM000041 0004-5 and §§121-122, BHM000041_0043-44

[93] See Annex 5 to Duncan Lewis Closing Submissions - Instances of racist language in disclosure, DL0000264.

prolonged, more extreme force and treatment. The fact and/or risk of unlawful and/or inhuman and/or degrading treatment was evident.

A "perfect storm" of conditions exists, which give rise to the conditions for mistreatment. In a context in which staff lack the skills and therapeutic tools or resources to care for vulnerable detained persons, treating their distressed behaviour as refractory recourse to coercive measures is inevitable.[94]

There was clear evidence that there was very poor governance of the use of force, which facilitated the persistent misuse of force and abusive practices. These failings in oversight by both G4S managers and the Home Office officials contributed to a climate of impunity where the abusive use of force and excessive force persisted unchecked. There were patterns of officers not using body-worn footage cameras as required, which could be to avoid accountability,[95] as well as evidence of actual active cover up and collusion in the failure to record and report use of force by both detention and health care staff.[96] The choking and threats to kill recorded by BBC Panorama was not reported by either the detention staff or the nurse present when it occurred.

This misuse of force is likely to be continuing across the detention estate. For example, documents obtained by Liberty Investigates through requests under the Freedom of Information Act revealed an excessive use of force during the intensive period of 22 charter flights from Brook House IRC, between July and December 2020. The documents reveal that guards using force remained on duty, despite being "effectively uncertified" in the safe use of restraint techniques. Those subjected to the use of force included suicidal asylum seekers. The documents showed that "Officers used force, including techniques that deliberately cause suffering to gain compliance, – called pain-inducing restraint – to prevent self-harm on 62 occasions from July to December, (including 20 in August alone). The population of Brook House IRC was around 100 people at any one time."[97] The documents also showed high rates of self-harm. This was at the time at which the IMB 2020 report on Brook House IRC found that the whole detained population was subject to inhumane treatment.[98]

Witness evidence from the IMB, one of the UK's monitoring bodies under the optional protocol to UNCAT, described of a wholly inadequate response from the Home Office to the 2020 Report. The IMB described the response as having "just a total disconnect and not, in my view, acknowledgement of the problem and the issues we had raised".[99]

Evidence of the use of handcuffing and restraints after individuals had self-harmed at Manston STHF have also come to light. Use of Force reports from October 2022 reveal how staff restrained detained individuals and locked them in "cell vans" where some began self-harming.[100]

HMCIP's 2022 report on Brook House IRC, based on an inspection between 30 May and 16 June 2022, reported several instances of prolonged solitary confinement and segregation, which may

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[94] Dr Rachel Bingham, 14 March 2022, 55/3-15

[95] Jon Collier, 30 March 2022, 157/3-25 and also 158/1-2

[96] CJS0073840-Nursing-Midwifery-Council-Fitness-to-Practise-Committee-decision-Jo-Buss-dated-23.02.pdf and Jo Buss, 14 March 2022.

[97] https://libertyinvestigates.org.uk/articles/revealed-guards-used-force-on-suicidal-asylum-seekers-after-training-had-expired/

[98] IMB (2021) Annual Report of the Independent Monitoring Board at Brook House IRC for reporting year 1 January 2020 – 31 December 2020.

[99] Closing submissions of Bhatt Murphy Core Participants 172.

[100] https://libertyinvestigates.org.uk/articles/asylum-seekers-at-manston-were-handcuffed-restrained-and-struck-internal-docs-show/

have resulted in an abuse of the detained persons' rights. The report stated that "Detainees were inappropriately locked in cells overnight. They could have been left unlocked if they had been given a key to their cell and if there had been sufficient staffing at night."[101] HMCIP highlighted two cases in particular, stating: "we looked at two cases where the justification for separation was poor, both involving the segregation of the victim of an assault. It was a concern that the unit had held a number of detainees with poor mental health, including at least one who was considered unfit for detention".[102]

6. Prolonged cell confinement of immigration detainees held in mainstream prisons

People detained under immigration powers may also be held in prisons, rather than IRCs. During the Covid-19 pandemic we had concerns about the use of prolonged cell confinement for detained people under immigration powers in prisons. These concerns are documented in a joint report with Bail for Immigration Detainees, titled *"Every day is like torture": Solitary confinement & Immigration detention* (2021).[103] This report documented witness statements from 5 individuals, reviewed 30 bail cases, and 6 MLRs. This report shows that since the start of the Covid-19 pandemic in March 2020, prolonged confinement is a practice that has become widespread in prisons, with people being held in their cells for 22 to 24 hours a day initially to contain the spread of Covid-19. We are concerned that the conditions and lengths of isolation amount to prolonged solitary confinement, which is prohibited by the UN Standard Minimum Rules for the Treatment of Prisoners (the 'Mandela Rules') and may breach individuals' Article 3 right not to be subject to cruel, inhuman and/or degrading treatment.

Prolonged cell confinement causes profound harm to individual's health and well-being. Our clients have described confinement as "psychological torture", feeling "trapped", "hopeless" and "suffocated". Symptoms were severe, including involuntary shaking, memory loss, physical pain and insomnia. Detained people with high-risk mental health conditions, including diagnoses of PTSD, severe depression, a history of self-harm and/or suicidal thoughts have experienced serious deterioration in such confinement. The experiences of our clients reflect the overwhelming medical evidence of the harm that prolonged solitary confinement causes; it is well established that by depriving people of meaningful social interaction and any sense of control, confinement causes damage to individuals' mental health, which can last beyond release. It can cause deterioration in those with pre-existing mental health conditions and precipitate the onset of new conditions. We also found a concerning lack of medical support available to people confined in prisons.

Since the covid-19 pandemic, this issue is not as prevalent. From our casework we know that clients who have education and work can leave their cells. We have some clients who do not have education or work, or are in prisons where there is limited provision, who are often still locked in for 23 hours a day.

7. Lack of accountability, oversight and institutional culture of impunity

There is a serious lack of oversight and accountability in IRCs due to the make-up of multiple contracted companies working in the centres. There is no robust oversight by the Home Office or process operated by the Home Office for effective monitoring of these contractors. Furthermore, there is no effective process for feeding back criticism made by others to those responsible such as managers of detention centres and G4S senior officials, individual decision makers, and healthcare staff. The Home Office does not have effective systems to learn or review after findings of unlawful

[101] HMIP (23 September 2022) Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons (30 May – 16 June 2022) 6.
[102] HMIP (23 September 2022) Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons (30 May – 16 June 2022) 12.
[103] Medical Justice and Bail for Immigration Detainees "Every day is like torture": Solitary confinement &Immigration detention (2021).

practice including Article 3 ECHR breaches in the detention context or following inquest jury findings. Without making systemic changes in light of such findings, it is unsurprising that little has changed.[104]

The lack of oversight and monitoring was clear in the evidence to the Brook House Inquiry; although it was found that the mistreatment and abuse was widespread in 2017, it was not identified by any internal process due to a toxic closed rank G4S staff culture, operational failings by G4S senior officials and also failings in Home Office oversight, an ineffective and corrupted complaints system. Additionally, there were failures in scrutiny by the external monitoring bodies, Independent Monitoring Board (IMB) and HMCIP who were not sufficiently robust in their structure or practices to identify the incidence and climate of abuse at Brook House IRC.

These systemic failings reflect the institutional culture and practice within the Home Office, including at its senior levels, of a resistance to recognising and understand its failings as well as willingness to address them. The Home Office has a history of failing to act on the recommendations from independent monitoring bodies, such as from HMCIP and the ICIBI and from reviews and investigations. As set out above, the Home Office has abandoned its commitments made following the Shaw Review to reduce the use of detention overall and for vulnerable people in particular, and recently ended the annual inspection it previously commissioned of the AAR policy by the ICIBI. The Home Office has also discontinued recommendation 10 from Wendy Williams' Windrush Review which had recommended a review of the remit and role of the ICIBI. This represents a significant downgrading of independent scrutiny and clearly indicates that the Home Office is intent on reducing independent monitoring of its practices despite clear evidence of continuing systemic failures.

8. Recent developments

We would like to draw the CPT's attention to four particular developments that have recently occurred in immigration detention settings.

a. The UK's plans to remove asylum seekers to Rwanda

In April 2022, the UK Government entered into a Migration and Economic Development Partnership (MEDP) with the Rwandan government. This agreement enables the UK to forcibly remove people whose asylum claims are deemed inadmissible[105] and who arrived by "dangerous" and "illegal" routes, to Rwanda to have their asylum claims processed there. They will not have the option to return to the UK.

The only scheduled removal flight to Rwanda was stopped at the eleventh hour on 14th June 2022 as a result of intervention by the European Court of Human Rights (EctHR). Decisions that people's asylum claims are inadmissible and to remove them to Rwanda have not been withdrawn. More people are still receiving notifications that they may be removed to Rwanda. Even without actual removals taking place, the MEDP is already having a profound adverse impact on those affected by it.

In the summer of 2022, Medical Justice was contacted by over 50 individuals who had received a notice that they may be removed to Rwanda, whilst they were in immigration detention.

[104] See Phil Schoenberger, 23 March 2022, 16/14-25, 17/1-4 and 17/5-15 and Reverend Nathan Ward, 7 December 2021, 167/23-25 and 168/1-4

[105] Asylum claims may be treated as inadmissible where the person has "a specified connection to a third country which is assessed as safe" and means that the "Home Office is not required to consider the asylum claim". See Home Office Guidance (2022) 'Inadmissibility: safe third country cases' Version 7.0. p.10.

At that time, people were only being served a Notice of Intent (NOI) for removal to Rwanda whilst in detention. A pattern emerged whereby some people who had arrived to the UK by small boat across the Channel would be detained upon arrival and transferred to the Short Term Holding Facility (STHF) at Yarl's Wood IRC. They would then have their initial asylum screening interview (the first stage of the asylum process), before being served an NOI, all whilst in detention.

Since late August 2022, people started being released from detention, and NOIs have since been served on people in the community.

However, there remains a serious concern that the harm that occurred to those whilst in detention, could be repeated again; if the government is able to schedule flights to Rwanda, which it repeatedly says it will, this will undoubtedly involve detention before removal on a removal flight.

Medical Justice analysed the casefiles of 36 individuals referred to us between May and July 2022 who were served an NOI whilst in detention, as published in our report *"Who's Paying the Price"*.

Vulnerability of the client group

Out of the 36 people reviewed in this report:

- At least 26 had indicators of a history of torture and at least 17 had indicators of human trafficking.[106]

Out of the 17 people Medical Justice clinicians conducted clinical assessments for:

- 15 had a diagnosis or symptoms of PTSD or complex PTSD.
- 1 is likely to have a psychotic disorder and lack capacity to even instruct his solicitor.
- 1 requires urgent investigations to rule out recurrence of a previous brain tumour.
- 11 people were found to have suicidal thoughts whilst they were in immigration detention. This includes one person who attempted suicide twice.
- 13 assessments found that detention is already or likely to have already caused harm to the client or that the client is likely to have already deteriorated in detention.
- 16 assessments conclude that treatment would only be effective upon release from immigration detention, in a safe and stable environment.
- Some were clinically considered to be at high risk of suicide if threatened with removal Rwanda.

Ineffective Safeguards

Our analysis revealed that detention safeguards were ineffective at identifying and protecting vulnerable individuals. We analysed those of the sample of 36 people who had a Rule 35 DCR 2001 report or an equivalent report under Rule 32 of the Short Term Holding Facility Rules (STHFR) 2018[107] for those held in STHFs.

Out of the sample of 36 people, the Rule 35 DCR 2001 or Rule 32 STHFR 2018 report and the Home Office responses to the reports, was available for 21 cases. All 21 Rule 35 DCR 2001/Rule 32 STHFR 2018 reports were under the third limb. There were no reports under the first or second limbs (Rule 35/32(2) or Rule 35/32(1)). The Rule 35 DCR 2001/Rule 32 STHFR 2018 reports did not mention the impact of the NOI or removal directions for Rwanda. The Home Office did not release anyone in response to a Rule 35 DCR 2001/Rule 32 STHFR 2018 report, who had a NOI for Rwanda. Detention was often justified on the basis of imminence or likelihood of removal. This includes 11 people who

[106] The number does not add up to 36 people because some had indicators of both torture and trafficking histories.
[107] The Short Term Holding Facility Rules 2018.

had their Rule 35 DCR 2001/Rule 32 STHFR 2018 report on or after the day of the scheduled flight on the 14th of June 2022.

As these individuals had recently arrived in the UK, there is no evidence that they would not comply with any reporting conditions or pose an absconding risk. Detention was not a measure of last resort and was the default for those issued with a NOI. The Home Office responses to Rule 35 DCR 2001/Rule 32 STHFR 2018 reports cited multiple reasons, including the following, as to why people may not stay in contact with the Home Office if they were released:

- They crossed the channel on a small boat and that this is an "illegal" and "dangerous" mode of entry;
- They have passed through another safe country;
- They did not claim asylum in the first safe country they passed;
- They have not agreed to return voluntarily.

Given the geographical location of the UK and the absence of legal routes, this is likely to apply to the vast majority of people seeking asylum in the UK.

For some, the Home Office recognises that outstanding protection claims may incentivise people to remain in contact, and that people have not yet been tested on reporting restrictions.

Moreover, as none of them have known criminal histories, the risk they pose to the public ought to be deemed low. The Rule 35 DCR 2001/Rule 32 STHFR 2018 report responses tend to recognise this, but nevertheless maintain detention.

<u>Impact of NOI on mental health</u>

Medical Justice clinicians conducted medico-legal assessments for 17 individuals who received a NOI for removal to Rwanda whilst in detention. They found that the prospect of removal to Rwanda exacerbated the mental health conditions of people in detention (including depression, anxiety and PTSD). It caused people to experience fear, confusion, uncertainty about their safety, and a loss of hope.

Medical Justice clinicians found that for some, the prospect of removal to Rwanda increased their risk of self-harm and suicide. Some individuals were clinically considered to be at high risk of suicide if threatened with removal Rwanda.

For some, the fear associated with removal to Rwanda, has reduced their resilience to the psychological effects of trauma and contributed to their worsening mental health symptoms and may have interfered with their ability to engage with treatment.

The experience of constant fear for their futures means that individuals facing removal to Rwanda are denied a sense of security and safety, therefore causing distress and exacerbating their mental health symptoms. The experience of such fear is noted to be is a strong re-traumatising factor which impacts the effectiveness of any treatment accessed while they remain in the UK subject to removal to Rwanda, and once they are removed to Rwanda. Specifically, PTSD symptoms are highly sensitive to insecurity or a lack of sense of safety, so the likelihood of success of treatment would be significantly decreased. It is important to note that the prospect of removal is enough to create this impact; people experienced this harm regardless of the situation they might encounter in Rwanda and despite the removals not going ahead. This highlights the damage that is already being caused by this policy.

Medico-legal reports (MLRs) record that for some individuals, the effect of the possibility of removal to Rwanda is similar to that of removing someone to their own country of origin, where they have fled persecution, because they do not perceive Rwanda to be a safe country or they believe that they are likely to be removed onwards to their country of origin from Rwanda.

There is real concern that if vulnerable people are detained in the future for the purposes of removal to Rwanda, the impact of both the prospect of removal and the detention environment will cause serious harm, and the safeguards will not identify or protect them from such damaging impact.

b. Harmondsworth power outage

In November 2022, there was a power outage at Harmondsworth IRC that lasted up to three days. We have concerns about how people were adversely impacted during the power outage.

Clients reported that detained people were left without light, heating, hot food, running water, and toilet facilities, and some were not given their regular medication. People were not able to charge their phones to contact family members or lawyers. We understand that people were locked in their cells for three days, and not allowed to leave.

Clients also informed another charity, Bail for Immigration Detainees, that some people who were made to stand outside in the courtyard for approximately four hours without hot drinks or toilet access.

There was a lack of information and communication about what was happening. When people were eventually moved out of the detention centre, people were being taken without any of their belongings and subsequently had nothing but the clothes that they were wearing. Others reported being told to pack a bag but having to wait hours for a bus.

As explained above, many held in immigration detention have histories of torture or other serious ill-treatment and trauma. The power outage and the resulting conditions are likely to have been particularly distressing for those whose trauma histories include experiences of being imprisoned or held against their will, being kept in isolation, being kept in the dark and being exposed to unsanitary conditions. It may have triggered flashbacks and nightmares, intense fear, agitation, and possible dissociation for those with PTSD symptoms.

This power outage followed repeated shorter power cuts in the preceding months at both Harmondsworth and Colnbrook IRCs. There does not seem to have been any adequate contingency plans. We submitted a request under the Freedom of Information (FOI) Act requesting the *"internal investigations into what went wrong and found that "a lack of preventative routine maintenance" caused "multiple power failures""*.[108] The internal investigations, as disclosed in the response to the FOI request, found that *"a lack of preventative routine maintenance" caused "multiple power failures"*.

One report dated September 2022 listed maintenance actions to be carried out *"as soon as possible",* warning that if they were not carried out, *"the establishment will remain at risk".* A second report from November 2022 stated that the issues identified in the maintenance system must be *"urgently addressed"*.

We are concerned that holding people in such conditions for up to three days was unlawful and could amount to a breach of Article 3 ECHR.

[108] Request Number 74033 submitted under the Freedom of Information Act on 17 January 2023. Response received on 8 February 2023.

Along with Bail for Immigration Detainees, Medical Justice wrote to the Home Secretary and the Home Office about our concerns, together with a series of questions and a call for an independent investigation into what happened. We have not received a response.

c. Manston

Manston, formerly a military base in Kent, opened in early 2022 as a non-residential STHF. With a maximum capacity of 1,600, Manston was overcrowded with the number of people detained there nearing 4,000 towards the end of 2022. The conditions have been criticised by independent inspectorate bodies and parliamentary committees, and widely reported in the media.

The ICIBI published a report following a visit to Tug Haven and Western Jet Foil in July 2022, raising concerns about overcrowding and hygiene at Manston.[109] David Neal, the ICIBI, visited Manston again on 24 October 2022 and gave evidence to the Home Affairs Select Committee (HASC) on 26 October 2022. He told the HASC: "*I was very concerned about Manston when I visited on Monday — as concerned, perhaps, as I have been about anything over recent years. It is a really dangerous situation. It is failing to address vulnerability. It is not something that I have any frame of reference to understand in terms of detention. I have been involved in detention a lot. There are risks there in terms of fire, in terms of disorder, and medically in terms of infection…*".[110]

He highlighted the level of overcrowding, confirming that 2,800 people were detained at Manston on the day he visited. He described the conditions at Manston as *"pretty wretched"*[111] with nearly 2,500 people being guarded by untrained detainee custody officers (DCOs)[112] and there being no full-time doctor or medical ward on site until 24 October 2022[113].

The HMCIP, having inspected Manston in July 2022, published their report in November 2022.[114] Their priority concerns included:

- *"Exhausted detainees were regularly held for more than 24 hours in non-residential accommodation".*
- *"Governance of health care processes was weak"*
- *"Detainees' vulnerability was not always recorded to inform subsequent assessments. Detainees with disabilities and trafficking victims were held at Manston, but no detainees had been designated as adults at risk."*
- *"Some children were detained for too long. The documented average length of detention for unaccompanied children was 27 hours and the longest was 48 hours."*

The Home Affairs Select Committee, the Justice Committee, the Women and Equalities Committee and the Joint Committee on Human Rights all wrote jointly to the Home Secretary on 2 November 2022.[115] The letter raised *"deep concerns about the dire conditions"* at Manston. They expressed shock at the evidence of *"the overcrowded and degrading conditions"* and highlighted the lack of

[109] ICIBI (July 2022) An inspection of the initial processing of migrants arriving via small boats at Tug Haven and Western Jet Foil December 2021 – January 2022.
[110] Home Affairs Committee Oral evidence: Channel crossings, HC 822 Wednesday 26 October 2022 Q146.
[111] Home Affairs Committee Oral evidence: Channel crossings, HC 822 Wednesday 26 October 2022 Q113.
[112] Home Affairs Committee Oral evidence: Channel crossings, HC 822 Wednesday 26 October 2022 Q112.
[113] Home Affairs Committee Oral evidence: Channel crossings, HC 822 Wednesday 26 October 2022 Q114.
[114] HMCIP (November 2022) Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston.
[115] Letter From the Chairs of the Committees on Home Affairs, Women and Equalities, Justice and the Joint Committee on Human Rights (02 November 2022).

"clear lawful basis for detention of individuals beyond 24 hours in holding rooms (or five days for holding facilities".

The media reported on the cases of diphtheria at Manston, in Autumn 2022. Recent responses to FOI requests, as reported in The Guardian, have revealed that the Home Office was warned about needing to improve infection control measures at Manston, weeks before the diphtheria outbreak.[116] The FOI revealed concerns about a lack of handwashing facilities, some toilets being blocked and overflowing, and confusion around the release of people from Manston who may have had infectious conditions.[117]

The CPT will be aware of the overcrowding, unsanitary conditions, and cases of diphtheria, having visited in November 2022.

Use of force

Responses to Freedom of Information requests for the use of force forms from October 2022 at Manston, obtained by Liberty Investigates, revealed concerning incidents of force.[118]

The documents reveal incidents of detained people being pinned to the ground and beaten after hitting their heads against a wall, detained people being forcibly restrained after asking for food, and one individual who was injured in a fight to have received "unacceptable" medical care as it was assumed that he was "faking it". Reports from a DCO who raised concern about the situation, reported that the person was treated in a "completely unacceptable" way and that situation was made out as "a joke".

It further revealed incidents of staff working for a private security contractor on site, Interforce, using force but apparently completing no documentation after such restraint. For private security staff to use force despite not having the necessary training, accreditation and qualifications poses dangerous risks for the detained people involved. If performed incorrectly, use of force techniques can have devastating consequences. Not completing use of force forms is extremely concerning because it prevents accountability, means abuse is not detected and lessons cannot be learned.

The information uncovered about the use of force at Manston points to a similar culture of abuse as uncovered at other immigration detention sites. It indicates that there has been little learned from the Brook House Inquiry evidence and raises serious questions about what oversight there is regarding the use of force.

We are concerned that the conditions at Manston are likely to have amounted to inhuman and degrading treatment in violation of Article 3 ECHR, including:

- Overcrowded living conditions
- Lack of beds resulting in people, including children, sleeping on thin mats on the floor
- Unclean and unhygienic facilities
- Inadequate food provisions and some days without sufficient food or drinking water
- Lack of privacy
- Lack of adequate medical care
- Spread of infectious diseases, including diphtheria
- Restrictions on when people detained at Manston could leave tents

[116] Diane Taylor, (6 February 2023) Manston health concerns raised with Home Office weeks before outbreak, The Guardian.

[117] Diane Taylor, (6 February 2023) Manston health concerns raised with Home Office weeks before outbreak, The Guardian.

[118] Lizzie Dearden, Aaron Walawalkar and Eleanor Rose (4 February 2023) Revealed: Shocking accounts of migrants handcuffed and self-harming in UK's chaotic asylum system, The Independent.

- Unchecked and likely highly dangerous use of force but untrained staff

New STHF (Amendment) Rules 2022

As outlined above, the new STHF (Amendment) Rules 2022 were laid before parliament on 15 December 2022 and came into force on 5 January 2023.

There was no opportunity for meaningful stakeholder engagement or parliamentary scrutiny.

The STHF (Amendment) Rules create a new category of detention facility, called a Residential Holding Room (RHR), where detained people can be held for up to 96 hours (extendable in exceptional circumstances). The introduction of this new category of facility appears to stem from a desire to be able to detain a larger number of people for longer than the 24 hours permitted in normal holding rooms, without offering the safeguards and facilities required in a Residential Short Term Holding Facility (STHF). It appears that Manston, even with any improvements that may be being made currently, will still fall short of the (relatively modest) requirements for being a residential STHF and that therefore it was deemed a new category is required.

Compared to residential STHF, safeguards are substantially diminished, including by the following changes:

1. Rule 32: The proposed changes dramatically raise the bar for vulnerabilities being identified and notified to the Home Office. This is because the mandatory timeframe for reviewing detention in light of evidence of vulnerability is removed. Moreover, the specific safeguard for survivors of torture is removed entirely for those held in RHRs.
2. Rule 13: The requirement to ensure that, from within a room used for sleeping, people can communicate with an officer at any time in order, for example, to alert the officer that a person is ill or requires help, appears to have been removed.
3. Rules 14 and 15: Detainees may be required to share sleeping accommodation with unrelated persons of the opposite sex and children with unrelated adults.
4. Rule 27: There is no guarantee that an individual in a RHR can meet with their legal adviser (unlike in an STHF) – the requirement for a detained person to be able to meet with their legal advisor is subject to the proviso that this is 'practicable'. To facilitate effective access to legal advice and representation it is essential that detained persons are able to communicate effectively with legal advisers, are able to send and receive documents in a timely manner. Sometimes effective communication is not possible remotely and face to face meetings will be required.
5. Rules 31: Access to medical care can be limited to those who are ill or sustain an injury. This particularly concerning as many of those held in RHRs such as Manston will have just experienced a difficult journey and may be unwell or injured. Some will have very recently escaped persecution or modern slavery. Some will have injuries such as fuel burns from dangerous boat crossings. Many will not speak English and may have difficulty in effectively communicating their need to be seen by a healthcare practitioner. Some will be reluctant to disclose sensitive information regarding their health condition to others, in order to gain access to a healthcare professional. In these circumstances it is essential that detained persons have prompt, unobstructed access to healthcare provision, even if it is not immediately obvious to an officer or other member of staff that they are ill or injured.

d. Quasi-detention and accommodation centres

Since spring 2020, the government have been developing and using new large scale institutional facilities to accommodate people seeking asylum. These facilities replicate many of the features of immigration detention, even though residents are not formally detained. They have therefore frequently been referred to as 'quasi-detention'.

Facilities have been opened on ex-military sites, including at Coltishall in Norfolk (now closed, despite an attempt to reopen it in 2022), Penally in Pembrokeshire (now closed) and Napier in Folkestone (still open). Abandoned atempts to open similar sites occurred in Barton Stacey in Hampshire, a facility on the Yarl's Wood IRC site in Bedfordshire, and at an ex-military base in the rural village of Linton-on-Ouse in North Yorkshire.

These sites have all been subject to controversy due to the poor conditions, limited access to services and support including legal advice, the risk of harm to people held there and the lack of government consultation with local communities. The conditions at Napier and Penally have been highlighted by the All-Party Parliamentary Group's Inquiry into Quasi-Detention (2021).[119] Their report found Napier and Penally to be "fundamentally unsuitable" to be used as asylum accommodation. For survivors of torture, trafficking or other serious forms of violence – as many asylum-seekers are – the prison-like conditions can cause them to relive past abuses and be highly re-traumatising. Serious operational failings by the Home Office and its contractors in the running of the sites created "appalling treatment and conditions" which has left asylum seekers placed there feeling "dehumanised, exhausted and suffering a profound deterioration in their mental health, in some cases to the point of attempting suicide".[120]

Housing large numbers of people seeking asylum in such concentrated sites risks exposing them to racist and xenophobic harassment and violence. In a judgment handed down on 24 June 2022, the High Court ruled that the Secretary of State's decision to grant herself permission for a further 5 years was unlawful. The judge ruled that there was a failure to have proper regard to the Public Sector Equality Duty and that the development raised *'very obvious issues…in particular in relation to…potential victimisation and harassment…and the fostering of good relations'*.[121]

We have concern about the government plans to continue attempts to open such institutional accommodation facilities. In the Levelling Up and Regeneration Bill[122], Clause 101 allows the 'appropriate authority' to apply to the Secretary of State, instead of the Local Planning Authority, for planning permission, specifically where a development on Crown Land in England is considered to be of national importance and urgent, or of national importance and not urgent. This would remove the obligation to consult local communities about planning developments, thereby avoiding public scrutiny. We are concerned that this will allow the Government to bypass controls that currently exist when developing large-scale institutional facilities to accommodate asylum seekers in the UK.

It appears that further such facilities are planned. There have been recent reports of the government earmarking £70m to a contract specifically for reception centres[123] and of a new asylum accommodation site at MDP Wethersfield[124] and the former Royal Airforce Scampton in Lincolnshire[125].

e. Nationality and Borders Act 2022

[119] All Party Parliamentary Group on Immigration Detention (December 2021) Inquiry into quasi-detention – full report
[120] All Party Parliamentary Group on Immigration Detention (December 2021) Inquiry into quasi-detention – full report.
[121] https://dpglaw.co.uk/high-court-home-office-self-grant-of-planning-permission-for-napier-asylum-camp-unlawful/
[122] Levelling-up and Regeneration Bill
[123] Home Office (last updated 22 December 2022) Home Office procurement pipeline.
[124] Diane Taylor (4 March 2023) Ministers urged to drop plans for asylum centre at former RAF base in Essex, The Guardian
[125] Illegal Migration Bill: 7 Mar 2023: House of Commons debates - TheyWorkForYou

Several provisions of the Nationality and Borders Act, including Sections 27 (detained accelerated appeals), 29 (removal to safe third countries), 40 (illegal entry and similar offences) and 48 (matters relevant to decisions relating to immigration bail) have the stated purpose and potential to greatly expand the UK's use of immigration detention, and on the basis of past experience and current practice therefore increase the risk of arbitrary immigration detention, mistreatment and abuse. At the time of Brook House abuse scandal in 2017 an additional 60 beds had been added to the Centre (and others) with increased use of Charter flight removals and high levels of vulnerable people in detention. As set out above, at various other times, these patterns have been repeated where the use of detention has increased, especially when combined with an accelerated process for removal on Charter flights such as during the second half of 2020 in Brook House and in May-August 2022 in relation to those detained for potential removal to Rwanda. During those times the anguish and distress of people detained in IRCs escalated, mental health deteriorated along with self-harm and suicidality. We now know that in 2020 the IMB at Brook House IRC identified 'inhumane treatment' of the entire detained population in that IRC at the time because of those conditions. Relevant IMB reports covering the period in 2022 are not yet available.

The Nationality and Borders Act 2022 provides for the re-introduction of an Accelerated Detained Appeals (ADA) process (section 27), following the suspension of the previous Detained Fast Track (DFT) process in 2015 after it was found to be systemically unfair and unjust by the courts[126] and after evidence of the continued systemic failure of screening and safeguards for unsuitable case and people that was particularly disadvantaging those with vulnerability.

So far, the Home Office have not been able to provide any reassurance that a new ADA process will not recreate the same systemic unfairness, and thereby put asylum seekers at risk of removal to countries where they may face persecution including torture and inhuman or degrading treatment. The Home Office have stated that only those whose cases have been certified as being suitable for processing under the detained accelerated process will be routed into the process. However, the mechanisms for identifying who is unsuitable rely on the same failing safeguards currently in place (the Rule 34/35 process, Adults at Risk Statutory Guidance, gatekeeper review, asylum screening interview) many of which were already in play and failing when the DFT process was suspended in 2015.

The Tribunal Procedures Committee consultation document, referred to the Home Office assertion that they have considered "an effective screening process is in place" - which must be a precondition for it lawful and fair operation but plainly none of the current safeguards constitute "an effective screening process".

f. Illegal Migration Bill 2023

The Illegal Migration Bill was published on 7 March 2023.[127] It has grave implications for immigration detention in the UK.

Its overall stated purpose is to "prevent and deter unlawful migration", particularly for those coming to the UK by "unsafe and illegal routes".[128]

[126] *Lord Chancellor v Detention Action* EWCA Civ *and R (on the application of) Detention Action v Secretary of State for the Home Department* [2015] EWCA Civ 840.
[127] Illegal Migration Bill (2023).
[128] Introduction, Illegal Migration Bill (2023).

Clause 11 introduces a new power to detain if the person is or seems to be subject to the duty to remove. The Home Secretary's duty to remove is set out in Clause 2 as the duty to remove those who satisfy the following four conditions:

1. Entered the UK in breach of immigration law;
2. Entered or arrived in the UK on or after 7 March 2023;
3. Entered or arrived from a safe third country;
4. Required leave to enter or remain in the UK but does not have it.

These provisions would allow for a dramatic increase in the powers and use of immigration detention, for a group of people, many of whom are particularly vulnerable to suffering harm if placed in immigration detention. The vast majority of those arriving in small boats are asylum seekers. As set out above, there is consistent evidence that asylum seekers in general have a high rate of poor mental health, including PTSD, placing them at increased risk of being harmed by detention. The top 5 nationalities of people arriving by small boats are from countries where torture occurs and is frequently recorded, including Afghanistan, Iran and Syria. It is highly likely that the provisions in the Illegal Migration Bill will lead to large numbers of torture survivors being detained, again placing them at risk of suffering harm in detention.

Clause 11(2B)-(2E) provides for the reintroduction of a power to detain families with children and unaccompanied children; the existing safeguards that protect families and children from detention beyond 7 days (families) and 24 hours (unaccompanied children) are disapplied. These strict limits on the detention of children were introduced in 2012 in recognition of the significant harms detention causes to the mental and physical health of young people. A joint briefing paper by the Royal College of GPs, Royal College of Psychiatrists and Royal College of Child Health found that arrest and detention compounded the existing high rates of physical and psychological morbidities experiences by children from families seeking asylum:

"*Almost all detained children suffer injury to their mental and physical health as a result of their detention, sometimes seriously. Many children experience the actual process of being detained as a new traumatising experience. Psychiatrists, paediatricians and GPs, as well as social workers and psychologists, frequently find evidence of harm, especially to psychological wellbeing as a result of the processes and conditions of detention. Reported child mental health difficulties include emotional and psychological regression, post traumatic stress disorder (PTSD), clinical depression and suicidal behaviour. Specific physical consequences include weight loss and inadequate pain relief for children with sickle cell disease. Children in detention are also placed at risk of harm due to poor access to specialist care, poor recording and availability of patient information, a failure to deliver routine childhood immunisations, and a failure to provide prophylaxis against malaria for children being returned to areas where malaria is endemic*".[129]

Clause 12 provides that someone may be "detained for such period as, in the opinion of the Secretary of State, is reasonably necessary to enable the examination or removal to be carried out, the decision to be made, or the directions to be given". The period of detention is based on the opinion of the Secretary of State and is indeterminate. It also provides for the power to detain to be extended for a further in determinate period "to enable such arrangements to be made for the person's release as the Secretary of State considers to be appropriate." Current practice is that this can be for prolonged periods particularly for those with significant mental illness.

Clause 13(4) reduces the scope of legally challenging detention by stating that *"In relation to detention during the relevant period, the decision is final and is not liable to be questioned or set*

[129] "Any detention of children for administrative rather than criminal purposes causes unnecessary harm and further blights already disturbed young lives (bbc.co.uk)

aside in any court." It removes the ability to challenge the legality of detention by way of judicial review in stating that *"the supervisory jurisdiction does not extend to, and no application or petition for judicial review may be made or brought in relation to, the decision".*

The Bill only allows for detention to be challenged through applying for a writ of *Habeus Corpus*, which specifically concerns only whether there is a power to detain or not and not whether the power was lawfully exercised.

Moreover, Clause 13 further limits when bail may be granted by the First-tier Tribunal to after someone has been detained for 28 days. Whilst people in detention will be able to apply for secretary of state bail under Schedule 10 of the Immigration Act 2016, a refusal of bail will not be able to be challenged by judicial review. There is, therefore, purported exclusion of any form of effective judicial scrutiny of the exercise of the power to detain for the 28-day period.

Overall, this Bill is a radical and alarming development aimed at significantly expanding the power of administrative detention and to deny or curtail judicial scrutiny and effect remedies to challenge unlawful or unjustified detention. Given the longstanding evidence of systemic failure of key safeguards that have been outlined in this submission, this is of grave concern and further intensifies the high risk of repeating the mistreatment, abuse and inhumane treatment that have been uncovered by the Brook House Inquiry and identified by the IMB in 2020, as explained above.

In addition to the clauses concerning detention, the Bill effectively dismantles the system for seeking and receiving international protection for those fleeing persecution for a huge number of those arriving in the UK to seek asylum. This will potentially deprive many people, most of whom will already be traumatised, from accessing the asylum process, joining or being joined by their families, obtaining the support they need to recover and integrating into the community.

There are broader serious concerns about the legality of the Bill, as outlined by the United Nations High Commissioner for Refugees (UNHCR): "The effect of the bill (in this form) would be to deny protection to many asylum-seekers in need of safety and protection, and even deny them the opportunity to put forward their case. This would be a clear breach of the Refugee Convention and would undermine a longstanding, humanitarian tradition of which the British people are rightly proud."[130]

The debate around the introduction of both Nationality and Borders Act 2022 and the Illegal Migration bill has been marked by deeply hostile rhetoric, xenophobia and racism. The deliberately provocative language of an *"invasion"* and repeated unjustified references to rapists and criminals leads to "*othering*" and promotes and an *"us and them"* mentality and risks entrenching a breeding ground for racist abuse and violence. Evidence provided to the Brook House Inquiry from a number of sources identified a correlation between the hostile environment measures and rhetoric of the government in the abusive, dehumanising and racist language and actions of the staff and as a contributory in its corrupt and toxic institutional culture. The intention behind both pieces of legislation, is to deter refugees from coming to the UK. By treating individuals in a hostile, punitive and inhumane way as a means of deterring others from coming to the UK represents an abandonment of core legal protections for those seeking asylum and in conditions that respect human rights and dignity. It is a refusal to see the *"face behind the case"* and is the complete opposite of building a *"fairer more compassionate Home Office"*, as was promised by the government in response to the highly critical Wendy Williams' Windrush Lessons Learned Review. Instead, it promotes the dehumanising attitudes and actions which were evident in the extensive

[130] UNHCR (7 March 2023) Statement on UK Asylum Bill.

evidence heard by the Brook House Inquiry, and which are increasingly being given expression in the community for example during the riot outside a hotel housing asylum seekers in the UK.

9. Conclusion: Forward Look

The evidence presented in this submission demonstrates the severity of the safeguarding failings in immigration detention. This results in vulnerable people, with histories of trafficking, torture and trauma, being subjected to prolonged and harmful periods in detention. This evidence is not new, and the harm is predictable and preventable. Yet, despite the Home Office's awareness of this evidence, not least through the Brook House Inquiry, inquests, Article 3 cases, and unlawful detention cases, it fails to learn lessons and implement meaningful improvements.

Medical Justice's position is that immigration detention should be phased out, and in the meantime, be subject to strict statutory criteria and a time limit to curtail its use and extent. This position is supported by a wide range of other independent organisations, statutory bodies[131] and parliamentary committees[132].

The urgent need for change is all the more compelling considering the evidence heard at the Brook House Inquiry, the government's current plans to open new IRCs and expand detention powers, and the attempts to dismantle the system for seeking international protection in the recent Illegal Migration Bill.

The detention release rate is at an all-time high, 82%[133], there is a growing backlog of asylum cases and a high asylum grant rate; which all strengthen the case to phase out detention.

Medical Justice
Friday 10th March 2023

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[131] See Annex 1 to Witness Statement of Emma Ginn, BHM000041_0070-73.
[132] Joint Committee on Human Rights, Immigration Detention: Sixteenth Report of Session 2017-19 and Home Affairs Committee, Fourteenth Report of Session 2017- 19.
[133] Home Office (24 November 2022) National statistics: How many people are detained or returned?