“IF HE DIES, HE DIES”

WHAT HAS CHANGED SINCE THE BROOK HOUSE INQUIRY?

December 2023



Medical Justice
working for health rights for detainees

MEDICAL JUSTICE

Medical Justice is the only charity in the UK to send independent clinicians into all the Immigration Removal Centres (IRCs) across the UK. Our medical reports document the physical and mental scars of torture, serious medical conditions, deterioration of health in detention, injuries sustained during violent removal attempts and challenge instances of medical mistreatment. We receive over 500 referrals for people in detention each year. Our evidence base is sizeable, unique and growing.

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

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

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Medical Justice would like to thank all its clients who took part in interviews and who gave their time and consent for their information to be used in this report and in its research.

A note on the title of this report

The quote on the front page *"if he dies, he dies"* was used by guards in 2017 undercover footage disclosed to the Brook House Inquiry. The justification that this was part of the culture and a joke was found by the Inquiry to be *"not only callous and unacceptable but betrays the extent of desensitisation to detained people's health issues and vulnerabilities, and the dehumanisation of detained people by some staff".* [1]

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'*"If he dies, he dies"*: What has changed since the Brook House Inquiry?' is published in December 2023 by Medical Justice.

[1] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) *The Brook House Inquiry Report Volume II*, HC 1789-II, page 232 paragraph 57.

FORWARDS

Medical Justice Client

In detention, it felt like human beings were just numbers. I don't think detention is any place for a human being and it's not a solution. We are human. We have families. The best value in life is freedom.

I was in detention for 10 months. It felt like prison. I had no one to talk to, I had no fresh air. The only fresh air was air that came under the door to my cell. My toilet was inside my cell, it was like a proper prison cell. Staying between four walls all the time makes you crazy. I was scared. It's bad for your mental health when you are locked down and not allowed to go outside. People were banging on the walls. It is really hard thinking about what a bad period it was in my life. I wasn't sleeping. I was scared for my life the whole time and wasn't given regular accurate information about what was happening in my case.

The staff did not seem to have much concern. When I tried to let people know how I was feeling, I got the impression that healthcare staff just wanted to cover it up and pass it along. I felt that I had to reach rock bottom before my mental health was taken seriously.

Now I am getting compensation for unlawful detention. When I was in detention there were barriers to removal, so they would not have been able to deport me, but they still kept me in there for 10 months.

The Lord German OBE

Hidden Spaces in our society is how the Brook House Inquiry report describes places of immigration detention. The state has responsibility for the people in its care who are detained in these hidden spaces. The shocking findings of the Brook House Inquiry illustrate that we are failing in this responsibility – to ensure the welfare and protection of some of the most vulnerable people in our society. This is not a case of a 'bad apple' within a system but of systemic failure, without proper accountability, transparency and robust monitoring of contractors.

This report by Medical Justice gives little confidence that treatment of those in immigration detention has improved since the circumstances that led to the Brook House inquiry were revealed.

There is now independent evidence that the state is unable to properly protect and care for those in immigration detention. It is deeply concerning that despite significant opposition, the Government will be expanding the immigration estate through the Illegal Migration Act. Such an approach is irresponsible and will leave many more people – including children, at risk of suffering the same kinds of abuse and harm uncovered not only at Brook House, but across the detention estate. We must hold the Government to account; we need to continue to shed light, ask questions, pursue answers and action so that these hidden spaces are not allowed to be places where fellow human beings are treated in such an appalling manner.

CONTENTS

Medical Justice 2
Acknowledgements 2
Forwards 3
Executive Summary 5
Glossary of terms 7
1. Introduction 9
Medical Justice Key Findings 10
Methodology 12
2. Vulnerabilities in Immigration Detention 13
2.1 Histories of trauma, torture and trafficking 14
2.2 High prevalence of detained people with mental health problems 15
2.3 Levels of mental health deterioration and harm caused by detention 16
2.4 Self-harm and suicidality in detention 17
3. Healthcare 20
3.1 Delivering healthcare: Inquiry and Medical Justice Evidence 20
4. Detention safeguards 26
4.1 The safeguarding system: the policy and legal framework 26
4.2 Clinical and custodial safeguards: Inquiry and Medical Justice Evidence 27
5. Use of Force 50
5.1 Use of force: Inquiry and Medical Justice findings 50
5.2 Further external evidence 52
6. Segregation 54
6.1 Segregation: Inquiry and Medical Justice findings 54
6.2 Further external evidence 57
7. Conclusion 58
8. Recommendations 59

EXECUTIVE SUMMARY

This report, based on clinical evidence from 66 clients detained in Immigration Removal Centres (IRCs) between June 2022 and March 2023, demonstrates how unsafe and harmful immigration detention can be. It shows how the detention of a population with high rates of vulnerabilities, in a prison environment creates a serious risk of harm. People suffer through damage to their mental health, inadequate safeguarding and healthcare, experiences of the use of force and clinically inappropriate use of segregation.

It provides an analysis of the Brook House Inquiry's report, the first public inquiry into immigration detention. The Inquiry found how the dangerous use of force, a wholesale failure of safeguards and a culture of dehumanisation led to 19 instances of inhuman or degrading treatment, breaching Article 3 of the European Convention on Human Rights (ECHR), within a 5-month period at Brook House IRC.

Medical Justice have been and continue to present clinical evidence of harm and dysfunctional safeguards to the Home Office. This report is the latest iteration of this work, which has stretched back over the past 18 years.

All the failings documented in this report have taken place after the Inquiry's public hearings, across the detention estate. [2]

This research has found that of the case set of 66 clients:

- 84% had evidence of a history of torture and/or trafficking.
- 95% had a diagnosis of at least one mental health condition, with a high proportion diagnosed with Post-Traumatic Stress Disorder (PTSD) or some trauma-related symptoms such as flashbacks and nightmares, and/or depression.
- There are alarmingly high suicide risk levels amongst the clients analysed for this report: 74% of the clients in the case set were recorded as having self-harmed, suicidal thoughts and/or attempted suicide in detention. 13 out of the 66 people in the case set attempted suicide and 17 self-harmed in detention.
- There were instances of healthcare failing to identify or to provide adequate treatment in detention for particular mental health conditions, such as PTSD.
- The clinical safeguards in detention – Rules 34 and 35 of the Detention Centre Rules 2001 – are not functioning effectively to identify, protect and route out those at risk of harm, suicide and/or self-harm and those who have a history of torture. The Home Office is failing to release vulnerable people from detention, when brought to their attention through Rule 35.

[2] Although no clients detained at Dungavel IRC were part of the 66 in this audit, Medical Justice knows from its continuous monitoring and documenting of the experiences of clients in detention - including Dungavel IRC - that these issues occur across the detention estate.

- Assessment Care in Detention and Teamwork (ACDT), including constant watch, remain custodial tools for staff to *"manage"* the risk of suicide and self-harm in detention. Neither processes are therapeutic or clinical, nor are they sufficient to deal with those who are actively suicidal or at risk of suicide or self-harm. These processes are not connected to the safeguards in the Rule 35 process.

- Seven people out of 66 in the case set were subjected to use of force and/or restraints in detention; three of whom had injuries attributed to the force used on them requiring medical treatment, documented by the Medical Justice clinician.

- Fourteen out of 66 in the case set were put in segregation during their detention, one of whom was assessed as lacking mental capacity by the Medical Justice clinician. Segregation severely impacted those detained there, including increased suicidal thoughts, self-harming episodes in response and a deterioration in their mental state.

The Brook House Inquiry unequivocally places responsibility on the Home Office, urging action at the highest levels of government. There has been a failure to learn lessons from previous reviews; such a failure is described by the Inquiry's Chair as a *"dark thread"* throughout her report. The Home Office publicly state their commitment to learning lessons to ensure that the mistreatment uncovered in Brook House never happens again.[3] Yet, such abuse can only be avoided if there is meaningful change – which has been sorely lacking after previous investigations and reviews. The Inquiry made 33 recommendations which need to be urgently addressed.[4]

The Home Office do not seem to acknowledge the severity of harm ongoing in detention and turns a blind eye to the failures over which it presides. They suggest that these are issues of the past.[5] This ignores the important findings of the Inquiry that many of the factors which allow for mistreatment to occur, are unchanged to date. The Inquiry reached these conclusions after hearing evidence from current Home Office, custodial and healthcare staff and reviewing recent reports from His Majesty's Inspectorate of Prisons (HMIP), the Independent Chief Inspector of Borders and Immigration (ICIBI) and the Independent Monitoring Board (IMB).

This research demonstrates how many of the issues in the Inquiry are still ongoing today, across the detention estate. Action could not be more urgent as the government plans to significantly expand detention and implement the provisions of the Illegal Migration Act, knowing the harm that is still being caused. This ongoing harm since the Brook House Inquiry, is apparent from our evidence, two deaths in detention this year reportedly by suicide, and the continuing failures in the Home Office safeguards.

[3] The Home Office (19 September 2023) The Book House Inquiry: Home Office Statement.

[4] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, page 374 paragraph 88.

[5] The Home Office (19 September 2023) The Book House Inquiry: Home Office Statement.

GLOSSARY OF TERMS

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

'Adults at Risk' Policy: Statutory Guidance and further executive policy on determining whether a person is vulnerable (an 'Adults at Risk') and whether they ought to be released from detention because of their vulnerability to suffering harm in detention. Its stated purpose is to protect vulnerable people who may be at increased risk of harm in detention. The guidance states that vulnerable individuals or 'adults at risk' should not normally be detained and can only be detained when 'immigration factors' outweigh their indicators of risk.

Constant Watch: A detained person can be put on constant supervision *"to reduce a serious risk of them carrying out acts of self-harm or other behaviours which could lead to them accidentally or intentionally killing themselves"*.[1] Constant watch is an extreme measure for those in immediate and acute risk of suicide. Crucially it is a member of custodial staff, not healthcare, who remains with the detained person.

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

Healthcare screening: Initial screening by a nurse or healthcare assistant, usually within 2 hours of arriving at the IRC.

IRC: Immigration Removal Centre.

IRC Healthcare: The healthcare team is responsible for the provision of healthcare for those held in Immigration Removal Centres and is commissioned by NHS England. The IRC healthcare team provides primary care and some secondary mental healthcare. Note that psychiatrists are not always available in every IRC, and work on a part-time basis.

IRC staff: Custodial staff in Immigration Removal Centres.

Medico Legal Reports (MLRs): These are detailed reports written by independent clinicians at Medical Justice, which provide evidence for asylum cases and other legal decisions. This may include details of the person's physical and mental health, examination findings, forensic assessment of scars and psychological consequences of ill treatment or torture, consideration of the impact of detention on the person's health, and identification of unmet health needs.

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

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

Rule 35 (of Detention Centre Rules 2001): This is a mechanism which aims to ensure that particular groups are brought to the attention of the Home Office who has the direct responsibility for reviewing detention. These are people whose health is likely to be worsened by detention - Rule 35(1), people in respect of whom there is concerns that they may have suicidal intentions– Rule 35(2), or people who may have been a victim of torture - Rule 35(3). It is the primary safeguard for vulnerable individuals whose health would be injuriously affected by continued detention.

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

Rule 40 (of Detention Centre Rules 2001): Under Rule 40, a detained person can be held in segregation for an initial period of up to 24 hours, but this may be extended to a maximum of 14 days.[1]

Rule 42 (of Detention Centre Rules 2001): Under Rule 42, a detained person can be held in segregation for up to 24 hours and this may be extended for up to 3 days after written direction from an officer of the Secretary of State.

1. INTRODUCTION

Medical Justice, as well as parliamentary bodies[6], independent inspectorates[7], and medical bodies[8], have consistently raised the alarm over the severe harm caused by immigration detention. The high prevalence of mental health conditions and histories of torture, trafficking and/or other trauma in detained populations make them highly vulnerable to this harm. The Home Office continue to fail to effectively safeguard vulnerable people in detention.

Every day, our caseworkers and clinicians see the devastating impact detention has, due to inadequate healthcare, inhumane treatment, and ineffective safeguards which fail to identify and protect vulnerable people. These failures lead to the deterioration of vulnerable people's health, with an associated risk in self-harm and suicide attempts. Ultimately, the buck lies with the Home Office, who are responsible for detaining vulnerable people, including those who should not have been detained in the first place, and to quickly identify, safeguard and route them out of detention to protect them from further harm.

The Brook House Inquiry is the first public inquiry into the mistreatment of those detained under immigration powers and the conditions of that detention.[9] The Inquiry was a unique opportunity to understand and uncover, in a public forum, the abuse and harm caused to people in detention. Set up by the then-Home Secretary in November 2019, the inquiry investigated the mistreatment of people detained at Brook House IRC, as uncovered by BBC Panorama.[10]

Due to our extensive experience of the clinical safeguarding failures and understanding of the inadequate healthcare provision in IRCs, Medical Justice was designated core participant status in the Inquiry.[11]

The Brook House Inquiry, which published its findings on 19 September 2023, exposed the inexcusable and unconscionable dehumanising abuse of vulnerable people held in immigration detention by the Home Office. It found the safeguarding system to be *"dysfunctional"*,[12] exposing vulnerable people to the risk of mistreatment and causing them actual harm.[13] It found a *"toxic culture"*[14] at Brook House, a *"breeding ground for racist views"*[15] and *"a culture of dehumanisation of detained people"*.[16] Healthcare staff were found to not understand their safeguarding obligations, with a tendency to view detained persons as "wilfully disobedient and obstructive, instead of countenancing the idea that behaviour may

[6] For example, see Home Affairs Committee (21 March 2019) Immigration Detention: Fourteenth Report of Session 2017–19, House of Commons HC 913; Joint Committee on Human Rights (7 February 2019) Immigration Detention HC 1484, HL Paper 278.

[7] For example, see reports by the His Majesty's Inspectorate of Prisons (HMIP), the Independent Chief Inspector of Borders and Immigration (ICIBI) and the Independent Monitoring Board (IMB).

[8] For example, see Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21; British Medical Association (2017) Locked Up, Locked Out.

[9] The Inquiry held public hearings over 46 days from 23 November to 10 December 2021, and from 21 February to 6 April 2022.

[10] As a result of legal proceedings brought by someone who was subject to the mistreatment uncovered by the BBC, the Home Secretary was compelled to set up the Brook House Inquiry.

[11] Evidence was heard from detained persons, detention officers, healthcare providers, G4S employees (the private contractor responsible for Brook House IRC in 2017), Home Office officials, members of IMB and HMIP, non-governmental organisations and visitor groups. The Inquiry also appointed three experts to each address the use of force, institutional culture and clinical care provision and safeguards. It was also provided with documentary material and video footage from the BBC that was not broadcasted and from G4S CCTV and body-worn cameras.

[12] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.1 page 3 paragraph 2.

[13] The Inquiry found there were 19 incidents of credible breaches of Article 3 of the ECHR, which prohibits torture, inhuman and degrading treatment within a 5-month period.

[14] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 182 paragraph 27.

[15] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.9 page 244 paragraph 89.

[16] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.9 page 252 paragraph 103.2.

be a manifestation of mental anguish or ill health." [17] The Inquiry also criticised widespread instances of *"unnecessary"*, *"inappropriate and excessive use of force"*. [18]

Medical Justice has a direct insight into, and clinical evidence of, ongoing issues in detention. This report further evidences the ongoing prevalence of people with vulnerabilities in detention, the continued systemic failures of the safeguarding system to identify, protect and route these people out of detention, the inadequate provision of healthcare in detention, and the continued misuse of force and segregation. Outside of the report findings, Medical Justice continues to see examples of the other key themes in the Inquiry such as the prisonisation, dehumanising attitudes, and a culture of disbelief in detention. Medical Justice has anecdotal information from clients of racist and derogatory language used in detention, reflecting the Inquiry's findings of detention being a *"breeding ground for racist views"*. It is important to note that that racism and racist abuse frequently remains hidden, unless exposed through video footage and whistle-blowers, such as was the case in the Inquiry. The risk of racism and racist abuse is inherent in immigration detention, particularly in a hostile political context where migrants are scapegoated, and dehumanising rhetoric used in politics and the media.

Our analysis supports the Brook House Inquiry findings and shows how what was uncovered in Brook House in 2017 is ongoing, across the detention estate. We have not seen evidence that there have been meaningful changes to Home Office policies and practices since 2017. Lessons have not been learnt and despite knowing the harm it causes, the government continues to indefinitely detain and harm vulnerable people, with plans for a large expansion of detention.

Medical Justice Key Findings

All the failings documented in this report by Medical Justice have taken place across the detention estate and after the Brook House public hearings. Detention continues to cause harm to already vulnerable people:

- People with histories and evidence of trauma, mental health problems, lack of mental capacity to make decisions about their immigration cases, and/or those who are age-disputed children, are being detained, putting them at high risk of harm every minute they are in detention.
- A high proportion of the case set (84%) had evidence of a history of torture and/or trafficking.
- Almost all (95%) of the clients in the study had a diagnosis of at least one mental health condition, with a high proportion diagnosed with PTSD or some trauma-related symptoms such as flashbacks and nightmares, and/or depression.
- There are alarmingly high suicide risk levels amongst the clients analysed for this report: 74% of the clients in the case set were recorded as having self-harmed, suicidal thoughts and/or attempted suicide in detention. 13 out of the 66 people in the case set attempted suicide and 17 self-harmed in detention.
- Medical Justice clinicians found very high levels of harm [19] and deterioration [20] amongst clients.

[17] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.11 page 325 paragraph 50.

[18] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.11 page 321-322 paragraph 48.1.

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

[20] When assessing whether detention has caused a deterioration in a client's health, Medical Justice clinicians consider not just the fact of incarceration, but also the features of detention as explained by the client, such as their separation from family and their community, and also their level of access to healthcare and treatment in detention.

Healthcare continues to fail to identify particular mental health conditions and to consistently provide adequate treatment. Analysis of the 66 clients in the case set found instances where:

- The IRC healthcare failed to identify or explore particular mental health conditions such as PTSD, and failed to assess or explore suspected lack of mental capacity.
- Healthcare was unable to or failed to provide adequate treatment in detention for mental health conditions such as PTSD and schizophrenia and for some physical health conditions.
- Those who lacked mental capacity to make decisions relating to their detention or immigration case were not identified in detention and there is still no process in place to enable them to access independent advocacy to advance their interests.
- There were examples indicative of a worrying culture of IRC healthcare including dehumanising language and behaviour, disbelief of clients' mental ill-health or around self-harm.

The clinical safeguards in detention – Rules 34 and 35 of the Detention Centre Rules 2001 – are not functioning effectively to identify, protect and route out those at risk of harm, suicide and/or self-harm and those who have a history of torture. This includes healthcare failures to implement the safeguards in practice and a lack of Home Office oversight to ensure compliance in practice:

- Almost half of the case set did not see an IRC GP within 24 hours of arrival in detention, as is the Home Office policy, and where they did, they rarely had a mental health assessment to identify any vulnerabilities that would make them unsuitable for detention.
- The safeguarding mechanism for IRC GPs to communicate an individual's risk of harm to the Home Office to review their detention (Rule 35) continues to be rarely used:
    - Very few Rule 35 (1) reports are being completed for those at risk of harm in detention and quite significant deterioration in their mental health or physical health issue has to occur before one is completed, if at all. This is despite the Rule being intended to be preventative and so no actual deterioration being required to trigger the reporting mechanism.
    - Very few Rule 35 (2) reports are being completed despite the high number of people experiencing suicidal thoughts. Even after people attempted suicide, they are rarely completed. Where reports are completed, the assessment is often inadequate and incomplete, for example missing information such as a suicide attempt.
    - A large number of Rule 35 (3) reports for torture survivors were completed but there were examples of failures to document or to adequately document scarring, a key element of the IRC GPs obligations in their documentation of the detained person's torture account for the Home Office.
- There is a disconnect between the different safeguards; those on ACDT for self-harm or suicide risk are not automatically assessed for the relevant Rule 35 report and therefore do not have their detention reviewed by the Home Office.

The Home Office fails to release vulnerable people, when brought to their attention through Rule 35:

- The Home Office took the decision to release very few people in relation to their Rule 35 report.
- Even when they did, most remained in detention for months after the decision to release them had been made.

Processes within detention often cause more harm:

- ACDT (including constant watch) remain custodial tools for staff to *"manage"* the risk of suicide and self-harm in detention. Neither processes are therapeutic or clinical, nor are they sufficient to deal with those who are actively suicidal or at risk of suicide or self-harm.
- Seven people out of 66 in the case set were subjected to use of force and/or restraints in detention; three of whom had injuries attributed to the force used on them requiring medical treatment, documented by the Medical Justice clinician.
- Fourteen out of 66 in the case set were put in segregation during their detention, one of whom was assessed as lacking mental capacity by the Medical Justice clinician. Segregation severely impacted those detained there, including increased suicidal thoughts, self-harming episodes in response and a deterioration in their mental state.

Methodology

This report analyses aggregate data from 66 Medical Justice clients,[21] referenced as the case set, who were selected on the basis that they had a medico-legal assessment by a Medical Justice clinician between 1 June 2022 and 27 March 2023 in an IRC, had their Medico-Legal Report (MLR) finalised at the time of data collection[22] and for whom Medical Justice had access to sufficient documentation. The documents reviewed included each client's IRC medical records[23], and their Medical Justice MLR. Where available, Medical Justice also reviewed their Rule 35 report and the Home Office responses to their Rule 35 report.[24] Where additional clinical information to the MLR was required, input was provided by Medical Justice clinicians. This report also draws on the organisation's continuous monitoring and documenting of the experiences of clients in detention.

This report includes analysis of the Brook House Inquiry's report. Supplementary information is included from responses to Freedom of Information requests and secondary sources, such as media reports and reports from HMIP and the IMB.

The anonymised case studies in this report are based on the experiences of six of the 66 clients in the case set, of whom four took part in semi-structured interviews conducted by Medical Justice. The clients featured in case studies have been given a different name to protect their identity.

At the time of their MLR assessment, of the 66 clients: 11 were detained in Yarl's Wood IRC, 12 in Harmondsworth IRC, 19 in Colnbrook IRC, 20 in Brook House IRC, one in Tinsley House IRC, and three in Derwentside IRC. None were detained at Dungavel IRC or any Short-Term Holding Facility (STHF).

Two clients were age disputed children[25] during this period of detention and both were detained at Colnbrook IRC. Three were women, who were all detained at Derwentside IRC and 61 were men.

[21] The MLRs were finalised between 16 June 2022 and 12 June 2023. One person had two MLR assessments and two MLRs during the same detention episode.

[22] Data collection was completed at the end of July 2023.

[23] Medical records for each client for at least the period up to the point of MLR assessment.

[24] 11 individuals had more than one Rule 35 report in the same detention episode. Medical Justice had access to 65 Rule 35 reports that were completed by the IRC GP in detention for the individuals in this case set and 44 Home Office responses. One of the 44 responses available to Medical Justice was incomplete. The information available and included in Medical Justice's statistics were the Adult at Risk level and date of Home Office response.

[25] The two individuals report that they are under the age of 18 and are challenging the Home Office decisions that they are adults.

2. VULNERABILITIES IN IMMIGRATION DETENTION

Research has consistently shown that populations in immigration detention have a high prevalence of mental health conditions and histories of torture, trafficking and/or other trauma, which make them highly vulnerable to harm in detention.[26] Survivors of torture, trafficking and other trauma are at particular risk of harm, as immigration detention impedes recovery[27] and increases the risk of re-traumatisation.[28] These vulnerabilities are compounded by immigration detention.

People in detention have described a range of factors that contribute to this, including fear for their safety, the prison-like environment, the feelings of criminalisation, and experiences of physical and verbal abuse. All of these contribute to experiences of loss of agency, entrapment and feelings of hopelessness. In addition, the indefinite nature of detention and limbo of their legal status increase the harm of all of these factors. Unmet medical needs, language barriers and isolation can all add to, and further complicate, deteriorating health.

The Royal College of Psychiatrists' 2021 position statement on detention of people with mental disorders concludes that being detained in an IRC was likely to precipitate a significant deterioration of mental health in most cases.[29] It has been found that the *"only efficient way to improve the detainees' mental health is to release them from detention"*.[30]

Those who lack mental capacity to make decisions about their immigration case and/or detention processes are at risk of suffering additional serious harm because of the lack of adjustments made for their needs in immigration detention.

Indeed, the Brook House Inquiry's findings further evidence the high level of vulnerabilities amongst those detained under immigration powers. It found there was a high prevalence of mental ill-health amongst the detained population. This includes people with high risks of self-harm and suicide, a significant number of victims of torture and other past trauma and vulnerability due to the loss of mental capacity.[31] The Inquiry found that this was not only the case during the relevant period, but also *"likely to still be the case"* today.[32]

The Inquiry, reflective of existing research, notes particular stressors associated with detention, including *"the sudden nature of being detained, uncertainty and anxiety about the future, separation from social support and other coping mechanisms, and the highly stressful environment of detention, may exacerbate mental ill health. Detention can also be very disruptive to pre-detention medical care"*.[33]

[26] 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; Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21.

[27] Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention.

[28] Helen Bamber Foundation, Medical Justice, Anti Trafficking and Labour Exploitation Unit and Focus on Labour Exploitation (2022) Abuse by the system: Survivors of trafficking in immigration detention.

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

[30] 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.

[31] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 178 paragraph 11.

[32] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 178 paragraph 11.

[33] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 178 paragraph 13.

Our analysis of 66 clients in detention further evidences the high level and range of vulnerabilities amongst people in immigration detention. We found that people with histories and evidence of trauma, mental health problems including PTSD, lack of mental capacity, and/or those who are age-disputed children, are being detained, putting them at high risk of harm every minute they are in detention.

2.1 Histories of trauma, torture and trafficking

The Inquiry highlighted that many detained people report a history of torture or serious ill treatment and for them, specific aspects of being detained, including the banging of cell doors and the jangling of keys, "*may trigger powerful and traumatising memories of past experiences of ill treatment"* which *"not only often exacerbate pre-existing mental ill health but also may specifically elicit trauma-related symptoms such as nightmares and flashbacks"*. [34]

Medical Justice consistently see that survivors of torture and trafficking are routinely detained, not identified and not routed out of detention. Of our case set of 66 people:

- 52 had evidence of a history of torture;
- 29 had evidence of a history of trafficking;
- 25 had evidence of a history of both torture and trafficking.

2.1.1 Evidence of torture: scarring

Scars often provide important evidence of a history of torture or other ill-treatment. As part of medico-legal assessments, Medical Justice clinicians document scarring [35] according to the *Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Istanbul Protocol). [36] The Istanbul Protocol provides internationally recognised guidance on documenting and identifying symptoms of torture, including evaluating scarring. This includes clinicians interpreting the degree to which scarring is consistent with accounts of torture, by assessing scarring using a range of terms with specific definitions in this context: not consistent, consistent, highly consistent, typical or diagnostic. [37]

In the case set of 66 clients, 49 people had physical scarring documented either by a Medical Justice clinician in their MLR assessment and/or by the IRC GP in their Rule 35 (3) report. [38] It is important to note that not all forms of torture leave physical scars, so for torture survivors who did not have scarring, the absence of physical evidence of torture or ill-treatment does not mean that it did not take place. [39]

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[34] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 pages 178-179 paragraph 14.

[35] Medical Justice clinicians document scarring if relevant and when able to do face to face assessments.

[36] Office Of The United Nations High Commissioner For Human Rights, United Nations (2004) The Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Professional Training Series No. 8/Rev.1.

[37] The Istanbul Protocol defines *"not consistent"* as *"the finding could not have been caused by the alleged torture or ill-treatment"*, *"consistent" as "the finding could have been caused by the alleged torture or ill-treatment, but it is non-specific and there are many other possible causes"*, *"highly consistent"* as "the finding could have been caused by the alleged torture or ill-treatment and there are few other possible causes", "typical" *as "the finding is usually observed with this type of alleged torture or ill-treatment, but there are other possible causes"* and "diagnostic" as *"the finding could not have been caused in any way other than that described"*. See Office Of The United Nations High Commissioner For Human Rights, United Nations (2004) The Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Professional Training Series No. 8/Rev.1., paragraph 380.

[38] 41 had scarring documented in their Medico-Legal Report. 8 others had scarring documented in their Rule 35(3) report but did not have scarring documented in their Medico-Legal Report as the clinician was unable to comment on their physical scarring because it was either a remote medical assessment or it was a psychiatric Medico-Legal Report.

[39] The Istanbul Protocol states: *"the absence of physical and/or psychological evidence of torture or ill-treatment, however, does not mean that it did not take place. Many factors may account for the absence of physical and psychological findings and documenting these factors can be useful in corroborating specific claims of torture or ill-treatment"*. See Office Of The United Nations High Commissioner For Human Rights, United Nations (2004) The Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Professional Training Series No. 8/Rev.1. paragraphs 390 and 393.

In this study, 40 of the clients who had scarring documented in their MLR were found to have scarring which was medical evidence of torture (in Istanbul Protocol terminology, was at least *"consistent"* with torture, with a higher degree of consistency in many cases).[40]

2.2 High prevalence of detained people with mental health problems

The Inquiry found that *"[c]onditions such as depression, anxiety, post-traumatic stress disorder (PTSD), psychosis and substance abuse are more common in IRCs than in the community"*.[41] It further highlighted that mentally ill people in detention *"may be more vulnerable to losing mental capacity to make decisions about their medical care and treatment"*.[42]

Owing to the ongoing high prevalence of mental health problems in detention, Medical Justice receives many referrals for clients with mental health concerns, reflected in this study. At the point of their medico-legal assessment with a Medical Justice clinician, of the 66 clients analysed, 63 had a diagnosis of at least one mental health condition and 38 were diagnosed with two or more mental health conditions.

These comprised of:

- 55 clients either had a diagnosis of PTSD or had some trauma-related symptoms while in detention, such as flashbacks and nightmares. Of the 55:
    - 34 clients were diagnosed with PTSD. Of those 34 people, two were also diagnosed with Complex PTSD and six had suspected Complex PTSD requiring further assessment;
    - 21 clients had trauma-related symptoms but either did not have all other symptoms meeting PTSD diagnostic criteria or required further assessment to establish this;
- 55 clients were diagnosed with depression and four others had some depressive symptoms;
- Seven clients were diagnosed with an anxiety disorder and 24 others had anxiety symptoms;
- 12 clients had psychotic symptoms such as delusions, hearing voices (auditory hallucinations), visual hallucinations, olfactory hallucinations, command hallucinations including instructions to kill themself, paranoid delusions, disorganised thinking, fixed or delusional beliefs, paranoid ideation, and lack of insight;
- Six clients were diagnosed with a psychotic illness, including schizophrenia;
- Two clients were diagnosed with bipolar disorder, one with acute stress reaction and one with a personality disorder;

[40] One person had scarring consistent with self-injury only and not mistreatment. Four of the 41 had scarring from both mistreatment and self-injury.

[41] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 178 paragraph 12.

[42] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 179 paragraph 15.

- One client had suspected memory/cognitive impairment, requiring further investigation, one had suspected learning difficulties and autistic spectrum disorder and one had possible acute stress reaction.

Having mental capacity to make a specific decision requires the individual to understand, weigh up information, retain the information and communicate information.

Four clients in the case set were determined by a Medical Justice clinician to lack mental capacity to make a particular decision. This included capacity to understand legal proceedings and provide instructions, to engage in the immigration process, to give evidence in court, to weigh up information, to trust others including a solicitor and have insight into their mental health diagnosis. This arose in the context of clients suffering from delusions, hallucinations, paranoia, or a psychotic disorder.

Three further clients were suspected to lack capacity but required further assessment. This included capacity to participate in their legal case, to make decisions concerning removal, to instruct a solicitor, and a mental state that may impair some of their judgements and decisions. This arose in the context of clients' variations in physical and emotional distress, a possible learning disability and possible autistic spectrum condition, and a client who was diagnosed with bipolar disorder.

There were also examples of other clients who would need to be treated as a vulnerable witness. This was because of clinicians' concerns that the person could be harmed by or unable to withstand aspects of the process of giving evidence in immigration proceedings, or that the person was not fit to be interviewed by the Home Office due to their mental state.

2.3 Levels of mental health deterioration and harm caused by detention

Medical Justice clinicians found extremely high levels of harm and deterioration caused by detention. Of the 66 cases analysed:

- Clinicians found that 64 of the clients they assessed had deteriorated[43] in their mental state because of detention or features associated with detention.[44]
- All 66 clients were assessed as likely to deteriorate or deteriorate further if they remained in detention.
- Detention or features associated with detention caused harm to all 66 clients.[45] Detention was also found to be likely to cause further harm to all 66 if they remained in detention.

Our evidence shows both how people with pre-existing mental health conditions deteriorated in detention, how people developed new symptoms of mental health conditions that were caused by the detention setting, and how people developed suicidal thoughts.[46]

[43] When assessing whether detention has caused a deterioration in a client's health, Medical Justice clinicians consider not just the fact of incarceration, but also the features of detention as explained by the client, such as their separation from family and their community, and also their level of access to healthcare and treatment in detention.

[44] The deterioration of the remaining two clients was assessed as unknown by Medical Justice clinicians. For one person it was unknown due to a lack of medical records at the time of the assessment which was done on an urgent basis. For the other, it was unknown as mental health symptoms continued when they were transferred from prison to detention.

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

[46] See for example Aaron's case study.

2.4 Self-harm and suicidality in detention

The Inquiry found that there is *"a heightened risk of self-harm and suicide among those in immigration detention, and self-harm is a risk factor for both mental ill health and suicide. Self-harm may be a symptom of complex PTSD, personality disorder or other mental ill health"*.[47] This is reflected in the evidence to the Inquiry which included people who had self-harmed or been suicidal and those who were at risk of self-harm and suicide.

Medical Justice clinicians found alarmingly high suicide risk levels amongst the 66 clients analysed for this report. This indicates that these issues are ongoing across the detention estate.[48] This corroborates existing research showing that detention can increase risk of suicide and self-harm.[49]

Medical Justice clinicians assessed that 43 clients' risk of suicide had increased since they had been detained. Clinicians expressed concern for a further 14 clients, assessing them as likely to have an increased risk of suicide if they remained in detention, even though the risk had not yet increased at the point of the assessment; this occurs because the risk of destabilisation does not reduce, but can increase, when people in this situation remain in detention.[50]

49 of the 66 people in the study were recorded as having self-harmed, suicidal thoughts and/or attempted suicide in detention. 10 people both self-harmed and attempted suicide in detention.

One week after he was detained, **Edward** took a large and dangerous overdose of medication with the intention to take his own life. Edward told Medical Justice: *"When I took the overdose, it was nighttime, I vomited a lot because I took too many at one time, and I had diarrhoea. The second [following] day, I was outside, and staff saw me, there was something different with my face, they asked what happened. I said I took an overdose. They called the manager and took me to my room, and they saw the packet of tablets. When the nurse saw the packet, they called the ambulance straight away."* Edward was in hospital for 3 nights before being discharged back to the IRC. His medical records state that "*healthcare staff were not aware of his discharged[sic] from the hospital and we are [sic] not having his discharge summary"*. This is very concerning considering the additional needs for care and monitoring of his suicide risk that Edward had following his discharge back to the IRC after an overdose.

2.4.1 Suicide attempts and suicidal thoughts

13 people were recorded in their MLR to have attempted suicide whilst in detention. Of those 13 people:

[47] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 178 paragraph 12.

[48] The proportion of Medical Justice's clients who have attempted suicide, suicidal thoughts and incidents of self-harm recorded is higher than the detention-wide statistics. This is because of Medical Justice's remit. Medical Justice's clients are some of the most unwell people in detention and are those in specific need of a medico-legal assessment and report.

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

[50] In 7 cases, it was unknown from their Medico-Legal Report whether their risk of suicide changed or not.

- Three attempted suicide more than once in the same detention episode: Two people attempted suicide twice and one person attempted suicide three times;
- One person attempted suicide while on constant supervision (see ACDT and constant watch);
- Nine had their suicide attempt documented in their medical records. For three people, it was not recorded in their medical records at all. [51]

People attempted suicide in a range of scenarios including after receiving their Removal Directions, just before they were taken to the airport for removal from the UK, being informed by the Home Office that they will be deported, after being refused bail and after hearing that there was a mass suicide attempt taking place in the IRC.

The suicide attempts took place across the detention estate. Four attempted suicide at Brook House IRC, three at Yarl's Wood IRC, three at Colnbrook IRC, two at Harmondsworth IRC, and one at Tinsley House IRC.

Evidence of the level of suicidality across the detention estate has also been documented independently of Medical Justice evidence. In March 2023, Frank Ospina died by suicide in Colnbrook IRC. [52] Shortly after his death, an attempted *"mass suicide event"* occurred at the next door Harmondsworth IRC. [53] In November 2023, an Albanian man is understood to have died by suicide in Brook House IRC. [54]

> **Aaron** told Medical Justice how knowing about the level of suicide attempts at the IRC affected him. He told Medical Justice that IRC officers told him they dealt with seven people attempting suicide and in the middle of talking with him would say 'I have to go because someone did a suicide attempt' and had to run off. He said *"even knowing that, having that information, the feeling of death around you. It feels awful, terrible. I don't wish anyone to suffer like that. If they ask me to go again there [detention], I would rather try and kill myself".*

46 people were recorded in their MLR to have had suicidal thoughts in detention. However, a large number of our clients' suicide risk was not identified by healthcare. Of the 46 people with suicidal thoughts in detention, only 23 had their suicidal thoughts documented in their medical records. This lack of clinical identification of suicide risk is very concerning considering that this is one of three integral safeguarding and reporting obligations that healthcare has (see Rule 35(2)). [55]

Non-disclosure of self-harming suicidal thoughts may be one of the reasons for this. [56] Medical Justice has previously highlighted the need for the development of clinical relationships in detention to increase the willingness of people in detention to disclose to healthcare staff, who detained people may perceive to lack independence from the Home Office and detaining authorities. [57]

[51] For one of the three, they told the Medical Justice doctor they recently attempted suicide, but it was not recorded in their medical records. For the 13th person it is not known how it was documented as the available medical records did not cover that date.

[52] Tom Symonds (14 September 2023) Colombian migrant begged to be sent home - but died in UK detention BBC News; Aaron Walawalkar (14 September 2023) Revealed: 'Mass suicide attempt' at immigration centre after detainee death Liberty Investigates.

[53] Aaron Walawalkar (13 September 2023) 'Attempted mass suicide' at Heathrow immigration centre after Frank Ospina death Open Democracy.

[54] Diane Taylor (18 November 2023) Investigations launched after death of Albanian man detained by Home Office The Guardian.

[55] The other two being identifying and reporting risk of injurious harm and victims of torture (Rule 35 (1) and (3)).

[56] Royal College of Psychiatrists (July 2020) *Self-harm and Suicide in Adults* CR229 page 46.

[57] For more information, see Medical Justice (April 2022) Harmed not Heard.

2.4.2 Self-harm

17 people were recorded in their MLR to have self-harmed while in detention. These self-harm instances led to injuries, pains, scars, poisoning, weight loss and other physical harms.

Those who self-harmed were detained in Brook House IRC, Harmondsworth IRC, Yarl's Wood IRC, Colnbrook IRC, Derwentside IRC and Tinsley House IRC. This again shows the level of self-harm is not contained to one IRC.

Of the 17 people who were recorded to have self-harmed whilst in detention, 14 people had this documented in their medical records.

Home Office statistics on self-harm

The high levels of self-harm found by Medical Justice are also reflected in the Home Office's own statistics. In the same period covered by this research (June 2022 to March 2023), there were 255 documented incidents of self-harm across the IRCs.[58] Of those, 202 incidents required on-site treatment and 12 required off-site treatment.[59]

These statistics may not reflect the true level of self-harm incidents, which is likely to be higher than those documented in IRCs by the Home Office due to non-disclosure to healthcare and/or custodial staff of self-harm or suicidal thoughts, as discussed above.

[58] This data refers to the number of incidents and does not necessarily equate to the number of individuals; some individuals may have had multiple self-harm incidents.

[59] This data is from Freedom of Information requests, obtained by Medical Justice, with reference numbers 76568, 72966, 75319 and 76239.

3. HEALTHCARE

It is particularly important to have good healthcare in circumstances where the state has removed a person's liberty and is placed in an environment which is known to be harmful. However, this is often not the case in detention. Health issues are not always identified, preventing the necessary treatment, and where health conditions are identified, the appropriate treatment is not always available. More fundamentally, the extent to which mental health care can be successfully provided in detention is limited, given that detention impedes stability, continuity of care and a holistic approach.[60] As the Royal College of Psychiatrists state *"the recovery model cannot be implemented effectively in a detention centre setting"*.[61]

IRC healthcare should play a leading role in identifying and diagnosing mental or physical health conditions that render someone vulnerable to harm in detention and should communicate this to the Home Office. (See Safeguarding Framework). If this does not take place, safeguards are not triggered for the most vulnerable people, and they are left to languish and deteriorate further in detention.

3.1 Delivering healthcare: Inquiry and Medical Justice Evidence

The Brook House Inquiry raised concerns about the provisions and delivery of healthcare services within detention, as well as the culture of IRC healthcare, which resonates highly with Medical Justice's experience and in the latest evidence collected for this report.

The Inquiry noted evidence regarding an inability to identify PTSD symptoms citing the Clinical Lead at Brook House who said that *"she was not confident her staff could identify symptoms of trauma and PTSD, and that neither she nor her staff had received any training on PTSD or torture awareness"*[62]

On the provisions, the Inquiry found that despite the clear need for a full range of mental health interventions for people with histories of torture and trauma, and those with PTSD or other mental ill health, access to this full range was absent.[63] Trauma-related psychological therapies and cognitive behavioural therapy was lacking during the relevant period.[64] The Inquiry found that these psychological interventions should have been available.[65] This lack of the appropriate mental health care *"contributed to an environment that rendered those vulnerable detained people yet more vulnerable"*.[66] Findings were made about current day practice too; such flaws in the healthcare provisions remained at the time of the Inquiry's hearings in 2022[67] and that the changes introduced by Practice Plus Group (PPG), the healthcare provider at a number of IRCs,[68] focused on the management of mental ill health and do not address significant concerns about the systemic and safeguarding deficiencies.[69]

[60] Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, page 3.
[61] Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, page 3.
[62] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 179 paragraph 17.
[63] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 179 paragraph 16.
[64] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 179 paragraph 17.
[65] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 179 paragraph 18.
[66] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 179 paragraph 18.
[67] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 180 paragraph 19.
[68] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 180 paragraph 20.
[69] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 pages 180-181 paragraph 21.

The Inquiry found there was a *"dismissive attitude of some Healthcare staff"*, the failure to fulfil safeguarding obligations and a failure to provide adequate healthcare all *"exposed vulnerable detained people to a risk of suffering harm in detention"*, and in some cases, resulted in detained people's mental health deteriorating.[70] There were instances of mocking or derogatory remarks about and in the presence of, detained people. The Inquiry particularly noted a view amongst healthcare staff that a detained person was *"exaggerating"* symptoms, conditions or histories to further their immigration case, as well as a failure to recognise particular behaviours as a manifestation of mental ill health, rather than wilful disobedience.[71]

Our evidence shows the continued absence of appropriate treatment or inability to treat particular health conditions in detention, either because the treatment is not available in detention or any treatment that is available in detention is likely to be largely futile within the detention setting.

Beyond the Brook House Inquiry findings on healthcare, Medical Justice continues to find that healthcare professionals working within IRCs, including GPs, often do not identify and diagnose a range of our clients' mental health conditions. This is important as an individual with an unidentified or undiagnosed mental health condition would not be identified and provided with the appropriate treatment, even if available in detention. This is particularly problematic given the high prevalence of mental health conditions in detained populations and given the harm that detention can cause, including as a causal factor in new mental health problems in people who were previously well. It is also concerning as the appropriate safeguards for those people would not be triggered.

3.1.1 Failure to identify or explore particular mental health conditions

According to client medical records, symptoms and diagnoses of mental health conditions are often missed or not further explored by IRC healthcare.

Of the 66 cases, Medical Justice clinicians diagnosed 34 clients with a mental health condition that was not already recorded in the client's medical records. The conditions included: PTSD, Complex PTSD, depressive disorders, psychotic disorders including schizophrenia, anxiety disorders, and acute stress reaction.

In some cases, symptoms of depression and anxiety were noted in the healthcare records and anti-depressant medication offered, however this does not always lead to onward referral or trigger safeguarding processes, as explored in Other mental health conditions.

Missed PTSD diagnoses

Identifying those with PTSD in detention is crucial to safeguard the individual and prevent harm caused by detention. This is because people with PTSD symptoms are likely to have their condition aggravated by the detention setting and threats of removal, triggering reminders of the loss of agency and powerlessness that are strongly associated with the traumatic events that cause PTSD.

It is recognised that refugees and asylum-seeking people are at increased risk of PTSD. Given that large numbers of refugees and asylum-seeking people are detained, it is particularly important for healthcare staff to be able to recognise this condition. As avoidance forms part of a diagnosis of PTSD, without support, people with PTSD may avoid rather than discuss their history and current symptoms. Medical

[70] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 184 paragraph 30.

[71] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume I, HC 1789-II, Executive Summary page 10 paragraph 47.

Justice continues to call for healthcare clinicians to proactively seek to screen for trauma-related symptoms rather than rely on disclosure, [72] as per National Institute for Health and Care Excellence (NICE) guidance. [73]

The Inquiry noted evidence of the frequent inability of healthcare staff to identify symptoms of trauma and PTSD, as explained above. Medical Justice found that the healthcare department explicitly considered the possibility of PTSD for only six of the 34 clients who had PTSD diagnosed by a Medical Justice clinician. For those six people, healthcare either confirmed the person had PTSD or stated that they required further assessment. [74] It was common in the other cases for symptoms of PTSD such as flashbacks, poor sleep and nightmares to be noted in the medical records but no exploration of the possibility of PTSD noted. There are also examples of *"trauma"* being noted in the medical records but PTSD is not identified or explored.

Medical Justice data also includes examples of Rule 35(3) reports stating that the individual *"does not have mental health problems"* but then describes symptoms of mental health issues such as poor sleep or refers to being *"stressed when thinking about past events"*, an indicator that the person may be suffering from trauma-related symptoms and may have PTSD. This reflects evidence to the Inquiry that in their Rule 35(3) reports, GPs on occasion *"sought to explain a conclusion that there was no concern regarding prolonged detention by reference to the absence of "acute mental health issues" or "psychotic features or acute deterioration""*, even though psychotic symptoms are not core diagnostic features of PTSD, depression or anxiety. [75] The Inquiry found that the *"absence of psychotic symptoms therefore could not be taken to be an indicator that harm was less likely"* [76]

Lack of mental capacity assessments

Medical Justice's evidence shows that there is a lack of assessments of detained people's mental capacity even where there are clear indicators that the person may have difficulty with some decisions, for example the presence of relevant delusional beliefs. Where relevant symptoms are recognised, individuals are referred to the healthcare team and should receive assessment of their mental capacity. Where concerns about mental capacity are confirmed, this should trigger further support and safeguarding processes alongside management of the underlying condition.

However, out of the seven clients who were assessed as either lacking mental capacity or suspected lack of mental capacity, [77] none of their medical records identified any concern from IRC healthcare about the clients' lack or suspected lack of mental capacity. This is resonant of Medical Justice's wider experience; that IRC healthcare teams may assess a detained person's capacity to make decisions related to their medical care but do not view it as their responsibility to assess capacity to make decisions in any other areas or to identify concerns in relation to this, and there is no mechanism for this to happen. If someone was identified as lacking capacity to make such decisions, there is still no process in place to enable them to access independent advocacy to advance their interests. (See Safeguards for those lacking mental capacity).

[72] See Medical Justice (April 2022) Harmed not Heard.

[73] National Institute for Health and Care Excellence (August 2022) Post-traumatic stress disorder: When should I suspect post-traumatic stress disorder (PTSD)?

[74] For one person, healthcare referred to trauma but did not refer to PTSD explicitly. For an additional three people, there were insufficient medical records to decide.

[75] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 83 paragraph 34.

[76] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 83 paragraph 34.

[77] See High prevalence of detained people with mental health problems

3.1.2 Inability and failure to provide adequate treatment in detention

Medical Justice's evidence from the 66 MLRs shows how the Inquiry's findings of the absence of appropriate treatments for mental health conditions is likely to be ongoing, across the detention estate. It further shows - echoing the Royal College of Psychiatrists - that some mental health care is not effective nor appropriate to have in a detention setting.

PTSD

Those diagnosed with PTSD should be referred to a specialist, usually for trauma-focused cognitive behavioural therapy (CBT) in line with NICE guidelines, which should be undertaken outside of detention setting. In some cases, another specialist treatment called Eye Movement Desensitization and Reprocessing (EMDR) Therapy may be recommended.

However, access to psychological therapies is severely limited in detention, and even if treatment was available, our clinicians advised it was unlikely to be effective, because treatment of PTSD requires a safe and stable setting in which the person can address traumatic memories. This is in line with NICE PTSD guidelines to avoid treating PTSD in *"trauma-inducing environments"*. [78]

Medical Justice had completed IRC medical records for 31 of the 34 people diagnosed with PTSD by Medical Justice clinicians. One person was offered low-intensity Cognitive Behavioural Therapy (CBT) in detention but was unable to fully engage with it, due to being detained. None of the others were offered any psychological therapy, and specifically were not offered the trauma-focused cognitive therapy or EMDR recommended in national guidelines. [79] For one person, the IRC psychiatrist explicitly recognised the person's need for trauma-focused therapy but noted that it is not available in detention. For another, the IRC GP recommended their release in a Rule 35 (3) report stating that *"Research has shown that PTSD is unable to be supported and treated adequately in a detention centre setting".* Conversely, for another client, the IRC GP raised the possibility of PTSD in a Rule 35 (3) report and referred them to the mental health team, but concluded that their *"health needs can currently be met at the IRC"* (See Rule 35 report quality lottery).

Other mental health conditions

For those diagnosed with depression, Medical Justice clinicians recommended that in line with national guidance, they should be offered treatment matched to their clinical needs and preferences. For some clients with depression, clinicians stated that detention was not an appropriate setting to benefit from treatment for their depression. Clinicians also had concerns that individuals may have been prescribed anti-depressants in detention as the sole intervention, which failed to address their needs holistically and was unlikely to sufficiently address their symptoms in isolation.

Clinicians recommended that those diagnosed with schizophrenia should be released (or released for transfer to hospital where needed) as treatment was likely to have poor outcomes in detention, again failing to address their needs other than for medication.

Other examples of inadequate healthcare in detention included those discharged from the IRC mental health service without being seen, and/or had no follow up with the IRC GP after the mental health team did not accept their case after referral by the IRC GP.

[78] National Institute for Health and Care Excellence (2021) Post-traumatic Stress Disorder paragraph 1.4.4.

[79] It was unknown if three clients were referred to trauma-focused therapy due to incomplete medical records. One client did not have trauma related symptoms in detention during their short stay in detention but was later diagnosed by MJ clinician with PTSD.

One client was told that he could not access therapy until he comes off ACDT, according to his medical records.

Shockingly, Medical Justice has seen an IRC GP suggest in a Rule 35(3) report that an individual would be more vulnerable outside of detention because of medical support available within, despite recognition of his mental health symptoms within detention. With detention being a harmful environment for those with mental ill health and the lack of adequate medical care and treatment inside detention as outlined above, it is very concerning that a GP would suggest the individual would be more vulnerable outside of detention.

Physical health conditions

In addition to inadequate care of mental health conditions, there are also examples of physical health conditions in the case set that were not treated or provided for in detention. This included Medical Justice clinicians recommending clients receive anti-viral treatment, treatment for asthma, a neuro-psychiatric assessment, and/or requiring referral to specialists such as rheumatology, the lipid clinic, neurology and infectious diseases and for, all of which clients needed but were not getting in detention.

Aaron raised concerns to Medical Justice about his access to and treatment by an IRC doctor: *"I had a doctor's appointment after one week [in detention], but he never actually saw me. He said 'you are for [the] mental health team' but I had other health issues like my back pain".*

3.1.3. Worrying culture of IRC healthcare in detention

Echoing the findings of the Brook House Inquiry, Medical Justice, in its daily casework with individuals in detention, continues to come across instances indicative of a worrying culture amongst IRC healthcare across the detention estate. This includes dehumanising language and behaviour towards detained people and disbelief of their mental and/or physical ill-health. This is indicative that the dismissive and unempathetic culture within healthcare that the Brook House Inquiry found, is still ongoing. Additionally, there are examples in the case set of disbelief or dismissive language used by staff around self-harm. See ACDT and Constant watch not working and causing further harm.

Mark experienced mocking behaviour from healthcare when he tried to harm himself.

"I refused to give the can to the officer, I was trying to harm my left hand with a can of red bull and two nurses were laughing. Then I got more frustrated, how can you laugh at this situation? We see this situation every day. How are you laughing when someone is trying to kill themselves?"

In his medical records, the healthcare staff member noted that Mark *"then made allegations that I had laughed at him and his mental health (I had smiled at an officer)".*

Aaron described the *"horrible conditions"* in detention which were *"like a prison"* and the dismissive and disbelieving treatment he experienced from healthcare staff.

"I became worse [in detention]... I had chest pain and when I went to the nurse she said 'why are you all coming for an ECG [Electrocardiogram] at this time'. It was hurtful to hear that. Imagine, how can you say that when you have an emergency somewhere and call the ambulance and they say 'why are you coming at this time?". He told Medical Justice "Even some nurses giving out medication said 'why are you all coming on my shift?'. Some staff there feel we deserve to be condemned." Following their MLR assessment, Medical Justice's clinician told healthcare that Aaron had already reported his chest pain to healthcare but that it remained uninvestigated. Only following this communication by Medical Justice, Aaron was booked to have an ECG and blood test.

Aaron told Medical Justice that at another time in detention he *"twisted [...a] nerve or something because of the bed, which is like a coffin. I started limping, I couldn't put my feet on the floor... The [IRC] officers offered to carry me on their back because I was in terrible pain. I went to the doctor and saw him in the corridor and he said 'not this time, make an appointment'. One or two hours later the nurse saw me in that condition and took me to see the doctor. The doctor told me 'what's the matter now with you? I saw you earlier and you were walking just fine'. I was in terrible pain, what a cruel thing".*

4. DETENTION SAFEGUARDS

4.1 The safeguarding system: the policy and legal framework

Highly vulnerable people, often with a history of trauma, have particular healthcare needs and are at a particular risk of harm in immigration detention. However, the lack of pre-detention screening results in many highly vulnerable individuals not being identified and subsequently routed into detention.

Medical Justice continues to find the Detention Gatekeeper (DGK) team - who review an individual's suitability for detention before they are detained - to be ineffective at identifying those at risk of harm in detention due to their vulnerabilities.[80] There continues to be no clinical pre-detention screening to seek to identify vulnerable people before they are detained.

Once in detention, an initial healthcare screening should be conducted by a nurse within two hours of arrival. Rule 34 of the Detention Centre Rules (DCR) 2001 then requires that detained people are offered an appointment with an IRC GP within 24 hours of arrival. At the appointment, the doctor is required to undertake a mental state and physical examination of their patient. The Rule 34 assessment has a dual function: (1) to promptly identify healthcare needs so that appropriate healthcare can be provided; and (2) to enable early identification of vulnerabilities and identify people who are at risk of suffering harm in detention so that they can be referred for a Rule 35 appointment which triggers a review of their detention and, if deemed appropriate by the Home Office, their release, promptly before harm materialises.[81] Rule 34 and Rule 35 DCR 2001 are therefore interlinked safeguarding mechanisms.[82]

Rule 35, as set out in the DCR 2001, is the key safeguarding mechanism which aims to identify those with particular vulnerabilities and bring them to the attention of the Home Office.[83] IRC GPs have specific reporting obligations to the Home Office under Rule 35 if the patient is identified as at risk in detention. A report under Rule 35 triggers the Home Office to review the individual's detention and decide whether to maintain detention or order the person's release.[84]

Within detention, multiple safeguards are, in theory, in place to identify, protect and route vulnerable individuals out. Healthcare screening upon detention and Rule 34 appointments with the IRC GP within 24 hours of detention should enable vulnerable people to be identified at an early point in detention and refer them into the Rule 35 process. This process should enable healthcare to communicate vulnerabilities regarding risk of being injuriously affected, risk of suicide and victims of torture to the Home Office at any point in their detention triggering a review of their detention. However, in reality, these processes for not function properly in reality.

In response to Rule 35 reports, the Home Office assesses the individual's level of vulnerability according to the Adults at Risk (AAR) policy and reviews whether the person should remain in detention or be released. Indicators of vulnerability as set out in the AAR policy includes those with histories of torture, trafficking and sexual violence, those suffering from a mental health condition, and from PTSD.[85] Identifying these indicators of vulnerability as early as possible is vital to preventing and reducing the

[80] The Detention Gatekeeper works independently of both referring operational teams and detained casework teams to ensure individuals only enter immigration detention where detention is for a lawful purpose – Home Office, Detention General instructions.

[81] *R (on the application of D and K) v Secretary of State for the Home Department* [2006] EWHC 980 (Admin).

[82] For more information on the link between safeguarding responsibilities of Rule 34 and Rule 35, see Medical Justice (April 2022) Harmed not Heard, page 15.

[83] Rule 35 Detention Centre Rules 2001 (SI 2001/238).

[84] Detained people should be given a copy of their Rule 35 report automatically. If this does not happen, detained people can get a copy upon request.

[85] Home Office (updated 16 March 2022) Statutory Guidance Adults at risk in immigration detention.

harm caused by detention. The AAR policy provides that vulnerable individuals or adults at particular risk of harm in detention should not normally be detained and can only be detained when *"immigration control factors"* outweigh their indicators of risk.[86] There are three levels of evidence of risk.[87] Only persons with the highest level of evidence of risk of harm in detention (Level 3 evidence) would have the greatest protection against continued detention.

This policy requires detained people to not only provide evidence of their vulnerability in detention, but directs the Home Office to balance *"immigration control factors"* against the risk of harm to the vulnerable person when taking a decision about whether the vulnerable person would be released.[88] In practice, what the Home Office considers are *"immigration control factors"*, tends to outweigh the risk of harm and vulnerable people are kept in detention.

Another mechanism at the disposal of healthcare to communicate clinical concerns to the Home Office is a 'Part C' form.[89] There is a stark contrast between the Part C form and Rule 35 report. Crucially, a Part C does not require the IRC GP to explain any clinical assessment, or to include information concerning the impact of detention on the patient, or any specific level of detail concerning their vulnerability in detention. Additionally, receipt of this document by the Home Office does not require a review of detention and there are no obligations to provide a formal response. The Court has found that use of a Part C form is not an adequate substitute for a Rule 35(3) report and given the limitations of the clinical information required by the form there is no reason consider it would be generally appropriate to use in place of safeguarding reporting via Rule 35 processes.[90]

In addition to clinical safeguards through Rule 35, there are custodial processes in place to prevent and *"manage"* self-harm and suicide risk in detention. This is through the use of ACDT, a system of observations (the highest level being constant watch) and regular reviews led by custodial staff.

4.2 Clinical and custodial safeguards: Inquiry and Medical Justice Evidence

The Brook House Inquiry found serious systemic failures within the safeguards provided by Rule 34, Rule 35 and the Adults at Risk policy.[91] It found that a number of entire safeguarding mechanisms to be *"dysfunctional"* which resulted in a failure to protect detained people.[92] Such *"wholesale breakdown"* of the detention safeguards was found to have likely caused actual harm to detained people.[93]

The Inquiry also found a complete absence of a consistent mechanism for the routine follow-up of detained people who were considered to be victims of torture or adults at risk, including the failures to complete Rule 35 reports, the failure to detect or monitor deterioration, and an overall failure to notify the Home Office and trigger a detention review.[94]

[86] This was introduced following the highly critical review by Stephen Shaw in 2016.

[87] The Adults at Risk policy contains three levels of evidence. 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.

[88] '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.

[89] This is an internal process which entails completion of a much shorter document form IS91RA Part C (risk assessment).

[90] *R (on the application of Medical Justice and others) v Secretary of State for the Home Department* [2017] EWHC 2461 (Admin).

[91] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 89 paragraph 47.

[92] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.1 page 4 paragraph 2.

[93] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter Ch D.5 page 86 paragraph 41.

[94] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 86 paragraph 41.

As a result, people were allowed to deteriorate in their mental and physical health and were failed by the very system that was designed to protect them.

Medical Justice's evidence shows the serious and continuing systemic failures in safeguarding of this population in detention at every safeguarding opportunity. This echoes longstanding evidence from Medical Justice, HMIP, the ICIBI and others of the flaws in clinical safeguards; such concerns have been repeatedly raised before, during and since the Brook House Inquiry.

Alan: psychotic disorder not identified by any detention safeguards

Alan ended up in immigration detention despite being severely mentally ill and unable to navigate the immigration processes he was subject to, indicating a total failure of the safeguarding processes both before entering detention and during his detention. His case illustrates how someone so demonstrably unwell in detention can fall through the cracks.

Alan did not have any contact with healthcare during his detention other than his healthcare screening where the nurse commented on his behaviour. He did not see an IRC GP at a Rule 34 appointment within 24 hours of detention or afterwards and did not have a Rule 35 report. After his healthcare screening, the only contact he had with a healthcare professional was an independent Medical Justice clinician. The clinician diagnosed him with a psychotic disorder and assessed him as lacking mental capacity to make decisions relating to his detention and immigration case.

It appears his ill-health was not picked up by any internal safeguarding mechanism at the IRC, despite him being sufficiently unwell for his solicitor to refer him to Medical Justice, who sent a clinician to carry out an MLR assessment in detention. The clinician diagnosed him with a psychotic disorder and assessed him as lacking mental capacity to make decisions relating to his detention and immigration case.

4.2.1 Defective initial healthcare screening

The Inquiry made damning findings on the healthcare screening in that it was effectively a tick box exercise.[95] It was *"sometimes the only appointment that occurred"* and *"was effectively treated as the examination required under Rule 34"*.[96]

In Medical Justice's experience, the healthcare screening often fails to identify vulnerability. When a vulnerability is identified, this does not consistently lead to the doctor at the Rule 34 appointment to investigate this vulnerability or trigger a Rule 35 appointment.

[95] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 74 paragraph 12.

[96] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page74 paragraph 12.

4.2.2 Rule 34 failings

The Brook House Inquiry found *"significant deficiencies in the operation of Rule 34"* which were *"likely to have caused detained people to suffer actual harm"*.[97] These deficiencies included Rule 34 appointments not taking place, Rule 34 appointments so short that they were rendered inadequate, and mental health not being properly assessed at Rule 34 appointments.[98]

It found that this *"left vulnerable detained people in particular at risk of mistreatment, such as the inappropriate use of segregation and the rapid resort to use of force to manage incidents of self-harm and mental health crisis. It also meant that vulnerable people were detained when detention was not appropriate for them".*[99]

Samuel is a survivor of torture and sexual abuse and suffers from PTSD, depression and has significant anxiety symptoms. When he was detained, during the healthcare screening process, the nurse booked him to have a Rule 35 appointment *"for all the abuse he suffered"* and noted that he had medication for depression, PTSD and anxiety. The nurse referred him to the mental health team in the IRC. During his Rule 34 GP appointment, which took place the following day, there was no discussion about the Rule 35 appointment made or any indication that the GP asked or explored his disclosure of abuse or diagnoses of PTSD and anxiety, according to his medical records. This information would have identified him early on into detention as a vulnerable person, which should be communicated to the Home Office. Instead, he had to wait a further 16 days to have a Rule 35 appointment with the IRC GP.

Edward is a torture and trafficking survivor and suffers from suspected complex PTSD which required further assessment. When he entered detention, Edward already had a history of self-harm and suicide attempts, including in prison. His healthcare screening however recorded *"no history of deliberate self-harm in a secure estate".* Edward saw the IRC GP for his Rule 34 appointment who noted *"no mental health issues identified"* in the medical records. One week after he was detained, Edward took a large and dangerous overdose of medication with the intention to take his own life. Later in his detention period, Edward was transferred to another IRC. Despite the information being documented in the healthcare records from the previous IRC, which would have been available to the new healthcare team, the healthcare screening failed to record that he had attempted suicide in the previous detention centre. Edward's medical records stated: *"no history of deliberate self-harm in community, no thoughts of deliberate self-harm, no history of deliberate self-harm in secure estate".* Edward's Rule 34 appointment the following day noted a history of depression and his medications but failed to note his suicide attempt in the detention centre he was transferred from, or the other vulnerabilities noted in his Rule 35 report.

[97] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 77 paragraph 21.

[98] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 pages 74-77 paragraphs 13-20.

[99] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 77 paragraph 21.

The Inquiry found *"the problems [with Rule 34] persist"*[100] and Medical Justice's findings further evidences this to be the case to date.

Of the 66 clients, only 35 saw an IRC GP within 24 hours of arrival at an IRC.[101] Of those 35, 11 did not have any mental health examination noted in their medical records as part of their Rule 34 appointment. This included a client whose medical records show the IRC GP noted their anti-depressant medication but did not explore why they were already prescribed anti-depressants. In other cases, it was common that the IRC GP noted a physical health issue in their medical records but did not conduct a mental health examination, according to their medical records.

For those who had their mental health mentioned in their medical records, it was rare that they had a sufficiently detailed assessment to fulfil the safeguarding function of Rule 34. For example, medical records for the appointment only state *"no"* or *"nil"* mental health problems.

In one case, an individual disclosed in their healthcare screening that they were a victim of torture but at their Rule 34 appointment, the IRC GP noted that they had *"no mental health problems"* and no exploration of their torture history or impact on their mental health was noted. The Rule 34 appointment did not trigger a Rule 35 appointment and it was another 3 months before a Rule 35 (3) report was completed by the IRC GP.

In a case where their Rule 34 appointment did include a mental health assessment and mental health issues that indicate that detention would be harmful to the individual were noted, the GP failed to communicate their findings to the Home Office through a Rule 35 (1) report.

27 of the 66 people in the case set did not see a GP within 24 hours of arriving to the IRC. Of those 27, the number of days between being detained and seeing a GP ranged from 2 to 42 days. Shockingly, three people were not seen by a doctor at all during their detention, according to the medical records available to Medical Justice.

George was placed on ACDT due to the mental health symptoms he experienced while held in a previous establishment, prior to being transferred to an IRC. In his initial screening appointment at the IRC, he told healthcare that he did not need to see a GP. Consequently, his medical records shows that healthcare did not book him to have a Rule 34 appointment, despite his medical records showing he was on ACDT up to that point. There is no mention in his medical records of any discussion of the purpose of the Rule 34 appointment being explained.

Ten people did not attend their Rule 34 appointment. According to Rule 34, those who don't *"consent"* to having an appointment can subsequently request an appointment.[102] However, none of the medical records noted that individuals were provided with an explanation of what the Rule 34 appointment was or the safeguarding purpose of it. Indeed, as explained above, Rule 34 and Rule 35 are linked safeguards. Those who did not attend their appointment or said they did not need to see a GP, therefore appear to not to have been properly informed of the safeguarding purpose of the assessment.

[100] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 78 paragraph 24. Also see Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 73 paragraph 10 and page 77 paragraph 22.

[101] For 4 additional clients we had insufficient access to medical records to see whether they saw an IRC GP within 24 hours of arrival at an IRC.

[102] Rule 34 Detention Centre Rules 2001 (SI 2001/238).

More broadly, people with a range of mental health symptoms may avoid seeking healthcare due to anxiety or fear, beliefs about stigma, social and cultural differences in perceptions about mental health. Severe mental health problems may impact on motivation, self-care and judgement about seeking healthcare. In addition, a common response to traumatic events, and a symptom of PTSD, is to avoid talking about what has happened and the resulting symptoms. This means that people may not present for healthcare, including to their Rule 34 appointment.

4.2.3 Rule 35 failings

The Brook House Inquiry *found "serious systemic failures [within the Rule 35 process], indicating a wholesale breakdown in the system of safeguards designed to protect vulnerable detained people"*. [103]

The Inquiry's concerns included that there was no system in place to automatically review a detained person's health and welfare when they had self-harmed, made a suicide attempt or there was apparent deterioration in their mental health and no mechanism for GPs to systematically review the person's condition. [104]

The Inquiry also found that in the relevant period, there was no systematic approach to using Rule 35(1) and Rule 35(2) and that such failure to complete Rule 35 reports resulted in detained people's mental health deteriorating and risk of self-harm and suicide increasing, leaving them more vulnerable to harm. [105] Although PPG have made some changes since, the Inquiry suggests that these have not been sufficient. [106] Sarah Bromley (the current National Medical Director for Health in Justice at PPG) herself told the Inquiry that the Rule 35 process was still failing at various points and that Rule 35(1) and Rule 35(2) in particular appeared to have been *"a little lost along the way"*. [107] Medical Justice's latest analysis and the Home Office's own data, detailed below, shows that this issue continues to persist.

Concerns were raised about the quality of Rule 35 reports and the lack of oversight mechanism in the Home Office to monitor both the quality of the Rule 35 reports and of the reasons why so many Rule 35 reports do not lead to the release of detained people. [108]

The Inquiry also found that instead of Rule 35 reports, healthcare inappropriately used alternative mechanisms (such as the Part C form), that were *"not designed for – and not capable of – adequately fulfilling the purposes of ensuring the safety and wellbeing of detained people and of notifying the Home Office of their vulnerabilities to ensure that their detention was reviewed*". [109]

Medical Justice continues to see examples of IRC GPs using Part Cs to communicate deterioration or concern rather than a Rule 35 (1) report, including at Brook House.

[103] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 86 paragraph 41.

[104] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 86 paragraphs 39.1 – 39.3.

[105] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 86 paragraphs 39.2 and 41.

[106] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 87 paragraphs 42.

[107] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 96 paragraph 62.

[108] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 89 paragraph 45.

[109] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 89 paragraph 47.

Edward experienced a further deterioration in his mental health in the months following his attempt to take his own life in detention and asked healthcare to help. Healthcare sent two Part Cs to the Home Office to communicate healthcare's concern about his mental and physical health. However, an IRC GP failed to use the correct safeguarding mechanisms; this would be to complete a Rule 35 (1) report to communicate their concern about Edward's health, which is necessary to flag vulnerabilities to the Home Office and trigger a detention review. It took two weeks for the GP's concern to be communicated in a second Rule 35 (3) report, referred to by the GP as an *"addendum"* to the previous Rule 35 (3), which is the incorrect template for these issues.

As explained above, this is problematic as Part Cs do not trigger a detention review and do not require a formal response from the Home Office. In addition, where IRC GPs are completing Rule 35 (3) reports for torture survivors and have concerns that they are being or may be harmed in detention, Rule 35 (1) reports are not subsequently completed, which is the appropriate mechanism to do so.

Samuel told Medical Justice: *"Rule 35 was an absolute disaster. He [the doctor that saw me] must have been on a timer bonus because within minutes he wants to get you out of the consultation room. He just says yeh yeh yeh you can go. He's uninterested in what you have to say... He took three minutes to do my first Rule 35 [report]".*

The doctor completed a Rule 35 (3) report which contained a very brief summary about Samuel's account of torture and mental health symptoms of PTSD and depression. However, the report did not address the risk of harm of detention on his mental health or the lack of access for treatment for PTSD in detention and did not document the scarring on his body. After reading his Rule 35 report, Samuel told healthcare that he was not happy with the report as it contained inaccuracies. Healthcare arranged for him to have another Rule 35 appointment with a different doctor which took place seven days after his first Rule 35 appointment. His experience with this doctor was very different to the first: *"He was very thorough. He asked various questions, he checked me physically, looked at my scars, he felt my scars. He took the time, he did a lot more thorough work than the first doctor. It was a lot better and improved version from the first one [first Rule 35 appointment]."* This shows an inconsistency in the quality of treatment of clients by IRC doctors; there seems to be a lottery in terms of the quality of clinical assessment and of Rule 35 report. See also Rule 35 report quality lottery.

The second Rule 35 (3) report further recorded his torture account and documented Samuel's scars and contained information about the deterioration of his mental health in detention. The doctor also recommended that he should be released from detention, stating: *"Research has shown that PTSD is unable to be supported and treated adequately in a detention centre setting. I believe that he should be released from detention".*

Despite both doctors documenting his PTSD symptoms and one stating that he should be released, both doctors should have also completed a Rule 35 (1) report with safeguarding concerns, which they did not do.

The Home Office's response to Samuel's Rule 35 (3) reports was very delayed. The Home Office did not respond to both reports until 22 working days after the second Rule 35 (3) report was sent by IRC healthcare. A month after his second Rule 35 report, Samuel was accepted as an Adult at Risk level 3 and as a torture survivor. The Home Office stated in its response to Samuel's Rule 35 report that it had already granted his release, pending *"suitable accommodation"*. Samuel described how he was shocked to find out he was granted release a week before the Home Office communicated with him.

Despite this, Samuel remained in detention for over four months after the Home Office's decision to release him. He told Medical Justice: *"Until now I feel desponded and pulverised".*

Rule 35(1)

Medical Justice clinicians found high levels of harm to clients. Of the case set, detention had already caused the mental state of 64 clients to deteriorate and caused harm to all 66 clients by the time of their MLR assessment. See Levels of mental health deterioration and harm.

However, only 5 people had a Rule 35(1) report as they should have done.[110] Four of the Rule 35(1) reports were completed in relation to a significant deterioration in their mental health in detention and one was completed in relation to their physical health issues and mental health deterioration. Significant deterioration included psychotic symptoms, significantly decreased nutritional intake, paranoia and refusal to take medication.

The IRC GP stated in all 5 Rule 35(1) reports that the person would or may benefit from release to access mental health care in the community or that prolonged detention will further harm their mental health.

Our evidence shows that Rule 35 (1) reports are not being completed for all those *"likely to"* suffer harm but that quite significant deterioration in their mental health or a physical health issue has to occur before one is completed, if at all. This is in clear breach of the rule, which has a low threshold designed to identify those who are *"likely to be injuriously affected"* by continued detention or the conditions of detention, so not requiring actual harm to already have occurred for a report to be required.

Only two of the 13 people who attempted suicide in detention had a Rule 35 (1) report completed. However, neither report mentioned their suicide attempt. In one case, the Rule 35 (1) report was not completed until several months after the suicide attempt. The report noted that the individual had suicidal thoughts but did not mention the suicide attempt or that they were on ACDT at the time of the report. [111] None of the 17 who self-harmed in detention had a Rule 35 (1) report completed.

Rule 35(2)

Analysis of the 66 clients' MLRs showed that whilst in detention, 46 people were recorded as having had suicidal thoughts and 13 people were recorded to have attempted suicide. Medical Justice assessments also found that 43 clients' risk of suicide had increased since they had been detained. See Self-harm and suicidality in detention.

[110] Three were completed in Brook House, 1 in Yarl's Wood and 1 in Colnbrook.

[111] In the second case, it is not known if the suicide attempt was known to healthcare as it was not noted in their medical records.

Despite the high suicide risk, our evidence shows that Rule 35(2) - which requires IRC GPs to complete a report if they suspect *"suicidal intentions"* - is not an effectively functioning safeguard. Rule 35(2) reports are not being completed where there are clear grounds to suspect suicidal intentions. Where Rule 35(2) reports are completed, the assessment is often inadequate and incomplete, for example missing information such as a suicide attempt.

Only five of the 46 people who had suicidal thoughts and/or attempted suicide in detention had such a report. [112]

This is particularly stark for the 13 who attempted suicide in detention, of whom only three had a Rule 35(2) report completed. [113] Only two of the three reports noted the person's suicide attempt.

Of these three Rule 35(2) reports, only two were in response to a suicide attempt, one of which was only completed after the detained person's second suicide attempt, three months after their first suicide attempt. In the third case, the Rule 35(2) report was only completed following several self-harm episodes and no report had been completed in response to their suicide attempt several months earlier.

Given only *"suspicions"* of suicidal intent are required for a report to be required, it is also concerning that of the 17 that self-harmed in detention, only three had a Rule 35 (2) report completed.

Aaron: Torture survivor, suicidal thoughts and at risk of harm in detention with no safeguarding report completed

Aaron is a trafficking and torture survivor and suffers from significant trauma-related symptoms and depression. When Aaron was first detained in a STHF, he told the nurse that he suffers from anxiety and depression and takes anti-depressant medication. He also told healthcare that he has a history of self-harm and would attempt suicide if he was returned to the country he fled from. Healthcare put Aaron on ACDT and hourly observations at the STHF. When he was transferred that night to an IRC, Aaron told the nurse during the initial healthcare screening that his life was in danger in the country he fled from, and that he would attempt suicide if returned there. He remained on ACDT but was not referred for a Rule 35 (1) appointment. Aaron told Medical Justice that *"they kept my medication [at the IRC], so the first night [at the IRC] I did not have it".*

Aaron saw an IRC doctor for his Rule 34 appointment the next day, who referred him to the mental health team for an urgent assessment as he was *"expressing suicidal thoughts"* and prescribed his medication. Despite this, the doctor failed to complete a Rule 35 (2) report for Aaron. As a result, the Home Office would not have been made aware of his suicide risk in detention and would not have considered Aaron's vulnerability or considered his release under the Adults at Risk policy as it should have done. After Medical Justice's clinician assessed Aaron in detention, the clinician came to the conclusion that detention had already caused Aaron to deteriorate in his mental state and caused him harm.

[112] Three Rule 35 (2) reports were completed in Brook House, one in Yarl's Wood and one in Harmondsworth.

[113] In one case, it is not known if the suicide attempt was known to healthcare as it was not noted in their medical records.

They further found that his risk of suicide had increased since being in detention and was likely to further increase if he remained in detention. However, no Rule 35 (1) or (2), was completed by the IRC GP during Aaron's time in detention. Additionally, despite his having disclosed torture and indicating that *"his life was in danger in the country he fled from",* no Rule 35 (3) was considered or completed.

Home Office statistics on Rule 35(1) and Rule 35(2)

The numbers of Rule 35(1) and Rule 35(2) reports that are completed have historically been, and continue to be, extremely low.[114] The stark lack of Rule 35(1) and Rule 35(2) reports found by Medical Justice is in line with the Home Office's own statistics. In the year ending September 2023, of the 2,147 Rule 35 reports completed across all the IRCs,[115] only 49 were Rule 35(1) reports and only 15 were Rule 35(2) reports.[116] Therefore, of the total number of Rule 35 reports, only 2.28% were Rule 35(1) reports and 0.69% were Rule 35(2) reports. This is concerning given the evidence of high rates of vulnerability, harm, deterioration, and suicidality in detention.

This small proportion is not unusual; since 2015, the proportion of Rule 35 reports that are Rule 35(1) reports has fluctuated between 1.17% at its lowest point in 2020, and 4.11% at its highest in 2015. Between 2015 and 2022, the proportion of Rule 35(2) reports has fluctuated between 0.22% in 2019 and 1.49% in 2022. Although the proportion of Rule 35(2) reports has increased over 1% of all Rule 35 reports completed for the first time in 2022, the proportion is still negligible.

As explained above, the Brook House Inquiry found failures of healthcare in Brook House IRC to ensure that Rule 35(2) reports were appropriately completed. Following the evidence heard during the Inquiry hearings, the Home Office and NHS England wrote jointly to all IRC healthcare departments to explain their basic legal duties and functions in implementing the key safeguards in accordance with the DCR 2001, since it had become apparent that these are not universally understood nor properly carried out.[117]

The healthcare provider, PPG, gave further evidence in April 2022 that interim measures had been introduced requiring that when an ACDT is opened (to identify and support detained people at risk of self-harm and/or suicide), a Rule 35(1) appointment will be booked for the same or following day, and a Rule 35(2) appointment will be undertaken for all patients on constant supervision.[118]

Despite the Home Office and NHS England's letter,[119] and the interim measures introduced during the Brook House Inquiry[120] (see ACDT and Constant watch), there has been no real change in the number of Rule 35(1) and Rule 35(2) reports. Home Office statistics reveal that the proportions are negligible. Of note, in the most recent quarter (July – September 2023), no Rule 35(2) reports were completed in Brook House IRC at all and only 2 Rule 35(1) reports were completed.[121] These negligible numbers are reflected across the IRCs, for example in Colnbrook IRC, no Rule 35(1) reports and only 1 Rule 35(2) reports were

[114] See statistics since 2015 in Home Office and Immigration Enforcement (published 23 November 2023) Transparency data: Immigration Enforcement data: Q3 2023 table DT_03.

[115] Out of 16,363 people detained in the year ending September 2023. Home Office national statistics: *How many people are detained or returned?* 23 November 2023.

[116] Home Office and Immigration Enforcement (published 23 November 2023) Transparency data: Immigration Enforcement data: Q3 2023 table DT_03.

[117] Phil Riley and Kate Davies, 1 April 2022, HOM0332160.

[118] Third witness statement of Sarah Bromley, paragraph 3 PPG000205.

[119] Phil Riley and Kate Davies, 1 April 2022, HOM0332160.

[120] Third witness statement of Sarah Bromley, paragraph 3 PPG000205.

[121] Home Office and Immigration Enforcement (published 23 November 2023) Transparency data: Immigration Enforcement data: Q3 2023 table DT_04.

completed.[122] Given that these are the Home Office's own statistics, the Home Office would have been aware that the letter had not resulted in any change. In March 2023, Frank Ospina died by suicide, whilst detained in Colnbrook IRC.[123] During this month, there were also no Rule 35(2) reports completed for suspected suicide risk at all.[124]

The Brook House Inquiry's report stated that the joint letter from the Home Office and NHS England was submitted one day before the Home Office director of immigration detention and escorting services was due to give evidence and was thus *"indicative of the superficial and cursory approach of the Home Office to addressing serious deficiencies in a dysfunctional system for which it is responsible*".[125]

Rule 35(3)

Given that Rule 35(1) and Rule 35(2) reports are not routinely completed, Rule 35(3) reports have in appropriately become the primary mechanism to identify those at risk of harm in detention.

As the Home Office's own statistics indicate, in the year ending September 2023, of the 2,147 Rule 35 reports completed, 2,083 reports were Rule 35(3) reports.[126] This is concerning as it only applies to those with a history of torture. Individuals without a history of torture will therefore not be identified; risk of harm cannot be considered by the Home Office caseworkers responsible for reviewing their detention.

Of the 66 clients in this case set, IRC GPs completed 55 Rule 35(3), with some clients having more than one Rule 35 report completed.[127]

Six clients who had evidence of a history of torture documented in their MLR by Medical Justice, did not have a Rule 35(3) report completed in their most recent detention episode in an IRC.[128] One of those six had a Rule 35 (3) report completed in a previous detention and a Rule 35 update was requested by healthcare in this detention episode but the appointment never took place, according to the medical records available to Medical Justice.

Failure to document or inadequately document scarring in Rule 35 (3) reports

Documenting scarring, where present, in a Rule 35 (3) report is hugely important to a person's case and level of vulnerability in the eyes of the Home Office, as it is medical evidence of their torture account.

40 clients had scarring documented by the Medical Justice clinician that formed clinical evidence of their account of torture (See Evidence of torture: Scarring). Of those 40, four did not have a Rule 35(3) report completed in detention which would have given rise to the opportunity to document the scarring in the IRC. One person had their scarring documented in a Rule 32 (3) report[129] in a STHF but did not have a Rule 35 (3) report in the IRC.

[122] Home Office and Immigration Enforcement (published 23 November 2023) Transparency data: Immigration Enforcement data: Q3 2023 table DT_04.

[123] Aaron Walawalkar (14 September 2023) Revealed: 'Mass suicide attempt' at immigration centre after detainee death Liberty Investigates.

[124] Home Office and Immigration Enforcement (published 24 August 2023) Transparency data: Immigration Enforcement data: Q2 2023 table DT_04.

[125] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 92 paragraph 53.

[126] Home Office and Immigration Enforcement (published 23 November 2023) Transparency data: Immigration Enforcement data: Q3 2023 table DT_03.

[127] The 55 Rule 35 (3) reports were completed for 50 clients. One person had three Rule 35 (3) reports completed in the same detention episode, and three people had two Rule 35 (3) reports completed in the same detention episode. Two additional people had a Rule 32 (3) report completed while they were detained in a STHF. This report was completed by a nurse, not a GP so is not included in the 55.

[128] This does not include those who had a Rule 35 (3) report done in a previous detention episode but not in the current detention episode or a Rule 32(3) report completed by a nurse while detained in a STHF. Rule 32 of the Short-Term Holding Facility Rules states that: by virtue of rule 32 a 'health care professional' may be either a registered medical practitioner or a registered nurse." Two had a Rule 32 (3) report documenting their torture in a STHF – including one age-disputed minor, prior to their detention at an IRC.

[129] Rule 32 is the equivalent to Rule 35 of the Detention Centre Rules 2001, for Short Term Holding Facilities. Rule 32 provides arrangements for the health care professionals in residential STHFs to report to the Secretary of State where they have concerns that: (1) an individual's health may be injuriously affected by their continued detention in a short-term holding facility or any conditions of detention; (2) an individual may have suicidal intentions; or (3) an individual may have been a victim of torture.

Under Rule 35(3), IRC GPs are obliged to provide *"details of all scarring or other physical marks, psychological symptoms, physical disability or impairment"*.[130] The IRC GP should also comment on the *"consistency of any physical (e.g. scars) and/or psychological findings with the detainee's allegations, including any evidence to the contrary"*.[131]

Despite these obligations, Medical Justice found that the quality of scarring documentation and clinical opinion on this varied in the Rule 35 (3) reports it analysed. The analysis included whether the IRC GPs document scarring at all, partially document scarring and whether they express an opinion on the consistency of the scarring with their account of torture and/or other ill-treatment.

In three cases, IRC GPs completing a Rule 35 (3) report failed to document any of the scars which were documented by the Medical Justice clinician in the clients' MLRs, stating for example *"no scars or wounds"* or no notes of either the presence of lack of scarring. One of the three failed to document scars in the first Rule 35 (3) and it was only after the individual complained and got another Rule 35 (3) report completed that multiple scars were subsequently documented.

In another case, the IRC GP notes that the individual says they were cut but does not document any scarring that was documented by the Medical Justice clinician.

An IRC doctor completed a Rule 35 (3) report for Samuel, a torture survivor, which stated that he *"did not have any scars"*. Samuel told Medical Justice: *"It was a trigger point for me when the [IRC] doctor said I don't have any scars. The [IRC] doctor did not even ask about scars*". Medical Justice's clinician documented scarring on Samuel's body. After reading his Rule 35 report, Samuel told healthcare that he was not happy with the report as it contained inaccuracies.[1] Healthcare arranged for him to have another Rule 35 appointment with a different doctor. His experience with this doctor was very different to the first: *"He was very thorough. He asked various questions, he checked me physically, looked at my scars, he felt my scars".*

Mark had a Rule 35 appointment with an IRC GP where a Rule 35 (3) report was completed. The doctor noted that Mark had *"no physical scars"* and did not include detailed information about his mental health. After seeing a copy of his report, Mark went directly back to healthcare as he was not happy with how the doctor reflected what he had told her and the report contained inaccuracies. Mark told Medical Justice: *"I was saying one thing and she [the Doctor] was writing another thing. She lied".* Another Rule 35 appointment was made to take place the following week and healthcare told him that the appointment had to be with the same GP he originally saw, according to his medical records. After self-harming and being put in segregation, the same doctor who completed his Rule 35 report came to check on Mark; Mark said he wanted to talk to her about changes to the report. The doctor said she had reviewed his written comments and will update his report. Mark then showed the doctor the scars on his face. The amended Rule 35 report included more details about his torture account and mental health and documented the scars on his face.

[130] Section 5: Relevant clinical observations and findings, Rule 35 (3).

[131] Section 6: Assessment, Rule 35 (3).

There are examples in the case set, of IRC GPs failing to document all visible scars in Rule 35 (3) reports when compared to those documented by the Medical Justice clinician. For example, in one Rule 35(3) report, the IRC GP states they cannot visualise where the individual had stated they had the scar, yet the Medical Justice clinician easily accessed this scar. Another example is where only scarring on the individual's head is noted in the Rule 35 report, and not those on the rest of their body which were documented by the Medical Justice clinician.

Not documenting relevant scarring which is present on the individual or not documenting all visible scarring results in a Rule 35 (3) report incorrectly understates the medical evidence. This can have a detrimental effect on the torture survivor's detention case in the eyes of the Home Office. This is because the Home Office caseworker has not been told of all physical evidence of their torture history.

In addition, the IRC GP uses a full-body diagram in a Rule 35 (3) report which is misleading and may be seen by the Home Office caseworker to indicate they did an examination of their entire body for scarring, when this is not the case.

Of those that had scarring documented in their Rule 35 (3) report:

- Seventeen people had their scarring and other injuries described by the IRC GP[132] as in keeping with their history or account of torture or mistreatment, reflecting the Medical Justice clinician's view in the clients' MLRs.[133] One person had their scarring described as "likely", for three it was described as "appears" or "may be consistent", and for nine it was described as "may be due to the history given".

- In four cases, the IRC GP does not state an opinion on the scarring.[134] This is concerning because it leaves the Home Office decision maker with no clinical opinion as to whether or not the scarring supports the torture account and they may not therefore consider this as evidence in their case.

It is not possible for Medical Justice to comment on the reasons an IRC GP does not document or fully document scarring or expresses an opinion or not about the consistency of scarring with the person's account of torture and/or other ill-treatment. However, clients have suggested they believe the issue is the time pressure on the GP. Whatever the reason may be, the high importance and weight the IRC GP's medical evidence carries in the eyes of the Home Office to base their decision regarding suitability in detention on, it is vital that this is addressed urgently.

[132] IRC GPs are not required to assess scarring according to The Istanbul Protocol. See Office Of The United Nations High Commissioner For Human Rights, United Nations (2004) The Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Professional Training Series No. 8/Rev.1.

[133] One more person who had their scarring documented by a nurse in a Rule 32 (3) report also described it as in keeping with their history.

[134] For three of the four cases, the IRC GP states on opinion on the consistency *"narrative"* or *"account"* but not on the scarring and for one, there is no opinion on consistency of either the scars or narrative.

Mark has a history of torture and suffers from PTSD, anxiety and depression. During his healthcare screening upon his arrival in detention, Mark disclosed that he has a number of mental health conditions, a history of self-harm in detention, telling healthcare that he had *"wanted to die"* and a history of being on hunger strike. Healthcare referred him to the IRC Mental Health Team.*"*. The IRC GP saw Mark for his Rule 34 appointment the next day, noting that he suffers from paranoia, anxiety and depression which *"only occurs when locked up"*. Despite this, it does not appear that the GP explored any further the impact of detention on Mark's mental health. Nor did the GP complete a Rule 35 (1) report. Additionally, there was no discussion of Mark's disclosure of previous self-harm and suicidal thoughts in detention noted by the GP in the medical records.

Mark was seen the following day by the Mental Health Team where he disclosed that he had been beaten up by the police in the past, *"hears voices"* and has panic attacks at night. Despite this disclosure, no Rule 35(1) report was discussed or completed. Several days later, he was taken to the segregation unit in handcuffs and told the officer that he *"would like a medication tablet/pill to end his life"*, as noted in his medical records. He was seen by the GP the following day in segregation. The records indicate that he raised 'no complaints', with the GP- it does not appear that the GP proactively explored his mental health, the events of the previous day or the impact of being in segregation on his mental health. No Rule 35 (2) report was completed.

Mark had a Rule 35 appointment with an IRC GP several days later where a Rule 35 (3) report was completed. However, Mark was not happy with the report as it contained inaccuracies and did not document his scarring. Healthcare booked him a second Rule 35 appointment, but on the day he was told that the doctor could not see him and he was directed to instead write down his concerns about his Rule 35 that the doctor would then review. In Mark's medical records, the doctor notes that he already had his Rule 35 appointment and *"a further appnt [sic] [is] not appropriate articularly [sic] given recent comments by [Mark]"*, referring to complaints by Mark that the doctor completing the report had "lied". Mark became very frustrated and argued with healthcare but was again told *"he wouldn't be seen due to the comments and statements he had made about the GP, but she would do the paperwork."*[1] Mark's medical records state that he became angry, shouted and was then removed from healthcare. Mark told Medical Justice *"she didn't want to see me".*

A few hours later, Mark tried to harm himself. He was put on constant supervision, taken to segregation and then back to his room. The following day, Mark tied a ligature around his neck. Over the next few days, Mark became more unwell and repeatedly threatened to harm himself, stating that he was still not happy with the report. He was transferred to segregation with officers using force to hold his hands. In segregation, he swallowed a battery. Mark told Medical Justice that he was laughed at when he did this. His medical records show that he was transferred to A&E. On return to the IRC, Mark remained on ACDT but continued to deteriorate in detention, with several further attempts to harm himself and stating that he would kill himself. Mark told Medical Justice: *"I tried to hurt myself, they start laughing. I tried to jump off the stairs and there is a camera [so] they tried to help. Only one [officer] was kind. Sometimes I cannot sleep when I remember".*

Mark was eventually given an appointment for a further amended Rule 35 report with a different doctor, whose report was more detailed and stated that he may be a *"victim"* of torture. The report also mentions Mark being on ACDT due to swallowing a battery. The Home Office accepted Mark as an 'Adult at Risk' in response to all three reports but did not change the Adult at Risk level in response to the amended reports, nor grant his release or accept his torture account due to not having *"evidence"* from his account to suggest that he was *"subjected to 'severe' pain or suffering".*

After Medical Justice's clinician assessed Mark in detention, the clinician came to the conclusion that detention had already caused Mark to deteriorate in his mental state and caused him harm. They further found that his risk of suicide had increased since being in detention and was likely to increase if he remained in detention. Despite the clear deterioration in Mark's mental health in detention, numerous self-harm episodes and suicidal behaviour, the IRC GPs failed to complete any Rule 35 (1) or (2) reports.

Misuse of Rule 35 (2) and (3) to communicate harm

Medical Justice found that IRC GPs often completed Rule 35(3) reports in which they mentioned the risk of harm to the individual but did not subsequently complete a Rule 35(1) report to communicate this risk to the Home Office.

Of those who had a Rule 35(3) report, only two also had a Rule 35(1) report despite extensive evidence of the harmful impact that detention has on torture survivors. [135]

More specifically, of the 55 Rule 35(3) reports completed:

- In 28 reports, the IRC GP stated that ongoing or prolonged detention will or may harm the individual's mental health. In three of those reports, the IRC GP recommended that the person *"should be released"* or *"would benefit from release"*. Only one was released as a result, though the Home Office response was delayed by 3 weeks. [136]

- In six reports, the IRC GP stated in strong terms that ongoing or prolonged detention "will lead" to deterioration, *"will affect"* or *"would be detrimental"* to the individual's mental health. In an additional report, the GP stated that the individual's symptoms *"are worsening in detention"*.

- In 19 reports, the IRC GP stated that ongoing or prolonged detention *"may be detrimental to"*, "*may exacerbate"* or *"deepen"* his mental health issues or symptoms, or that their mental health *"may"* or *"is likely"* to deteriorate.

- In four reports, the IRC GP stated *"he [the detained person] has noted an increase in the severity of his symptoms since being detained"*.

[135] Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, page 13; 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.

[136] For one it was unknown as the Rule 35 (3) response is not available.

In one shocking case, a person who attempted suicide in detention and who was put on ACDT and constant watch, not only did not have a Rule 35 (1) or (2) report considered or completed but their Rule 35 (3) also did not mention they had attempted suicide.

Medical Justice also found a Rule 35 (2) report which states the harm detention is causing the individual, but no Rule 35 (1) report was subsequently completed by the IRC GP.

After Edward was discharged from hospital back to the IRC following an overdose in detention, an ACDT was opened but the IRC GP failed to complete Rule 35 (1) and (2) reports. As a result, the Home Office would not have been required to consider his suicide attempt and increased suicide risk in detention and would not have considered Edward's vulnerability or considered his release under the Adults at Risk policy. The Medical Justice clinician that assessed Edward in detention came to the conclusion that detention had already caused him to deteriorate in his mental state and caused him harm. They further found that his risk of suicide increased since being in detention and was likely to increase further if he remained in detention.

It took a further two months in detention before Edward first disclosed to healthcare that he had been tortured. Healthcare booked him a Rule 35 appointment however it did not take place until a month later. In the Rule 35 (3) report, in addition to documenting Edward's torture account and scarring from self-harm, the doctor stated that he recently took an overdose and that *"he should be released as his mental health will deteriorate further if held in detention*". The doctor also noted that Edward *"exhibits symptoms of depression and PTSD*". The IRC doctor again failed to complete a Rule 35 (1) report at this point.

Edward did not receive a response from the Home Office until 37 working days after the report was completed, during which time he was transferred to another IRC. Edward refused food, fluid and his medication in protest of not having a response. In the response to the Rule 35 (3) report that he eventually received, the Home Office stated that the delay *"was due to awaiting further information in relation to the harm risks in your case"*. The Home Office assigned Edward an Adults at Risk level 3 but did not find that his account met the definition of torture and did not grant his release, despite the doctor having recommended his release.

When he was transferred to the second IRC, Edward's health deteriorated further. He asked healthcare to help. Two Part Cs were sent to the Home Office to communicate healthcare's concern about his mental and physical health. Healthcare failed again to complete a Rule 35 (1) report to communicate their concern about Edward's health. After two further months in detention and increasing deterioration, a mental health nurse and GP advised to make an addendum to Edward's previous Rule 35 (3) report *"to say that his mental health is being affected being in detention*". A second rule 35 (3) report was completed the same day stating that *"being in detention for this prolonged period of time has started to have a negative effect on his mental health.... Being in prolonged [sic] may have a significant impact on his mental health*". There was no additional information added on his torture account which indicates that another Rule 35 (3) report was not required. Concerns raised about the harm detention was causing Edward should have been communicated using the Rule 35(1) mechanism.

The Home Office response to Edward's second Rule 35 report was also delayed. It took 11 working days for the response and it included no explanation for the delay. In the response, the Home Office decided to keep Edward in detention as *"appropriate measures are currently in place"*, referring to the use of ACDT and anti-depressant medication.

Three months in detention later, the GP notes in the medical records that Edward *"has been having fleeting suicidal thoughts at night",* but again no Rule 35 (1) was sent to the Home Office despite this evidence of deterioration and increased risk of suicide.

Edward was in detention for 10 months and was consistently failed by safeguards throughout that time and in all three places of detention – a Short Term Holding Facility and two different IRCs. At no point did an IRC GP complete a Rule 35(1) or Rule 35 (2) report for Edward, despite him attempting to take his own life in detention and the IRC GP completing two Rule 35 (3) reports stating that detention was harmful to Edward, one of which recommended his release. His Rule 35(3) appointment was delayed, as was the response from the Home Office. Even when the IRC GP recommended Edward be released due to the harm detention was causing him, this medical opinion was outweighed by *"immigration factors"* in the eyes of the Home Office which decided to keep Edward in detention.

Rule 35 report quality lottery

Medical Justice also found other problems persist with the Rule 35 process in detention such as the varying quality of the assessment and completed report.

Medical Justice continues to have concerns about the quality of Rule 35 reports, which varies depending on the IRC doctor that writes them – making the quality of Rule 35 reports a lottery in terms of which IRC doctor a detained person sees for their Rule 35 appointment. For example, one IRC GP concluded in the report that a client with PTSD cannot be treated in detention and should be released, whereas another IRC GP concludes that the health needs of a client with PTSD can be met in detention. See Inability and failure to provide adequate treatment in detention - PTSD.

Another client told their Medical Justice clinician that they did not know their Rule 35 appointment was a Rule 35 assessment and did not know they were speaking to a doctor.

In its daily casework with people in detention, Medical Justice continues to come across instances of IRC GPs misusing certain phrases in Rule 35 reports such as *"no concerns"* about ongoing detention or their mental health, or that a person's *"health needs can be managed"* or *"met in detention"*, where those individuals have significant mental health issues such as PTSD. Indeed, we continue to see some IRC GPs finding significant mental health problems in circumstances where other IRC GPs are finding none.

Home Office Decision Making in Response to Rule 35 Reports

The Home Office must provide a response two working days after receipt of a Rule 35 report. Within the response, the Home Office assesses the individual's level of vulnerability according to the Adults at Risk (AAR) policy and reviews whether the person should remain in detention or be released.

In 31 cases, there was a delay of more than two working days for their response.[137] The shortest delay was 1 further working day and the longest was over two months.

A delayed decision – which may be a decision to release them - can have dire consequences for a person's health in detention and should be urgently addressed by the Home Office. This is because while waiting for the decision the person languishes in detention, at risk of further harm and deterioration.

Overall, of the Rule 35 responses for 41 people Medical Justice had access to, the Home Office designated one person at AAR level 1, 33 at AAR level 2, and 7 at AAR level 3. The Home Office took the decision to release seven people in relation to their Rule 35 report. Six were assigned AAR level 3 and one at level 2, indicating that it is very unlikely for the Home Office to decide to release those without level 3 evidence.[138] These statistics are broken down by each type of Rule 35 reports:

Home Office decision making in response to Rule 35(1) reports:

The Home Office assigned AAR level 3 for at least three of the five clients with a completed Rule 35(1) report.[139] The Home Office decided to release all three;[140] despite this, they all remained in detention for several months following the decision to release them, during which time the harm detention was causing them continued.[141]

Home Office decision making in response to Rule 35(2) reports:

Out of the five clients with a Rule 35(2) report, the Home Office assigned four clients as AAR level 2 in their response. The fifth client was assigned AAR level 3 in response to their Rule 35 (3) report and this was maintained by the Home Office in response to their Rule 35 (2) report.

The Home Office took the decision to maintain detention for three and release the other two. However, the decision to release them was based either on upholding the decision made by an Immigration Bail Judge prior to the report or not in relation to the Rule 35 (2) report.[142] One of the two who were to be released remained in detention for almost a month after the decision had been made, and the other was released three days later.

Home Office decision making in response to Rule 35(3) reports:

As part of their decision, the Home Office considers whether the person's *"claim of torture"* meets the definition set out in the Detention Centre Rules. Torture is defined as: *"Any act by which a perpetrator intentionally inflicts severe pain or suffering on a victim in a situation in which the perpetrator has control (whether mental or physical) over the victim and, as a result of that control, the victim is powerless to resist".*[143]

For 24 people the Home Office accepted that their account met the definition of torture above.[144] It did not accept that the definition was met for 14 people. Explanations given by the Home Office included *"it*

[137] Of the 41 Home Office responses Medical Justice had access to

[138] Though not all who were assigned Adults at Risk level 3 received a Home Office decision for release.

[139] Medical Justice is unable to state the Adult at Risk level designated for the remaining two clients as their Home Office response was not available to Medical Justice.

[140] Medical Justice is unable to state the Home Office decision for the remaining two clients as their Home Office response was not available to Medical Justice.

[141] The Home Office made the decision to release two in response to their Rule 35(1) report and in the other case, upheld a previous decision to release but who remained in detention waiting for approval by the Home Office of *"suitable"* accommodation.

[142] The Home Office response stated that the decision was *"unrelated"* to the Rule 35 (2) report.

[143] Rule 2 The Detention Centre (Amendment) Rules 2018 (SI 2018/411).

[144] For 9 clients, it is unknown if they were accepted as a torture survivor as Medical Justice did not have access to the Home Office's response to their Rule 35 (3) report.

For another, the response is incomplete, so it does not show whether the Home Office accepted them as a torture survivor or not but did include information about their Adult at Risk level.

was not clear you were powerless" or "powerless to resist", *or "were not subjected to 'severe' pain and suffering".* For example, it was not accepted that there was severe pain or suffering for someone who was beaten to the point of causing a brain bleed and other injuries requiring medical attention.

The Home Office considered 36 people[145] as an Adult at Risk in response to their Rule 35 (3) report.[146] One person was not considered an Adult at Risk in response to their Rule 35 (3) report as their account did not meet the definition of torture and no other vulnerabilities were raised in the report which would have qualified the person to be considered an AAR.

Five were assigned AAR level 3, 30 at AAR level 2 and one at AAR level 1.[147] The Home Office made the decision to maintain the detention of 33 people and release four people.[148] [149] However, the decision to release one was based on upholding the decision made by an Immigration Bail Judge.

Despite the decision to release them, two people remained in detention for several months awaiting approval from the Home Office regarding *"suitable accommodation".* One person was released within a week and another within 24 hours of the decision.

4.2.4 ACDT and constant watch: Disconnected and non-therapeutic processes

ACDT is the custodial process to manage detained people at risk of self-harm and/or suicide, including setting out their care plan. The Home Office provides that the ACDT process should be used to *"manage detained individuals who are identified to be at risk of suicide or self-harm"*.[150] The ACDT process consists of observations (the most frequent level being constant supervision) and regular reviews led by custodial staff.

A detained person can be put on constant supervision *"to reduce a serious risk of them carrying out acts of self-harm or other behaviours which could lead to them accidentally or intentionally killing themselves"*.[151] Constant watch is an extreme measure for those in immediate and acute risk of suicide. Crucially it is a member of custodial staff, not healthcare, who remains with the detained person. The safeguarding policy of Mitie, who are contracted by the Home Office to run Heathrow and Dungavel IRCs, acknowledges that *"Constant supervision must only be used at times of acute crisis and for the shortest time possible. The process of being constantly supervised by a member of staff can be de-humanising which may increase risk"*.[152]

Failure to always use the ACDT and constant watch processes

Medical Justice's evidence shows that not all people who our clinicians had identified as at risk of suicide or self-harm were put on ACDT. Only 22 of the 49 who were recorded in their MLR to have self-harmed,

[145] For those with multiple Rule 35 (3) reports, the Home Office kept their decision to consider them an Adult at Risk and did not change their Adult at Risk level from previous Rule 35 (3) reports.

[146] For 12 clients, it is unknown if they were considered an Adult at Risk or what level they were assigned as Medical Justice did not have access to the Home Office's response to their Rule 35 (3) report. For one additional client, the Home Office did not respond to their Rule 35 (3) report as the decision to release them had already been made.

[147] One person was assigned Adults at Risk level 1 due to their modern slavery claim rather than their torture claim, which was not accepted by the Home Office.

[148] An additional client was released before the Home Office response was sent and not in relation to their Rule 35 report

[149] It is unknown for 12 people what decision the Home Office made as their response was not available to Medical Justice. An additional person did not get a response for their Rule 35 (3) report as the decision was made to release them before a response was completed by the Home Office.

[150] Home Office (October 2022) Detention Services Order 01/2022 Assessment Care in Detention and Teamwork (ACDT) paragraph 9.

[151] Home Office (October 2022) Detention Services Order 01/2022 Assessment Care in Detention and Teamwork (ACDT) paragraph 89.

[152] Mitie Care & Custody (4 December 2022) Safer Detention Operational Instruction for Heathrow IRC and Mitie Care & Custody (July 2021) Safer Detention Policy for Dungavel IRC. These policies were obtained by Medical Justice through a Freedom of Information Request, with reference number 76852.

to have had suicidal thoughts and/or to have attempted suicide were put on ACDT during their detention, according to their medical records. [153] Some were put on ACDT more than once during their detention.

Of the 13 people who attempted suicide in detention:

- 12 were put on ACDT during their detention;
- Seven were put on ACDT following their suicide attempt, two [154] were already on ACDT when they attempted suicide and continued to be on ACDT following the suicide attempt; [155]
- One person was not recorded by healthcare as being put on ACDT at all during their detention, including following their suicide attempt.

15 of the 17 people who self-harmed in detention were put on ACDT during their detention.

Other failings found by Medical Justice in relation to ACDT include failure to open an ACDT for 11 days after an ACDT referral was made by a Home Office caseworker during an asylum interview and another client being told that he could only have therapy when he comes off ACDT, as per the medical records, and his treatment was therefore delayed.

Not all 13 people who attempted suicide were put on constant watch in relation to their suicide attempt. Of the 13, 11 were put on constant watch during their detention; eight of whom were put on constant watch in relation to their suicide attempt. [156]

Medical Justice found evidence that constant watch is not working to safeguard against acts of self-harm or suicide. Shockingly, one person attempted suicide while on constant watch. [157] Healthcare raised a concern in their medical records about how this could happen while on constant supervision by a guard, and a Rule 35 (2) was then considered and booked. Another person was taken off constant watch and put on hourly observations before they attempted suicide. They were then put back on constant watch following their suicide attempt and a Rule 35 (2) report was considered and completed. Outside of Medical Justice's latest evidence, there have been past inquests into deaths that occurred while the person was supposed to be on constant watch.

Of the 17 people who were recorded to have self-harmed in detention, only 10 were put on constant watch.

Disconnect between ACDT, constant watch and clinical safeguards

The Inquiry found that there was not a holistic view which is needed in relation to self-harm and suicide risk and identified a disconnect between ACDT and the other safeguarding processes, which should work together to protect vulnerable people. As a result, these issues were found to have *"undoubtedly exposed vulnerable people to a risk of harm and caused actual harm to be suffered in some cases, as well as leaving*

[153] 28 people in the total case set were put on ACDT.

[154] One person who attempted suicide twice had an ACDT opened following their first attempt and remained on ACDT during their second attempt.

[155] One person was not put on ACDT following their suicide attempt and for two people, it was unknown as the suicide attempt was either not documented in the medical records or the medical records did not cover that time period.

[156] For two people, it was unknown if it was in relation to their suicide attempt either because the suicide attempt was not recorded in the medical records or the medical records did not cover that time period.

[157] The individual was kept on constant watch following their suicide attempt.

certain individuals susceptible to mistreatment". [158] The Chair's view is that such disconnect is *"indicative of a system not fit for purpose"* [159] and that the resulting risk of harm remains today.

One clear disconnect is between ACDT and the Rule 35(1) and Rule 35(2) processes. The Inquiry found that the lack of Rule 35(1) and Rule 35(2) reports, in comparison to the numbers on ACDT was *"indicative of a continuation of the serious failure in the safeguards"*. [160] Sarah Bromley (the current National Medical Director for Health in Justice at PPG) suggested that a literal interpretation of Rule 35 could result in a Rule 35(1) for potentially everyone or a Rule 35(2) for anyone placed on ACDT, and thereby prevent the most vulnerable from being identified. Such explanation was found to be *"deficient and a further indication of an abdication of corporate responsibility"*. [161]

The Inquiry's report raises concerns about relatively high numbers of ACDTs, episodes of constant watch, and incidents of self-harm, compared to extremely low numbers of Rule 35(1) and Rule 35(2) reports between January and October 2022, under Serco and PPG's management. [162] The Chair states that she *"did not receive any satisfactory explanation for this discrepancy"* and that this indicates a continuation of the disconnect and a serious failure in safeguards to protect vulnerable people. [163]

As explained above, in evidence to the Brook House Inquiry, Sarah Bromley confirmed that interim measures had been introduced in IRCs requiring that when an ACDT is opened, a Rule 35(1) appointment will be booked for the same or following day. [164]

Within Medical Justice's case set, at least 23 [165] of the 28 who was placed on ACDT in the case set, had it opened after the interim measure was confirmed on 5 April 2022, showing that this has not resulted in Rules 35(1) appointments being systematically booked or even considered following an ACDT being opened; Rule 35(1) numbers remain concerningly low [166] Of those 23:

- Two people had a Rule 35 (1) report considered, though not on the same or following day the ACDT was opened and neither led to a Rule 35 (1) appointment being booked. For one of the two, a Rule 35 (1) report was considered after they had been on ACDT for a while but a report was not completed. The other had a Rule 35(1) report considered a few days after ACDT was opened but healthcare decided it was not needed.

- For the remaining 26 people, there was no record of consideration being given to a Rule 35 (1) report while on ACDT, according to their medical records.

Medical Justice also assessed whether those 23 people had a Rule 35 (2) appointment considered and/or completed. Of those 23:

- Five people had a Rule 35 (2) considered and completed but not immediately after an ACDT was opened: For two, it was completed after they attempted suicide, whilst on ACDT. For one person their Rule 35 (2) was completed after self-harming and subsequently being put on ACDT.

[158] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 pages 96-97 paragraph 63.

[159] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 97 paragraph 64.

[160] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 95 paragraph 60.

[161] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 96 paragraph 62.

[162] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 95 paragraph 60.

[163] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 95 paragraph 60.

[164] Third witness statement of Sarah Bromley, paragraph 3 PPG000205.

[165] One person had an ACDT opened before 5 April 2022 but due to incomplete medical records available to Medical Justice, it is not known if another ACDT was opened after that time period.

[166] Two others had an ACDT opened before 5 April 2022 but remained in place after. Another two had an open ACCT in prison before being transferred to an IRC after 5 April 2022 and were on an ACDT at the IRC, however, the medical records do not note when the ACDT was opened and therefore it is not possible to say whether a Rule 35 (1) report was considered at that point.

- For three others a Rule 35 (2) report was considered - though not immediately after an ACDT was opened – but not booked or completed. For example, the medical records of one person note that a rule 35 (2) had been considered by healthcare after self-harming while already on ACDT but it was not deemed *"appropriate"* due to their observations being reduced from constant watch. For another person, the medical records note that a Rule 35 (2) was considered but not deemed *"applicable"* despite the person self-harming multiple times very recently, being on ACDT and on constant watch.

- For all others, there was no record [167] of consideration being given to completing a Rule 35 (2) report when they were put on or during their time on ACDT.

The interim measures confirmed during the Brook House Inquiry by Sarah Bromley further required a Rule 35 (2) appointment to be booked for the same or following day when someone is put on constant watch. [168] However, this also has not been implemented consistently and has not resulted in significant increases in Rule 35(2) reports.

All 15 individuals in the case set on constant watch were put on after the interim measures were confirmed on 5 April 2022. [169] However, according to their medical records, only four of them had a Rule 35(2) appointment considered, two of whom also then had the appointment booked and a Rule 35 (2) report completed. Neither of them had a Rule 35 (2) appointment considered and/or booked when initially put on constant watch.

For the remaining 11 who were on constant watch, there was no note in their medical records of consideration being given to a Rule 35 (2) report.

Home Office statistics on ACDT and Constant Watch

The Home Office's own statistics mirror our findings. In the period covered by this report (June 2022 to March 2023), 773 ACDTs were opened across the IRCs [170] and constant supervision was opened 240 times for individuals being managed under ACDT. [171] However, only 37 Rule 35(1) forms and only 26 Rule 35(2) reports were completed [172] during that period.

ACDT and Constant watch not working and causing further harm

The Brook House Inquiry highlighted that the ACDT process is not a clinical response and does not include any therapeutic interventions or clinical input into the management of the detained person. [173] As a prison-style response, it does not address the underlying psychological symptoms. It is a pure management tool, lacking clinical intervention.

Medical Justice agrees in the strongest terms with the Inquiry that ACDT and constant watch are custodial tools for staff to *"manage"* the risk of suicide and self-harm in detention. Neither processes are therapeutic or clinical, nor are they sufficient to deal with those who are actively suicidal or at risk of

[167] According to the healthcare records available to Medical Justice.

[168] Third witness statement of Sarah Bromley, paragraph 3 PPG000205.

[169] One was put on constant watch before and again after.

[170] This data is from Freedom of Information requests, obtained by Medical Justice, with reference numbers 76568, 72966, 75319, 76239.

[171] This data is from Freedom of Information requests, obtained by Medical Justice, with reference numbers 76568, 72966, 75319, 76239. Note that this number does not necessarily equate to the number of individuals who have had a constant supervision opened against them whilst being managed under ACDT, as a constant supervision may have been opened for one individual on more than one occasion whilst being managed under ACDT.

[172] The data for June 2022 is from a Freedom of Information request, obtained by Medical Justice, with reference number 71801. The data for 2022 Q3, 2022 Q4 and 2023 is from Home Office and Immigration Enforcement (published 24 August 2023) Transparency data: Immigration Enforcement data: Q2 2023 table DT_03.

[173] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.5 page 94 paragraph 58.

suicide or self-harm. Given the high rates of self-harm, suicidal thoughts and attempts in the case set, it is clear from Medical Justice's evidence that ACDT and constant watch are not effective in managing those at risk or in triggering the appropriate safeguards and therapeutic interventions (see the rates of Self-harm and suicidality in detention).

Medical Justice's analysis found that individuals were put on and off ACDT and constant watch on several occasions throughout their time in detention and/or in response to multiple self-harm episodes and/or suicide attempts. The longest time someone was kept on an ACDT constantly was for over a year. This individual had no Rule 35 (2) completed and had one Rule 35 (1) completed during that time in relation to a physical health issue and deterioration in their mental health.

The fact that individuals who are so unwell in detention that they require long periods of ACDT or are put on and off ACDT and constant watch should indicate to IRC custodial and healthcare staff that the person requires urgent healthcare intervention as they may not be suitable for detention. This should be communicated to the Home Office through a Rule 35 (1) and/or Rule 35 (2) report triggering a review of detention. However, Medical Justice evidence shows that this is rarely being done and ACDT and constant watch are being used to contain the episodes of self-harm and/or suicide attempts in detention, rather than being used as an interim measure while healthcare communicates to the Home Office that the individual should be released from detention.

ACDT and constant watch can be highly intrusive. Indeed, Medical Justice also found examples in the case set of individuals' mental health worsening because of constant watch. While some people find ACDT intrusive, others report having found it supportive. **Edward** described his experience on ACDT at that IRC: *"On ACDT, staff come to check every hour, or stay with you continually. At that time I needed someone to look after me...my health was not very good. The security [officers] were helping me in [the IRC]. They have time to talk to you, we are human and they care."*

A more extreme example of the misuse of safeguards in the case set is of an individual who was put on constant watch after they self-harmed but medical records described that this was *"due to disruptive behaviour",* rather than exploring clinical concerns. This may indicate a further example of the culture of disbelief surrounding self-harm in detention and that these intrusive measures may serve management or disciplinary purposes and fail as a safeguard. See also Worrying culture of IRC healthcare in detention.

4.4.4 Lack of identification and safeguards for those who lack mental capacity

Safeguards for those who lack mental capacity are severely limited.[174] Yet, those who may lack mental capacity to make decisions about their immigration case and/or detention processes are at risk of suffering serious harm in detention. In 2018, the Court of Appeal found a wholesale failure on the part of the Home Office to ensure arrangements were in place to identify and safeguard people with severe mental ill-health and mental incapacity in detention.[175] The absence of any measures to support those lacking mental capacity to understand their rights and access legal remedies was found to be unlawful. The Court directed the Home Secretary to take urgent steps to remedy this serious systemic lacuna. Such steps should include ensuring access to an independent advocate in detention.

The Brook House Inquiry has echoed this, finding the Home Office policy in the Detention Services Order 04/2020: Mental Vulnerability and Immigration Detention to be inadequate due to the absence of any

[174] Home Office (July 2023) Detention Services Order 04/2022 Mental Vulnerabilities and Immigration Detention instructs non-clinical staff on the process to follow for those who lack mental capacity.

[175] *VC, R (On the Application Of) v The Secretary of State for the Home Department* (Rev 1) [2018] EWCA Civ 57 (02 February 2018).

provision for independent advocacy for those who lack mental capacity. [176] The Inquiry found that during the relevant period, the lack of independent advocacy provision caused harm. The Inquiry urges the Home Office to address this. The Inquiry also found that there were *"serious omissions in the system of safeguards to protect detained people who may have either a disability arising from mental impairment or a mental health condition, which failed D1275"*. [177] D1275 was detained at Brook House from May 2017 to June 2018 ; their severe mental ill health - which presented as *"erratic and strange behaviour"* as noted by detention staff - was not identified or managed and he received no mental health treatment, repeatedly being discharged from the mental health team because of non-attendance. The Inquiry found that there was no exploration by healthcare staff as to why he did not attend appointments and no evidence that D1275's mental capacity was considered or assessed by healthcare. When he was released, D1275 was diagnosed with schizoaffective disorder and assessed as lacking mental capacity and hospitalised under the Mental Health Act 1983. [178]

In Medical Justice's experience, those who lack mental capacity to make decisions relating to their detention or immigration position are not identified and there is still no process in place to enable them to access independent advocacy to advance their interests. As explained above, out of the seven clients who were assessed as either lacking mental capacity or suspected lack of mental capacity, none of their medical records identified any concern from IRC healthcare about the clients' lack or suspected lack of mental capacity (see Lack of mental capacity assessments).

[176] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 207 paragraph 76.

[177] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 206 paragraph 73.

[178] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 page 205-206 paragraph 72.

5. USE OF FORCE

Force can be used on people detained under immigration powers, both by Detention Custody Officer in IRCs and by escort staff during removals. Rule 41 of the DCR 2001 provides that force shall not be used *"unnecessarily"*, and that *"no more force than is necessary shall be used"*.[179] Home Office policy permits force if it is *"necessary", "reasonable"* and *"proportionate to the threat being faced or the intended aim"*.[180] The excessive use of force is unlawful.[181] Where force is used, the detail of the use of force must be recorded and reported to the Secretary of State.[182]

The perfect storm for the conditions that give rise to the abuse and mistreatment of vulnerable people continue to exist within in detention; these conditions include staff lack the therapeutic tools or resources to care for vulnerable detained persons, treating distressed behaviour as refractory, resulting in an inevitable recourse to coercive measures to manage mentally unwell detained people.

5.1 Use of force: Inquiry and Medical Justice findings

The Brook House Inquiry report raised a number of *"concerning themes"* regarding the nature of force used, the purpose for which it was used, whom it was used against, the monitoring and oversight and the rules currently in place governing the use of force in IRCs.[183] The report recognises that force is *"a coercive tool which, even if used correctly, carries a risk of injury"*.[184] The Inquiry found instances where force had been used to provoke and punish detained people.[185] De-escalation techniques were not always employed at all, or for long enough, and there were many incidents where force was used as a first, rather than a last, resort.[186]

Unauthorised use of force techniques were found to be employed, including the practice of handcuffing detained people with their hands secured behind their back when seated, which creates a risk of restricting oxygen to the person and thereby causing serious injury or death (referred to as 'position asphyxia'). This practice had been removed from the Use of Force Training Manual in 2015 after the unlawful killing by guards of Mr Jimmy Mubenga in 2010.[187] Authorised techniques were in some instances found to have become *"dangerous due to their incompetent application"*.[188]

Force was inappropriately used against naked or near-naked detained people.[189] Force was used inappropriately against people who were mentally and/or physically unwell; in such circumstances, it was often unnecessary and disproportionate in type and duration given the person's health condition.[190] Healthcare were found to have failed in their safeguarding role and instead, actually *"facilitated the use of force"*.[191] The Inquiry raised concerns about healthcare staff not understanding their safeguarding role

[179] Rule 41 Detention Centre Rules 2001 (SI 2001/238).

[180] Home Office (2022) Use of force: Guidance for Immigration Enforcement Officers Version 3.0 6.

[181] Home Office (2022) Use of force: Guidance for Immigration Enforcement Officers Version 3.0 6.

[182] Rule 41 Detention Centre Rules 2001 (SI 2001/238).

[183] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 138 paragraph 17.

[184] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 146 paragraph 33.

[185] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 138 paragraph 18.

[186] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 142 paragraphs 26-33.

[187] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 139 paragraphs 20-21 and page 141 paragraph 25.

[188] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 140 paragraphs 22-23.

[189] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 pages 149-151 paragraphs 43-46.

[190] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 154 paragraph 55.

[191] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 154 paragraph 55.

in the context of use of force on a detained person, emphasising that healthcare staff have a duty to intervene or declare a medical emergency, and to instruct restraints or force to be immediately stopped, in certain circumstances.[192] The Inquiry Chair states that she remains concerned as to whether the deficiencies relating to the role of the healthcare staff in use of force incidents have been addressed.

The Inquiry found it to be common that force was used as a response to, and a way to manage, symptoms of mental-ill health. For example, there was a *"routine and quick resort to force in response to incidents of self-harm"*.[193]

The monitoring and oversight of the use of force in the relevant period was found to be *"inadequate"* and as a result, to have *"led to dangerous situations for detained people and staff"*.[194] The serious failings included the absence of senior management[195], the failure to activate body worn cameras or a failure to film[196], inaccurate, undetailed or missing use of force reports[197], debriefs that were *"cursory and demonstrated a complete lack of reflection"*[198], and a lack of a proper review process or overall governance system.[199]

The Inquiry found that governing the use of force in immigration detention by a prison service order (a policy for prison and probation professionals) is inappropriate as IRCs have a different purpose and type of population; it therefore does not take the detained population's needs, circumstances or vulnerabilities into account.[200]

The Inquiry therefore recommends that a new detention services order addressing the use of force is introduced, as a matter of urgency. The Inquiry sets out that this new detention services order must set out the justifications for the use of force in detention, the circumstances in which force can be used against people with mental ill-health, and provisions for the monitoring, oversight and reporting of the use of force by contractors and by the Home Office.[201] It further recommends that Home Office to urgently commission an independent review, with the power to make recommendations, of the use of force on detained people with mental ill health,[202] as well as the urgent improvement of use of force reviews.[203]

Of the 66 clients, seven of their MLRs mentioned that they were subjected to the use of force and/or restraints whilst in detention. This took place at Colnbrook, Yarl's Wood, Brook House and Harmondsworth IRCs.

Force and/or restraints were used in the context of forced removal to the airport, transfer to segregation, removal from suicide netting and for transfer to external hospital appointments. For torture survivors, the use of force can be a terrifying re-enactment of past abuse.

[192] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.8 pages 190-201 paragraphs 43-61.

[193] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 155 paragraph 58.

[194] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 158 paragraph 65.

[195] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 158 paragraph 66.

[196] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 164 paragraph 78.

[197] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 pages 164-5 paragraphs 79-83.

[198] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 165 paragraph 84.

[199] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 pages 166-173 paragraphs 87-104.

[200] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 pages 151-152 paragraphs 47-53.

[201] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Recommendation 15.

[202] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Recommendation 16. For full details of what the review should consider, see Recommendation 16.

[203] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Recommendation 17

Three of the seven people had injuries attributed to force used on them documented by the Medical Justice clinician, all of whom required medical treatment. One person was diagnosed by the Medical Justice clinician with acute stress reaction in response to the force used on them in detention.

5.2 Further external evidence

Beyond Medical Justice's case set, there has been recurrent evidence of the ongoing concerning or excessive, use of force across the detention estate. From the end of July until December 2020, leading up to the UK's withdrawal from the European Union, there was a large-scale compressed programme[204] of charter flights removing people to European countries. Documents obtained through the Freedom of Information Act reveal that officers used force, including pain-inducing restraint which deliberately causes pain to gain compliance, to prevent self-harm on 62 occasions from July to December. [205] 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 IMB found that the combination of the effects of the compressed charter flight programme, the high level of vulnerabilities and the complex needs of the detained people, led to a *"dramatic increase in levels of self-harm and suicidal ideation" and reciprocal deficiencies in the detention safeguards. The IMB described the compressed charter flight programme as creating created the circumstances in Brook House IRC to amount to "inhumane treatment of the whole detainee population by the Home Office"*. [206]

More recently, evidence has emerged of instances of force being used in June 2022, ahead of the scheduled flight to Rwanda.[207] The 2022 Annual Report of the IMB Charter Flight Monitoring Team (CFMT) revealed that some of these instances may have been excessive. The CFMT observed the scheduled flight to Rwanda and noted that two people were subjected to the use of force whilst on the plane and in their seat belts. The report described that *"The two started to scream out their fear and distress, each trying to hurl his torso and head backwards and forwards. Each was still in his WRB [waist restraint belt], and each was seated with an escort on either side, his arms tightly held, his head controlled by an escort facing him. The legs of one had been 'secured'"*. [208] The CFMT concluded that *"the head control on one man may have involved excessive pressure"*. [209] Their report highlights the distress impact of the use of force: *"There was nothing the two men could physically do, except possibly hurt themselves and the head controls were continuously applied to prevent this. The men's actions were sustained over more than 20 minutes up to the moment when the senior escort on board announced that the flight was cancelled"*. [210]

Evidence of the misuse of force has also been highlighted in 2022 reports following HMIP inspections in Derwentside, Brook House and Colnbrook IRCs, mirroring the evidence heard in the Brook House Inquiry. This included a case where inappropriate techniques were used by some staff[211], a case where force was used against a detained person who was not fit to be detained[212], and a case where force was initiated

[204] Responses to requests sent by Liberty Investigates under the Freedom of Information Act show that there were 22 charter flights from Brook House IRC between July and December 2020. See Aaron Walawalkar, Jessica Purkiss, Eleanor Rose and Mark Townsend (26 December 2021) Revealed: Guards Used Force On Suicidal Asylum Seekers After Training Had Expired, Liberty Investigates and The Guardian.

[205] Aaron Walawalkar, Jessica Purkiss, Eleanor Rose and Mark Townsend (26 December 2021) Revealed: Guards Used Force On Suicidal Asylum Seekers After Training Had Expired, Liberty Investigates and The Guardian.

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

[207] Lizzie Dearden, Aaron Walawalkar and Eleanor Rose (5 September 2022) Documents Show Asylum Seekers Were Forced Onto Plane And Restrained, Liberty Investigates.

[208] Independent Monitoring Board (June 2023) Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 paragraph 3.2.7.

[209] Ibid

[210] Independent Monitoring Board (June 2023) Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 para 3.2.7.1.

[211] HMIP (July 2022) Report on an unannounced inspection of Colnbrook Immigration Removal Centre by HM Chief Inspector of Prisons (28 February – 18 March 2022) 23.

[212] 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) 23.

without *"sufficient de-escalation"*.[213] The IMB CFMT found that some instances of use of force was *"questionable"*.[214] For example, one Zimbabwean was *"not released from his WRB until five hours after take-off, seemingly because of his perceived defiant manner by refusing to communicate with anybody"*, despite not being obliged to.[215] The CFMT noted that they were *"not confident risk had been continuously reviewed or that it was necessary to keep him in his WRB for so long"*.[216] It is also important to note that the misuse of force is often under-identified. As the Inquiry found, neither the IMB nor HMIP identified the abuses shown by undercover footage from the Panorama programme, and it is not necessarily surprising that monitoring bodies would not directly witness such abuse.[217]

Recent concerns have also been raised regarding filming and record keeping of uses of force, reflecting the Inquiry's findings. HMIP also found that the systems of collecting and storing video and paperwork were *"not properly organised, making it difficult to track incidents"*.[218] Body-worn camera footage was not available for all use of force incidents reviewed. Overall, record keeping of use of force was *"poor"*; there was *"no systematic process for collating all footage and paperwork after an incident"*.[219] The failure to film all incidents of force and poor record keeping was also raised by the IMB CFMT. They observed that not all incidents were filmed on a charter flight to Zimbabwe.[220] They further highlighted the poor reports on the use of restraint and force, including in the lead up to the scheduled Rwanda flight.

The concerning use of force is reflected across the detention estate as evidenced by documents obtained through a Freedom of Information request regarding Manston Short-Term Holding Facility from October 2022.[221] These reveal evidence of concerning use of force and 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.

[213] 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) 24.

[214] Independent Monitoring Board (June 2023) Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 para 3.2.11.

[215] Independent Monitoring Board (June 2023) Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 para 3.2.11.

[216] Independent Monitoring Board (June 2023) Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 para 3.2.11.

[217] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.11 page 303 paragraph 3.

[218] HMIP (December 2022) Report on an unannounced inspection of Derwentside Immigration Removal Centre by HM Chief Inspector of Prisons (8 – 25 August 2022) 3.

[219] HMIP (December 2022) Report on an unannounced inspection of Derwentside Immigration Removal Centre by HM Chief Inspector of Prisons (8 – 25 August 2022) 24.

[220] Independent Monitoring Board (June 2023) Annual Report of the Independent Monitoring Boards' Charter Flight Monitoring Team For reporting year 1 January 2022 – 31 December 2022 para 3.2.9.

[221] Lizzie Dearden, Aaron Walawalkar and Eleanor Rose (4 February 2023) Asylum Seekers at Manson were Handcuffed, Restrained and Struck, Internal Docs Show, Liberty Investigates.

6. SEGREGATION

Home Office policy stipulates that segregation may be used in the interest of safety or security under Rule 40 of the DCR 2001, or to manage actively violent detainees under Rule 42 of the DCR 2001. When deciding if someone should be put in segregation, their Adults at Risk Level, if they have one, or concerns about mental capacity, must be *"taken into account"* in the decision.[222] Those at risk of suicide or self-harm must only be put in segregation in "exceptional circumstances*", "for the shortest time possible"* and as a *"last resort"*.[223] Additionally, Rule 40 and 42 should not be used *"to manage detained individuals with serious psychiatric illness or presenting with mental health problems"*.[224]

Under Rule 40, a detained person can be held in segregation for an initial period of up to 24 hours, but this may be extended to a maximum of 14 days.[225] Under Rule 42, a detained person can be held in segregation for up to 24 hours and this may be extended for up to 3 days after written direction from an officer of the Secretary of State.[226]

Once the decision has been taken to put someone in segregation, a Medical Practitioner must be notified *"without delay"*.[227]

Medical Justice has long documented the devastating impact of segregation on our clients and the misuse and over-reliance of segregation in detention. Our evidence has highlighted the unlawful use of segregation as a form of punishment, the use of segregation to manage those with mental health disorders and those at risk of self-harm and the indiscriminate use of segregation as a means of aiding removal, all which contravened the DCR 2001.[228] Our latest analysis and the Brook House Inquiry findings show that little has changed.

6.1 Segregation: Inquiry and Medical Justice findings

The Brook House Inquiry recognised how segregation restricts the liberty of detained people and has a potentially harmful impact on those segregated.[229] It found that there was a widespread lack of understanding about who could authorise the use of Rule 40 and Rule 42, which was perpetuated by inadequate training during the relevant period and this problem was found to persist under Serco's current contract.[230] This misunderstanding was found to be amongst senior staff too.[231]

Restrictions under Rule 40 and Rule 42 were found to be inappropriately used, including as a punishment (which is not a permissible use[232]),[233] for pure administrative convenience[234], and to manage people

[222] Home Office (September 2020) Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) paragraph 30.

[223] Home Office (September 2020) Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) paragraph 34.

[224] Home Office (September 2020) Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) paragraph 31.

[225] Rule 40(3) and Rule 40(4) Detention Centre Rules 2001 (SI 2001/238).

[226] Rule 42 Detention Centre Rules 2001 (SI 2001/238).

[227] Rule 40(5) and Rule 42(6) Detention Centre Rules 2001 (SI 2001/238).

[228] See Medical Justice (2015) Secret Punishment: The misuse of segregation in immigration detention.

[229] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 page 113 paragraph 22.

[230] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 page 133 paragraphs 24-26.

[231] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 page 125 paragraph 56.

[232] Rule 40 and Rule 42 cannot be used as a punishment, as set out in Rule 42(1) and the DSO para 29.

[233] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 pages 118-119 paragraphs 34-37.

[234] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 pages 119-121 paragraphs 38-44.

with mental ill health (contrary to clear mandatory guidance)[235]. The Inquiry found evidence of Rule 40 and Rule 42 still being used for administrative convenience under Serco at Brook House.[236]

The Detention Centre Rules 2001 provide that the use of Rule 40 and 42 must be *"recorded"*.[237] When someone is segregated under Rule 40 or 42, the following must be notified: a member of the visiting committee (namely the IMB)[238], the medical practitioner,[239] the manager of religious affairs[240], and the Home Office Detainee Escorting and Population Management Unit.[241] However, the Inquiry raised concerns about the reporting and oversight of the use of Rule 40 and 42 within the contractor[242], Home Office, IMB and HMIP, and noted that the issues may be persisting today.

Within Medical Justice's case set, 14 people were put in segregation during their detention. Some of them were put in segregation more than once and for several days. The longest length of time in segregation was two weeks. One person was put in segregation four times during their detention.

Some were on ACDT while they were in segregation, and some were on constant watch and ACDT.

One client who was put in segregation was assessed by a Medical Justice clinician as lacking mental capacity. Two further clients who were put in segregation were identified by a Medical Justice clinician as possibly lacking mental capacity, requiring further assessment.

Force and restraints were used in some cases to transfer clients to segregation and in other cases, the clients were described in medical records as going *"voluntarily"* to the Care and Separation Unit (CSU), another name for segregation.

Medical Justice also found an example of IRC healthcare not being told that an individual had been moved to CSU, according to their medical records.

6.1.1 Reasons clients were put in segregation

The reasons noted in the medical records explaining why the 14 people were put in segregation varied from disciplinary action for *"behaviour",* apparent logistical reasons such as for removal from the UK and for *"safety"* reasons following self-harm or suicide attempts in detention.

The most common reason recorded in medical records was *"for good order and discipline"*, which was a term used to describe those that had "disruptive*", "aggressive"* or *"angry"* behaviour or actions. One person was described in the medical records as having *"misbehave[d]"*. It is important to note that behaviour rooted in ongoing and untreated mental health issues is often mistaken as confrontational behaviour and managed through the use of segregation.

Medical Justice found very concerning examples of clients with severe mental health conditions such as psychosis put in segregation due to their *"behaviour"* in detention. This included clients diagnosed by a Medical Justice clinician with possible learning difficulties and autistic spectrum disorder, psychotic

[235] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 pages 121-125 paragraphs 45-55.

[236] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 page 121 paragraph 44.

[237] Rule 40(8) and Rule 42(7) Detention Centre Rules 2001 (SI 2001/238).

[238] Rule 40(5) and Rule 42(6) Detention Centre Rules 2001 (SI 2001/238).

[239] Ibid

[240] Ibid

[241] Home Office (September 2020) Detention Services Order 02/2017 Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42).

[242] The monitoring of the use of Rule 40 and 42 by G4S at the time, was found to be "plainly inadequate" due to a failure to identify and act upon any the significant issues. See Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 page 127 paragraph 60.

symptoms, or a psychotic illness. The individual with a psychotic illness was noted in the medical records to be told to *"behave appropriately"* when they were put in segregation.

For others it was for *"non-compliance"* or their reaction to custodial staff attempting to move them elsewhere within the IRC ahead of removal. Others were moved to segregation in preparation for their transfer to hospital or for their Removal Directions.

There were also examples of segregation used in response to the person self-harming, attempting suicide or threatening suicide. Medical records state that in these cases, segregation was *"for their own safety"* or to *"provide better support"*. One person asked staff to be put in segregation to protect them others in the IRC.

6.1.2 Impact of segregation

Segregation has been associated with worsening symptoms of depression, severe anxiety, psychotic symptoms and exacerbation of PTSD. Suicidal thoughts and risks of suicide are also increased. In the context of asylum seekers suffering from PTSD, for instance, it can precipitate or intensify the traumatic memories of flashbacks of their past mistreatment and increase their feelings of powerlessness.

In this case set, clients were severely impacted by being detained in the segregation unit, as noted in their medical records or recounted by clients and recorded in their MLR. This included increased suicidal thoughts, a deterioration in their mental health, feeling *"isolated", "lonely"* and/or *"anxious",* feeling *"very low",* feeling *"like no one cares",* crying and *"making [them] go crazy".* A Medical Justice clinician described segregation as causing *"significant psychological distress"* to a client and a worsening of their mental health symptoms. One client told Medical Justice that segregation reminded them of being in prison.

Some clients self-harmed or threatened to self-harm in response to being put in segregation. Others continued to refuse food and fluid in protest of segregation and their removal directions.

Aaron told Medical Justice about his harrowing experience in segregation:

"Some managers used force, threatened me. [For example] when I asked for help to let me go to have a doctor's appointment, they prevent[ed] me to go there. I asked the manager to help me to go there and instead of helping, to mute me, to mute my voice they used force and took me in isolation. They took my shoes off, my jacket off and left me on the cold floor for 3 days. I was completely isolated. I was having difficulty to breathe, I was anxious. They left me without medication there. The main [guard] came and I asked him for 'help, I can't breathe'. He came inside and said 'you can breathe just fine here'. I could breathe for a moment but I was there 24 hours [a day]. I suffered from close environment [claustrophobia] I need fresh air. Even the main manager came and said 'you are fine because the nurse saw you'. It was the same nurse who said 'why you coming for ECG'. The nurse did no medical checks, nothing. She didn't come in. She only saw me from outside the door with eye contact. It was a bad joke. Treating me like a dog." Aaron told Medical Justice *"I couldn't bear it anymore".* He refused to eat food for four days. A different doctor visited him because he was becoming more unwell, who was *"nice"* to him.

Mark told Medical Justice he was put into segregation five times during his detention and was told *"the reason is to keep you safe. To keep you safe there are special rooms, [and] constant watch. [But they were] punishing me to keep me 'safe'. You can't see them harm you, they are not going to come up to you and do it [physically]."*

Segregation gravely impacted Mark's mental health. One of the times he was taken to segregation in handcuffs he told the officers he *"would like a medication tablet/pill to end his life",* according to his medical records. Another time, he swallowed a battery whilst in segregation. Mark told Medical Justice that he was laughed at when he did this. His medical records show that he was then transferred to A&E.

6.2 Further external evidence

Beyond Medical Justice's case set, the reports following inspections by both the IMB and HMIP have revealed a concerning use of segregation of vulnerable detained people. HMIP's 2022 report on Brook House IRC, 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"*.[243]

In their 2022 annual report on Brook House IRC, the IMB noted use of Rule 40 was higher in 2022 compared to the previous year, and the average time individuals spent on Rule 40 had also substantially increased.[244] The report raised concerns about the use of Rule 40 in situations where they did not believe such use to be justified[245] and the use of Rule 40 for prolonged periods as a means to manage *"unpredictable or otherwise problematic behaviour"* of detained people with serious mental health issues[246]. The IMB criticised the pre-emptive use of Rule 40 for people who *"might not comply with removals"* and found that on occasion, there was not sufficient justification for this. Similarly in their report on Heathrow IRCs, the IMB *questioned "the use of segregation at all for detainees exhibiting behaviour which appeared to be rooted in ongoing mental health issues"*.[247] In Yarl's Wood IRC, the IMB noted numerous incidents of detained people being placed under Rule 40 separation for non-compliant or aggressive behaviour and raised concern that the use of rule 40 was becoming a default option.[248]

[243] 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.

[244] Independent Monitoring Board (2023) Annual Report of the Independent Monitoring Board at Gatwick IRC/RSTHF For reporting year 1 January – 31 December 2022 page 11.

[245] Ibid

[246] Independent Monitoring Board (2023) Annual Report of the Independent Monitoring Board at Gatwick IRC/RSTHF For reporting year 1 January – 31 December 2022 pages 27 and 39.

[247] Independent Monitoring Board (2023) Annual Report of the Independent Monitoring Board at Heathrow Immigration Removal Centre For reporting year 1 January 2022 – 31 December 2022 page 26.

[248] Independent Monitoring Board (2022) Annual Report of the Independent Monitoring Board at Yarl's Wood IRC and RSTHF For reporting year 1 January – 31 December 2021 page 17.

7. CONCLUSION

The clinical evidence of the experiences of the 66 people in this report shows that many of the same circumstances that were behind the abuses in Brook House, continue to exist across the detention estate. The Brook House Inquiry provided a forensic analysis of how the abuse uncovered by *Panorama* in 2017 occurred. It exposed failures, mistreatment and indifference at every level; from nurses and doctors, IRC staff, to Home Office civil servants. Light was shone on the structural deficiencies in detention safeguards and processes around use of force, segregation and responses to self-harm and suicidal thoughts.

These fundamental frameworks are still the same as they were in 2017. We have not seen evidence of any significant or material improvements.

This report demonstrates that people who have mental health conditions and histories of trauma, torture and trafficking, making them particularly vulnerable to detention, continue to be detained. The mental health of detained people continues to be harmed and deteriorate in detention. The safeguarding system remains ineffective and dysfunctional, with low numbers of Rule 35(1) and (2) reports, low release rates and a focus on custodial rather than clinical responses to self-harm and suicidality. Segregation continues in clinically inappropriate circumstances and concerning instances of force has been widely documented. All the failings documented in this report have taken place after the Inquiry's public hearings, across the detention estate.

The detention of a population with high rates of vulnerabilities in a prison environment, risks causing harm through damage to their mental health, inadequate safeguarding procedures, experiences of force, clinically inappropriate use of segregation, and experiences of dismissive and derogatory attitudes. Ultimately, detention remains a wholly unsafe environment.

8. RECOMMENDATIONS

Medical Justice sets out the following recommendations to the Home Office and government more widely:

1. We agree with Kate Eves's request that the government to appoint a Senior Civil Servant who has direct responsibility for monitoring the response to each of the 33 recommendations in the Brook House Inquiry's report. [249]
2. We urge the government to promptly address all 33 of the Inquiry's recommendations. This is the only meaningful way to ensure that the mistreatment and abuse, including the breaches of Article 3 ECHR, do not happen again.
3. We call on the government to issue an apology to those who experienced abuse in its care at Brook House IRC and elsewhere. To have any real meaning, an apology must be accompanied by the necessary changes to ensure that no one else is abused or harmed in immigration detention like this again.
4. Rather than expanding the use of detention, we agree with the British Medical Association [250] that the only solution is to phase out detention and consider credible alternatives (as identified by UNHCR). This must be done urgently.

[249] Kate Eves (19 October 2023) Letter to Rt Hon Rt Hon Suella Braverman KC MP, Secretary of State for the Home Department.

[250] British Medical Association (2017) Locked Up, Locked Out.


Medical Justice
working for health rights for detainees



Medical Justice Annual Review

The state of healthcare and harm in UK immigration detention in 2024

July 2025

Medical Justice
health rights for people in immigration detention

Medical Justice

Medical Justice is the only charity in the UK to send independent clinicians into all the Immigration Removal Centres (IRCs) across the UK. Our medical reports document the physical and mental scars of torture, serious medical conditions, deterioration of health in detention, injuries sustained during use of force incidents and challenge instances of medical mistreatment. We help clients access competent lawyers to harness the strength of the medical evidence we generate. We receive over 500 referrals for people in detention each year. Our evidence base is sizeable, unique and growing.

Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused by these shortcomings, as well as the toxic effect of immigration detention itself on the health of people in detention. Our casework evidence guides our policy work and strategic litigation to secure lasting change.

Medical Justice was designated core participant status in the Brook House Public Inquiry. The Inquiry was set up to investigate mistreatment of those detained in Brook House IRC in 2017, as uncovered by BBC Panorama. In September 2023, the Inquiry found that the dangerous use of force, a wholesale failure of safeguards and a culture of dehumanisation led to 19 incidents in which there was credible evidence of acts or omissions that were capable of amounting to inhuman or degrading treatment in breach of Article 3 of the European Convention on Human Rights (ECHR), within a five-month period at Brook House IRC.

Medical Justice continues to witness the continuation of many of the issues uncovered in the Brook House Inquiry across all IRCs. Detention continues to be dangerous and severely harmful. Medical Justice believes that the only way to eradicate endemic healthcare failures is to end immigration detention. Likewise, the British Medical Association believes that the use of detention should be phased out and abolished.

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Contents

Medical Justice 2

Acknowledgements 2

Executive summary 5

Introduction 6

Key findings 8

Methodology 12

Glossary of terms 13

The state of healthcare and harm in UK immigration detention in 2024 16

What happened to people detained in 2024, where do they come from and what is their background? 16

Medical Justice case set: Who is being detained? 17

What was their immigration status when they were detained? 18

Where are people in this case set from? 19

Where were people being detained and for how long? 19

How many were granted bail, released or removed? 20

Delayed release 20

What vulnerabilities do people in detention have and why does that matter? 21

Survivors of torture, trafficking and/or other trauma 21

Mental health diagnoses 24

The harm and suffering caused in immigration detention 24

Mental health deterioration in detention 24

Suicidality in detention 25

How vulnerable people are failed by detention safeguards 27

Defective initial healthcare screening 29

No or insufficient Rule 34 GP appointment 29

Rule 35 safeguarding reports 34

Suicide watch: ACDT and constant supervision failing people in detention 42

Failure to use ACDT and constant supervision as required 43

Clients remain in distressed state and at risk of self-harm or suicide despite ACDT process 43
ACDT and constant supervision disconnected from safeguards 43
Home Office statistics on ACDT and constant supervision 44
The state of healthcare in detention: are needs being met? 45
Quality of healthcare in detention 45
Missed diagnoses 45
Treatment not offered and/or available in detention for PTSD 45
Lack of action by GPs in response to Medical Justice clinical letters 46
Mental health referrals 47
Use of segregation in detention 48
Home Office statistics on use of segregation 50
Use of force in detention 50
Use of force for hospital appointments 51
Home Office statistics on use of force 52
Deaths in detention 52
Forms of protest or resistance in detention 52
The state of detention under immigration powers in prison 53
Disruption of continuity of healthcare 53
Disruption of continuity of care by being detained 53
Disruption of new appointments made in detention 54
Unsafe release and disruption of continuity of care when released or forcibly removed 54
Conclusion 54
Recommendations 56

Executive summary

Through its close analysis of clinical and other evidence from Medical Justice's clients, this report provides a snapshot of the conditions in immigration detention in 2024. It highlights the continuing systemic failure of clinical safeguards to effectively protect vulnerable people in detention seven years after the events that led a public inquiry to find 19 incidents of inhuman or degrading treatment at Brook House IRC. The evidence presented in this report and Medical Justice's daily casework clearly shows that the government has not learned the lessons of the Brook House Inquiry. Indeed, the UK's monitoring body His Majesty's Inspectorate of Prisons (HMIP) found that another IRC, Harmondsworth, had the "worst conditions they have seen in immigration detention" in July 2024.[1]

With the government's current acceleration of the forced removal process and use of charter flights, as well as plans to expand detention further, the harm our clients already experienced in detention in 2024 risks being greater and for a higher number of vulnerable people held in detention with no time limit.

We know that people with pre-existing vulnerabilities such as a serious mental health condition or history of torture, trafficking and/or trauma are at particular risk of harm in detention.[2] 82% of our clients in this case set of 73 clients were torture survivors and 63% reported a trafficking history. 91% had Post-Traumatic Stress Disorder (PTSD) or PTSD symptoms, 78% had suicidal thoughts and 23% self-harmed. They were detained for up to two years.

In line with warnings in all Medical Justice reports for the last 20 years that immigration detention can cause those with pre-existing vulnerabilities to deteriorate in their mental state, it should come as no surprise to the government that our clients' health deteriorated. 90% were eventually released, calling into question the justification for their detention in the first place.

Our case set includes clients with mental health conditions who were held in segregation for extended periods and not checked daily by an IRC doctor as they should have been. Force was used on 16 clients including highly concerning use of force applied to two clients' head and neck. Force was used to take clients to segregation, during external medical appointments, and in response to self-harm and distressed behaviour. We continued to see segregation being used as a wholly inappropriate response to a mental health crisis and misused as a form of punishment.

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[1] HMIP, Harmondsworth Immigration Removal Centre: drugs, despair and decrepit conditions, July 2024

[2] See Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention; and Helen Bamber Foundation, Medical Justice, Anti Trafficking and Labour Exploitation Unit and Focus on Labour Exploitation (2022) Abuse by the system: Survivors of trafficking in immigration detention

Medical Justice client, Aaron, was taken to hospital where a doctor refused to treat him in handcuffs. Guards escorting him refused to remove the handcuffs. Aaron told Medical Justice: *"I don't know why they treated me like that. I was vulnerable. They know I suffer from mental health as well; I'm a vulnerable adult. I feel mistreated."*

For 94% of our clients in the case set, the IRCs failed to properly document harm detention had caused them in a Rule 35 (1) safeguarding report. Even when its own IRC GP did provide a Rule 35 report documenting that a detained person was being harmed by detention, had suspected suicidal intent or was a survivor of torture, the Home Office decided to continue detention – this was the case for 72% of these clients.

Medical Justice believes that the only way to eradicate the harm caused by immigration detention is to end detention. Meanwhile, the Home Office must implement all Brook House Inquiry recommendations to reduce the ongoing harmful conditions which risk leading to inhuman and degrading treatment.

Introduction

This review of immigration detention in 2024 is the first edition of Annual Reviews produced by Medical Justice based on its medical evidence. It provides an insight into the harm of immigration detention in the UK in 2024 based primarily on clinical and other evidence from Medical Justice clients who were detained in an IRC in 2024.[3]

This review provides statistical findings and an analysis of the experience and treatment in detention of Medical Justice clients in 2024 (the "case set"). It looks at who was being detained, where and for how long. It draws on the clinical assessment provided in medico-legal reports of their health vulnerabilities and the harm and suffering caused to them by being held in immigration detention with no time limit. It examines how vulnerable people are failed by the detention safeguards, the state of healthcare provided in detention and whether their health needs are being met. It also reviews the use of segregation and force in detention, deaths in detention, forms of protest or resisting IRC and Home Office processes, the conditions of detention under immigration powers in prison and the disruption of continuity of care.

Understanding and providing clinical evidence about the treatment and experiences of vulnerable people in detention and the systemic failings of the current safeguarding system in detention to protect, identify and route out vulnerable people is crucial to assessing whether needs are – or could ever - be met in such a harmful environment. Understanding who ends up

[3] People in immigration detention in the UK can be held in IRCs, Short-Term Holding Facilities, Pre-departure accommodation, and in prison under immigration rules.

in detention and their background is also important for those wanting to challenge the often dangerous, false and divisive narrative about immigration in the UK media and the current government rhetoric.

This review should not be viewed in isolation of other developments in 2024 relating to immigration detention and the treatment of asylum seekers.

2024: Change of government but immigration policies continued to cause harm

In March, the Conservative government extended by three years the use of the quasi-detention facility RAF Airfield Wethersfield to hold asylum seekers, having initially opened the previous year as a temporary measure for 12 months.[4]

Following the passing of the Safety of Rwanda Act in April, the government started detaining people in preparation for their forced removal to Rwanda in April and May 2024. Although no flights went ahead, this experience caused irrevocable harm to many of those detained.[5]

In July, the incoming Labour government confirmed the end of the Rwanda policy[6], as well as announcing plans for a Border Security, Asylum and Immigration Bill and the use of the plane originally destined for Rwanda to forcibly return people to Vietnam.[7] The government also announced that they would not be renewing the contract for the Bibby Stockholm barge, which held asylum seekers in quasi-detention facilities on board until November 2024.[8]

In August, the government announced the ramping up of removal flights and a significant expansion of the UK's detention capacity, with the intention to maintain the previous government's plan to reopen Campsfield and Haslar IRCs.[9] Napier military barracks which houses asylum seekers in quasi-detention facilities remained open throughout 2024.

August also saw racist riots and violence take place across England and Northern Ireland following months of dangerous rhetoric from politicians vilifying those coming to seek protection which was amplified by the media. Rather than resisting the trend to scapegoat asylum seekers, the Labour government stated it was looking at other offshoring schemes for 'failed' asylum seekers like those signed with Albania.[10] It also ramped up charter flights and

[4] The profound harm caused to those held there has been well documented: Asylum accommodation at RAF Wethersfield | Helen Bamber and High Court Judgement 14 March 2025: TG & Ors v Secretary of State for the Home Department [2025] EWHC 596. The APPG on Immigration Detention Inquiry into quasi-detention facilities similar to Wethersfield found the impact on those held there were similar to those caused by detention in IRCs.
[5] Medical Justice, *"You'll see the outside when you're in Rwanda": Mistreatment in UK detention and mass round ups for forced removals,* September 2024
[6] BBC News, Sir Keir Starmer confirms Rwanda plan 'dead' on day one as PM
[7] BBC News, Failed asylum seekers to be sent back to Vietnam
[8] BBC News, Bibby Stockholm: Migrant barge to be closed
[9] BBC News, Ministers promise 'large surge' in returning illegal migrants
[10] BBC News, Keir Starmer looks to Italy on how to stop migrant boats

deportations, as well as 'voluntary' return flights such as those to Brazil carrying hundreds of Brazilian nationals, including children, between August and September. [11] Medical Justice saw this surge of removals and use of charter flights in its casework.

In November, Labour signed new returns agreements with Iraq and Vietnam. [12]

In December, the government increased the cap on numbers at RAF Wethersfield from 580 to 800. [13] The same month, a judge ruled that the UK had unlawfully detained dozens of Sri Lankan asylum seekers, including 16 children, in camps on the remote British territory of Diego Garcia. [14]

Medical Justice is deeply concerned that recent political developments and rhetoric from the Labour government will result in an increased number of people detained in 2025, [15] and with it, an increased risk that more vulnerable people will be detained, harmed and speedily removed without having proper access to good legal support. We have already seen this reflected in our casework in 2025.

Below, we provide Medical Justice's key statistical findings and overarching analysis of the experience and treatment of our clients held in IRCs in 2024.

Key findings

In this annual review, Medical Justice analysed the documentation of 73 detained clients who had a medico-legal report (MLR) finalised in 2024. They included:

- People in the process of claiming asylum
- People who had come to the UK as children
- Members of the LGBTQ community
- Women
- EU nationals
- Nationals of countries that have a high approval rate for asylum claims
- People detained for forced removal to Rwanda

[11] Caribbean Television Network, Hundreds of Brazilians secretly deported from UK: Rights groups sound the alarm
[12] In April 2024 the then conservative government signed a returns agreement with Vietnam. In November 2024, Labour signed a returns agreement with Iraq.
[13] The Minister of State, Home Department, Asylum: MOD Wethersfield: Home Office written question answered 10 Dec 2024
[14] BBC News, Diego Garcia: Judge finds UK unlawfully detained migrants on British territory
[15] Prime Minister Keir Starmer, PM remarks at Immigration White Paper press conference: 12 May 2025

Clients were detained for periods ranging from seven days to almost two years. 90% of these clients were released into the community. Despite having received bail in principle, 32% continued to be held in detention for a further one to seven months, all the while being further harmed.

Despite safeguards in place prior to the decision to detain that are meant to prevent vulnerable people from being detained,[16] large numbers of people who have a mental health condition and/or a history of trauma are detained and harmed in detention:

- 82% of the case set were survivors of torture and 63% reported a history of trafficking.
- 93% of those who reported a history of trafficking were referred into the National Referral Mechanism (NRM): 40% of whom received a positive reasonable grounds decision and 9% received a positive conclusive grounds decision.
- 99% of the clients in the case set had a diagnosis of at least one mental health condition, according to the Medical Justice clinician: 91% had a Post-Traumatic Stress Disorder (PTSD) diagnosis or had PTSD symptoms which caused significant distress or warranted further assessment and 92% had depression or symptoms of depression.

Clients' mental health deteriorated and their suicide risk increased in detention:

- 97% of clients deteriorated in their mental state and 74% had an increased risk of suicide since they were detained.
- 23% self-harmed and 78% had suicidal thoughts in detention, including many of those detained for forced removal to Rwanda.
- 4% attempted suicide and clients also witnessed other detained people attempting suicide and/or self-harming in detention.
- The Home Office's own statistics show that 616 self-harm incidents were recorded in 2024 across all IRCs in the UK. 7% required medical treatment in hospital.

Safeguards in detention failed many vulnerable people in detention, meaning that clients' vulnerabilities were not properly identified and they remained in detention being further harmed:

- All had an initial healthcare screening but there were many inadequacies in the identification of vulnerabilities, offering and explaining what the Rule 34 GP appointment is, a lack of interpretation and late-night screening for some.
- In the screening, 77% did not disclose or have their history of torture identified, 89% did not disclose or have their reported history of trafficking identified and 71% did not

[16] A Detention Gatekeeper reviews an individual's suitability for detention

disclose or have identified their history of self-harm, attempted suicide and/or suicidal thoughts.

- 77% of clients in this case set either did not see a GP within 24 hours of their detention as per Rule 34 of the Detention Centre Rules (DCR) or had an insufficient mental health assessment to qualify as a Rule 34 appointment. 74% of clients who had a Rule 34 appointment had no physical examination by the IRC GP and/or no detailed questions from the GP recorded about their physical health or possible symptoms.
- IRC GPs failed to always write good quality and/or accurate Rule 35 safeguarding reports. There were examples of the IRC GP concluding that a client's needs were being met in detention, which Medical Justice clinicians found not to be an accurate portrayal of the client's health needs, mental or physical health conditions, nor of the treatment given or available in detention.
- IRC GPs completed a high number of Rule 35 (3) reports for the clients in this case set: 83% of the torture survivors in the case set received a Rule 35 (3) report.
- IRC GPs failed to complete Rule 35 (1) reports for 94% of the clients that Medical Justice clinicians assessed had been harmed by detention and therefore required one.
- IRC GPs failed to complete Rule 35 (2) reports for many of the clients that required them: 96% of clients who had suicidal thoughts in detention – some of whom would likely meet the Rule 35 (2) threshold of 'suspicions of suicidal intent' - did not have a Rule 35 (2) report completed and 60% of clients who were on constant supervision Assessment Care and Detention Team (ACDT) - a large proportion of whom would likely meet the threshold - did not have a Rule 35 (2) report completed.
- In 72% of the decisions made in response to Rule 35 reports, the Home Office decided to maintain detention and released very few people, despite the harm clients were suffering.
- 30% of Home Office decisions on Rule 35 reports were delayed.
- Similar to our figures, the Home Office's statistics show that it made the decision to maintain detention for 76% of those who had a Rule 35 report across all IRCs.

Suicide watch - ACDT including constant supervision - remained deeply flawed:

- ACDT monitoring/reviews is not a therapeutic intervention; responsibility lies with IRC custodial staff and is not carried out by trained healthcare professionals.
- There were failures to always use ACDT, including constant supervision, as required. When it was used, clients were frequently transferred on and off ACDT or remained on ACDT for long periods and/or self-harmed or attempted suicide whilst on ACDT, showing that clients remained in a distressed state and at risk of self-harm or suicide in detention.

Constant supervision continued to not be linked to safeguards in detention:

- None of the clients who were on constant supervision had a Rule 35 (1) appointment considered and/or booked by healthcare at the time or within a day of being put on constant supervision.
- Only 40% had a Rule 35 (2) appointment considered and/or booked at the time or within a day of being put on constant supervision.
- Medical Justice's findings echo the Home Office's own data on the wider detained population in 2024; very low numbers of Rule 35 (1) and (2) reports were completed for those that required them. While 1292 ACDTs and 419 Constant supervision ACDTs were opened, only 74 Rule 35 (1) reports and 35 Rule 35 (2) reports were completed.

Healthcare in detention remained woefully insufficient and meant that many vulnerable people were severely harmed in detention:

- High numbers of mental health conditions including PTSD were missed or not explored by the healthcare team in detention. PTSD symptoms were not proactively screened contravening National Institute for Health and Care Excellence (NICE) guidelines.[17]
- IRC GPs rarely took action in response to recommendations from Medical Justice clinicians following an MLR assessment.
- 89% of the case set were referred to the mental health team in detention. However, this did not always result in the clients receiving an assessment or treatment by the mental health team.

Vulnerable clients were put in segregation. This measure continues to be over-used, misused and harmful to those held in isolation there.

- All clients put in segregation had at least one mental health condition or symptoms of a mental health condition and 68% had an increased risk of suicide.
- People were detained up to several weeks in segregation, despite Rule 40 of the DCR allowing up to a maximum of 14 days to be authorised at a time and three days under Rule 42 of the DCR.
- Clients were put in segregation for purposes other than those allowed under the DCR and associated guidance, including in response to deterioration in their mental state and as a form of punishment.
- 53% of clients held in segregation were not seen daily whilst held in segregation by the IRC GP, as required by Rule 40 and 42.
- The Home Office's own statistics show that *at least* 1,340 people were held in segregation under Rule 40 and *at least* 25 under Rule 42 in 2024.

[17] NICE, Post-traumatic stress disorder: When should I suspect post-traumatic stress disorder (PTSD)?, August 2022

Force was used on men and women in detention, including excessive, disproportionate and/or unnecessary force:

- Force was used 18 times on 16 clients in the case set.
- Force was used on those at higher risk of harm such as torture survivors, those with a history of suicide attempts and self-harm and those with a serious physical health issue.
- Force was used on detained people during forced removals, transfer to segregation, on the journey to and during external medical appointments, in response to self-harm and in response to physical altercations in detention.
- Types of force reported included being subjected to handcuffing, being physically held by security staff and direct pressure to the head or neck.
- According to the Home Office's own statistics, there were 1,363 recorded use of force incidents across all IRCs in 2024.

Eight clients in the case set were detained in prison under immigration powers.

Continuity of medical care was disrupted on 26 occasions when individuals were detained, during their detention and after their release.

Methodology

Medical Justice sends independent clinicians into all IRCs across the UK to conduct clinical assessments of clients who have been referred to us. The majority of these assessments lead to the Medical Justice clinician producing a medico-legal report (MLR), documenting clinical evidence of torture, serious medical conditions and/or injuries sustained during use of force incidents.

This annual review is based on an analysis of MLRs for Medical Justice's clients which were completed in 2024.[18] The findings are supplemented by further documentation produced by Medical Justice clinicians, including clinical letters and clinical opinions, as well as other documents including MLR instructions from the clients' legal representative, IRC healthcare records, Rule 35 reports, Home Office response letters to the Rule 35 report and other relevant Home Office case information such as bail documentation and NRM documentation.

For the 2024 annual review, Medical Justice analysed documentation for 73 clients ("the case set"). Four of those clients also had an Addendum MLR to update the assessment following events after the initial report was finalised. Both MLRs and Addendum MLRs were analysed for the findings in this review. Clinical assessments of clients for their MLR took place between

[18] 17 MLRs were excluded from this review. This included MLRs where the clinician found the client lacked mental capacity or suspected the client lacked capacity, the client was not detained under immigration rules, it was an interim MLR or Addendum MLR of an MLR that had been finalised before 2024.

October 2023 and November 2024. Sixty-six were conducted in person in an IRC, two were conducted in person at the Medical Justice office and five were conducted remotely.[19]

The review findings reflect the experience of Medical Justice's MLR clients between March 2023 (the earliest date of entering detention in this case set) and May 2025 (when data collection stopped).[20] The findings provide insights based on our clients' experiences but cannot claim to be representative of the situation in immigration detention as a whole. Whilst there are people in detention who may not have pre-existing vulnerabilities that necessitate an MLR, there are others who are so unwell that they are not able to engage with support organisations like Medical Justice and have their information included in reviews such as this.

The majority of information in this review is anonymised and presented in statistical format. Where a case study is featured or information relates to a particular individual, Medical Justice sought specific informed consent from the client. In most cases a pseudonym is used to protect the identity of the individual, unless they requested Medical Justice to use their own name.

Glossary of terms

'Adults at Risk' (AAR) Policy: Statutory Guidance and policy on determining whether a person is vulnerable (an 'Adult at Risk') and whether they ought to be released from detention because they may be at increased risk of harm in detention. The guidance states that vulnerable individuals or 'adults at risk' should not normally be detained and can only be detained when 'immigration factors' outweigh their evidence of risk.[21] Indicators of risk include those with histories of torture, trafficking and/or sexual violence, those suffering from a mental health condition, and those suffering from PTSD.

The AAR policy contains three levels of evidence. The first evidence level (Level 1) is a declaration by the detained person about their medical or other aspects of their history that they had an indicator of risk. The second evidence level (Level 2) is where a professional provided information that the detained person had indicators of risk. The third evidence level (Level 3) is evidence from a professional that the person has an indicator of risk and detention would be likely to cause them harm.

[19] Two of the 23 follow up MLR appointments were conducted in person in the Medical Justice office, whilst the initial MLR assessment took place in the detention centre. Other follow up appointments took place remotely.
[20] Sadly, there are more requests for MLRs than Medical Justice has the capacity to produce. Medical Justice makes the decision to take on the client for an MLR based on the severity of their illness, how significant an MLR would be in their legal case and the capacity of the Medical Justice team.
[21] 'Immigration control factors' encompass the following factors: timescale for removal, compliance such as breaching immigration rules or non-compliance with conditions, and risk to the public such as criminal convictions.

AAR Vulnerable Adult Care Plan (VACP): Under the AAR policy, staff working in IRCs must address and put in place reasonable adjustments for mental or physical health vulnerabilities that may impact on the safety and wellbeing of a detained individual. This must be documented in a VACP.

Assessment Care in Detention and Teamwork (ACDT): A process used in IRCs intended to reduce the risk of self-harm and/or suicide, modelled on a process used in prisons. It is a custodial process involving regular reviews, with observations and/or periods of constant supervision carried out by custodial staff, and not trained clinicians, for risk-management purposes rather than for a therapeutic role.

Constant supervision: This is the highest level of observation under ACDT for those at immediate and acute risk of suicide or serious self-harm. A detained person can be put on constant supervision *"to reduce a serious risk of them carrying out acts of self-harm or other behaviours which could lead to them accidentally or intentionally killing themselves"*.[5] Crucially it is a member of custodial staff, not healthcare, who remains with the detained person.

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

Healthcare screening: Initial screening by a nurse or healthcare assistant which should be conducted within two hours of arriving at the IRC. The screening should identify immediate healthcare needs and risks relevant to their detention. Everyone should be offered a Rule 34 GP appointment in addition to their screening.

IRC Healthcare: The healthcare team is responsible for the provision of healthcare for those held in IRCs and is commissioned by NHS England. The IRC healthcare team provides primary care and some secondary mental healthcare. Psychiatrists are not always available in every IRC.

IRC staff: Custodial staff in Immigration Removal Centres.

Medical Justice Medico Legal Reports (MLRs): These are detailed reports written and peer-reviewed by independent clinicians at Medical Justice, which provide evidence for asylum cases and other legal decisions. This may include details of the person's physical and mental health, examination findings, forensic assessment of scars and psychological consequences of ill-treatment or torture, consideration of the impact of detention on the person's health, and identification of unmet health needs.

Medical Justice Clinical Letters: These are letters written by independent clinicians at Medical Justice to raise immediate concerns about a client with healthcare, following a medico-legal report assessment in detention. They are sent to healthcare within 24 hours of the assessment.

National Referral Mechanism (NRM): This is the UK's framework for recognising and supporting survivors of modern slavery and trafficking. When someone has indicators of trafficking, they should be offered referral into the NRM. Once referred, there are two stages of decision-making. First, they receive a decision which states whether or not there are 'Reasonable Grounds' to believe that they are a victim of trafficking. This decision should be made within five days of a referral. Second, they will receive a 'Conclusive Grounds' decision, which will accept or not accept the person as a victim of trafficking on the balance of probabilities.

Part C procedures: This is an internal process which involves the completion of a document titled IS91RA Part C which may be filled out by any member of IRC staff and those working in IRC healthcare to report information concerning a detained person to the Home Office. Unlike a Rule 35 report, it does not require a detention review or formal response from the Home Office.

Rule 34 (of DCR 2001): This is the requirement that detained people are given an appointment for a physical and mental examination. The appointment must be with the GP and within 24 hours of arrival. Rule 34 has a dual function: (1) to promptly identify healthcare needs so that appropriate healthcare can be provided; and (2) to enable early identification of vulnerabilities so that those at risk of suffering harm in detention can be referred to the Rule 35 mechanism.[50]

Rule 35 (of DCR 2001): This is the key statutory safeguarding mechanism which aims to identify those with particular vulnerabilities and bring them to the attention of the Home Office who has sole responsibility of reviewing whether the person should remain in detention or be released. Under Rule 35, IRC GPs have specific reporting obligations to the Home Office if an individual is identified as within the following three Rule 35 limbs: they are likely to be injuriously affected by detention (Rule 35(1)); they may have suicidal intentions (Rule 35(2)); or they may have been a victim of torture (Rule 35(3)).

Rule 35 response letter: The Home Office is required, within two working days following receipt of a Rule 35 report, to review the person's detention in light of the information contained in the report. The Rule 35 response letter is then sent to the person (and copied to the healthcare unit at the IRC to communicate the outcome of the review). The response usually summarises the information contained in the Rule 35 report, determines what the AAR evidence level (1, 2 or 3) is, summarises how this has been balanced against any 'immigration factors', and the outcome of the review (to maintain detention or release).

Rule 40 (of DCR 2001): Under Rule 40, segregation ("removal from association") may be used in the interest of safety or security. A detained person can be held in segregation for the minimum time necessary to maintain safety/security, for an initial period of up to 24 hours, but this may be extended to a maximum of 14 days. While a fresh authority can be sought to continue

holding someone for more than 14 days, "every effort must be made to keep the time for which a detained individual is subject to restrictions as short as possible."

Rule 41 (of DCR 2001): Rule 41 provides parameters around the use of force. Force shall not be used “unnecessarily”, and “no more force than is necessary shall be used”. The detail of the use of force must be recorded and reported to the Secretary of State.

Rule 42 (of DCR 2001): Under Rule 42, segregation (“temporary confinement”) may be used to manage an actively violent detained person. They can be held in segregation for as long as they pose a risk, for up to 24 hours and this may be extended for up to three days after written direction from an officer of the Secretary of State.

The state of healthcare and harm in UK immigration detention in 2024

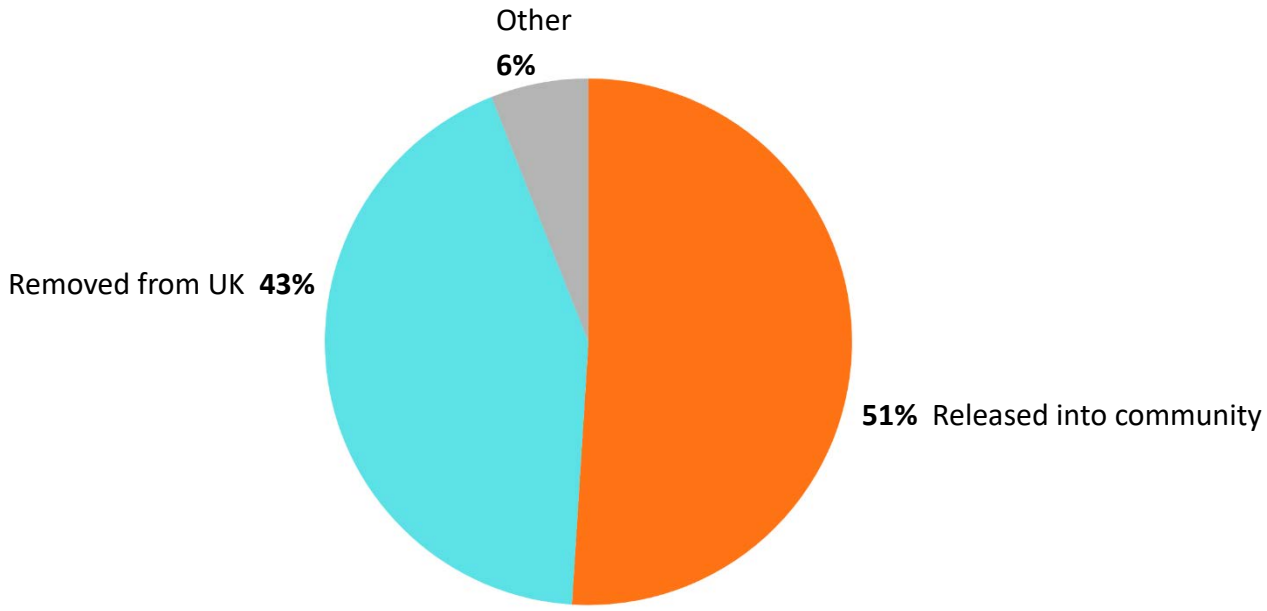
Immigration detention in the UK is indefinite, harmful and unnecessary. Medical Justice’s statistical findings and analysis of clients detained in 2024 - read in conjunction with the Home Office’s own statistics showing similar patterns in the wider detained population that year - shows what was uncovered by the Brook House Inquiry in 2023 is still ongoing and takes place across all IRCs. We continue to see a “dysfunctional” safeguarding system,[22] where vulnerable people are exposed to the risk of mistreatment and are caused actual harm.

What happened to people detained in 2024, where do they come from and what is their background?

20,604 people entered detention in 2024, an increase of 12% compared to 2023.[23] Eight children were detained.[24] Over half of those detained in the UK were released into the community after being granted bail or leave to enter/remain. [25]

[22] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.1 page 3 paragraph 2
[23] Home Office national statistics, How many people are detained under immigration powers in the UK?
[24] Home Office national statistics, Home Office detention summary tables year ending December 2024 _Det_02b
[25]Home Office national statistics, Home Office detention summary tables year ending December 2024 _Det_04a

Home Office statistics: What happened to people detained in the UK in 2024



Medical Justice case set: Who is being detained?

In 2024, the Medical Justice case set included detained men, women and those identifying as transgender, including LGBTQ individuals. Many were survivors of torture and had reported a trafficking history.

Clients had a range of different immigration situations at the time of their MLR assessment. This included those in the process of claiming asylum, those refused asylum and/or those awaiting determination of whether there were reasonable or conclusive grounds that they had been trafficked. Some clients were subject to a deportation order following a conviction for a criminal offence and were detained after serving their prison sentence. For some, consideration was ongoing as to whether to make a deportation order. Others had no criminal convictions.

Clients' immigration status changed after the MLR assessment took place with many challenging their status with access to good legal representation facilitated through support from organisations like Medical Justice. Many went on to appeal or put in a fresh asylum claim, make a human rights claim, European Union Settlement Scheme (EUSS) application or trafficking claim or challenge the inadmissibility of their asylum claim and notice for removal to Rwanda.

Of the 73 Medical Justice MLR clients in this case set:

Gender	Age	Histories of trauma
11 Women 61 Men 1 Transgender	All were over the age of 18 at the time of their detention	60 were survivors of torture 46 reported a history of trafficking

What was their immigration status when they were detained?

At the time of their MLR assessment:

- 29 were in the process of claiming asylum in the UK, 15 of whom were detained for removal to Rwanda.
    - Four were also in the process of a trafficking claim, applying for EUSS or had a positive trafficking claim. One had their refugee status previously revoked.[26]
    - Eight had a pending deportation order and two were subject to a deportation order.
- Nine had their asylum claim withdrawn. Two also had a positive trafficking claim or were in the process of a trafficking claim.[27]
    - Two had a pending deportation order and three were subject to a deportation order.
- One had their asylum claim treated as inadmissible
- For two people, the Home Office had either revoked or intended to revoke their refugee status, pending or subject to a deportation order.
- 25 had their asylum claim refused. One also had their EUSS application refused, two had a positive trafficking claim and two were in the process of a trafficking claim.[28]
    - 11 were subject to a deportation order and three had a deportation order pending.
- One had their EUSS application refused, pending a deportation order
- One had a positive trafficking claim but EUSS status revoked.
- Three others were subject to a deportation order with no other immigration status

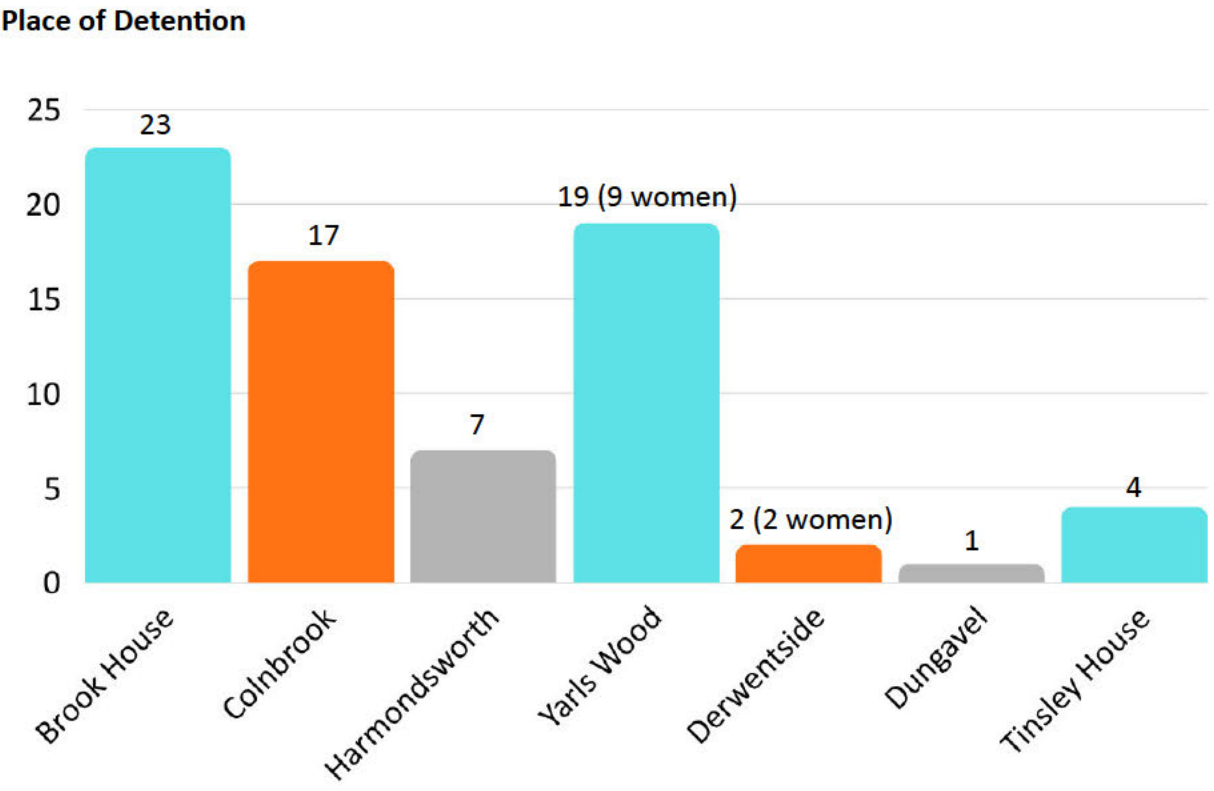
[26] Three others had received a negative reasonable grounds (RG) decision and one other received a negative conclusive grounds (CG) decision.
[27] Four others had received a negative RG decision and one other received a negative CG decision.
[28] Four others had received a negative RG decision, four others received a negative conclusive grounds decision and two had received a positive RG decision but were disqualified on public order grounds.

Where are people in this case set from?

The 73 were nationals of: Afghanistan, Albania, Algeria, Bangladesh, Brazil, Egypt, Eritrea, Ethiopia, Ghana, Guyana, India, Iran, Iraq (including Kurdistan Region of Iraq), Kuwait (Stateless Bidoun), Liberia, Nigeria, Palestine, Poland, Slovakia, Somalia, Sri Lanka, Sudan, Syria, Thailand, The Gambia, The Philippines, Vietnam and Zimbabwe. The case set also included those with a disputed nationality.

Four of our clients had come to the UK as children.

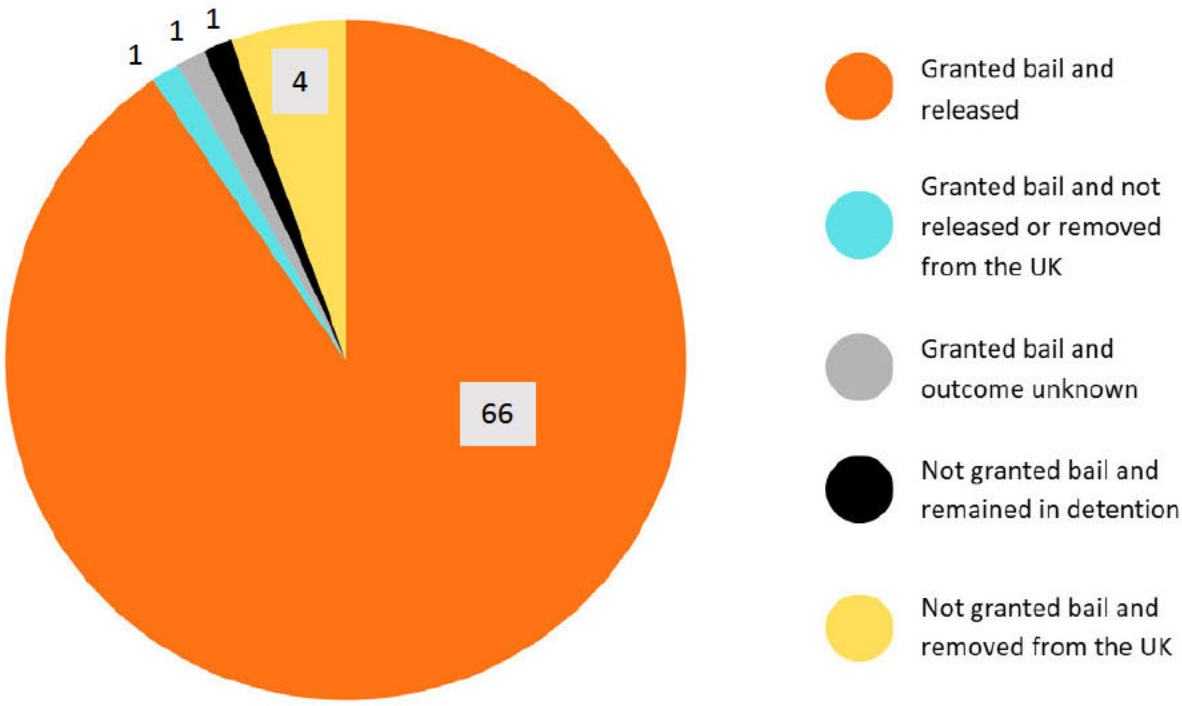
Where were people being detained and for how long?



The longest time a client was detained for was almost two years. The shortest time was seven days.

How many were granted bail, released or removed?

Clients granted bail, released, removed or remained in detention



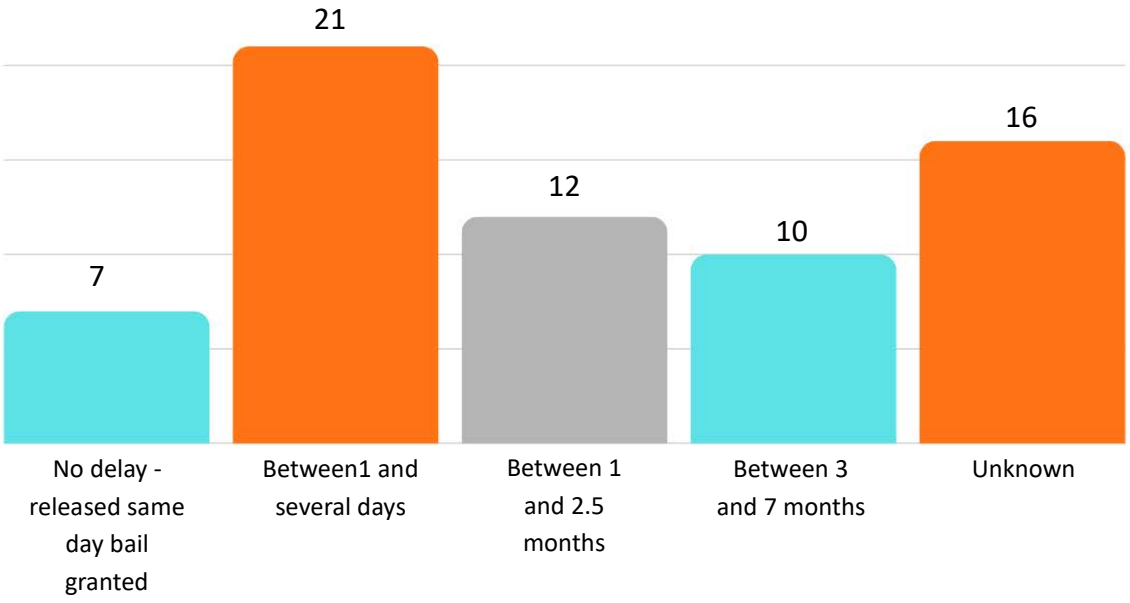
The vast majority of our clients (90%) were released into the community.

Delayed release

Despite being granted bail in principle, many of our clients remained in detention for days and months after the decision. This was due to delays in appropriate housing and support being available, including for many individuals who were eligible for housing and support from the Home Office. Every further day they were detained, they were being harmed by detention.

66 of the 73 clients were granted bail and released from detention, but for 22 of them there was a further delay of one to seven months after the bail decision before they were actually released or removed.

Delays to release after being granted bail in principle



What vulnerabilities do people in detention have and why does that matter?

Immigration detention can cause those with pre-existing vulnerabilities such as a mental health condition or history of trauma to deteriorate, putting them at particular risk of harm.

Survivors of torture, trafficking and/or other trauma

Immigration detention can cause severe mental and physical suffering for survivors of torture and human trafficking. Immigration detention impedes recovery and increases the risk of retraumatisation.[29] Survivors of torture and trafficking should not be detained.

60 clients in this case set had evidence of torture,[30] 10 of whom were women.

One further client reported a history of torture in their MLR but was too unwell for the clinician to make a clear assessment of whether the medical evidence was of torture or other trauma.

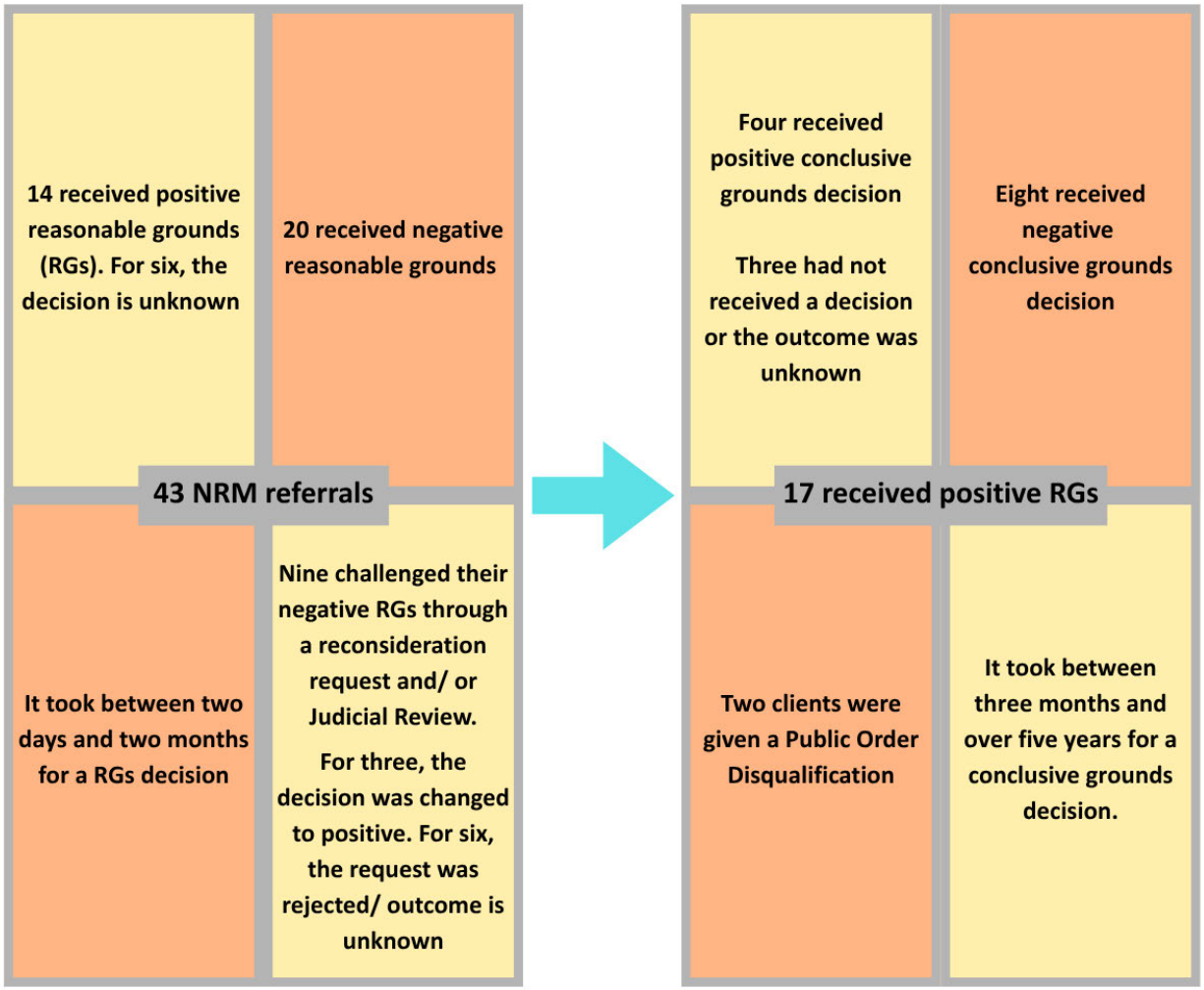
[29] See Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention; and Helen Bamber Foundation, Medical Justice, Anti Trafficking and Labour Exploitation Unit and Focus on Labour Exploitation (2022) Abuse by the system: Survivors of trafficking in immigration detention

[30] Evidence is based on either a physical and/or psychological assessment in the MLR and/or where the Home Office accepts there is evidence of torture in the Rule 35 response.

46 reported a history of trafficking,[31] 10 of whom were women.

Trafficking histories and delays in the National Referral Mechanism process

43 of the 46 who reported a history of trafficking were referred into the NRM:



Several clients did not access the NRM process until several weeks into their detention.

The delays in accessing the NRM process in detention and delays in receiving a reasonable grounds decision in the NRM process can have a profound impact on trafficking survivors in detention. It can delay their access to protections afforded under the AAR policy and impact the Home Office's consideration of their release as a positive reasonable grounds decision is both

[31] The client's trafficking history was either reported and documented in their MLR and/or they were referred into the NRM.

treated as an indicator of vulnerability to harm in detention and constitutes a barrier to removal.

If a client receives a positive reasonable grounds decision, they are considered an AAR entitling them to the same protections in detention as other AAR, including the consideration of release. They are also entitled to a recovery and reflection period of a minimum of 30 days during which time they are "protected from removal or deportation" unless they have a public order disqualification.[32] Following that period of time, a conclusive grounds decision should also be made, though there are frequently long delays,[33] as is the experience for those in our case set with clients waiting between three months to over five years for a decision. A person cannot be removed from the UK until a conclusive grounds decision has been made.

Medical Justice believes no survivor of trafficking should be detained.

Limited disclosure of trafficking histories

Whilst the Home Office asks about experiences of trafficking histories in the asylum screening interview and the Detention Engagement Team induction that everyone receives when they enter detention, there is no mechanism by which IRC healthcare would systematically enquire about or identify experiences of trafficking. The well-recognised barriers to disclosure that survivors face,[34] coupled with the detention environment not being conducive for disclosure of their exploitation and abuse,[35] has resulted in limited disclosure or identification of a client's trafficking history in detention.

50% of those that reported a trafficking history in this case set did not disclose it to healthcare in detention. For the three clients who did not access the NRM process and several clients who did not access the NRM process for several weeks into detention, not disclosing or having their trafficking history identified meant they remained without access to any of the aforementioned NRM protections and support, all the while suffering harm.

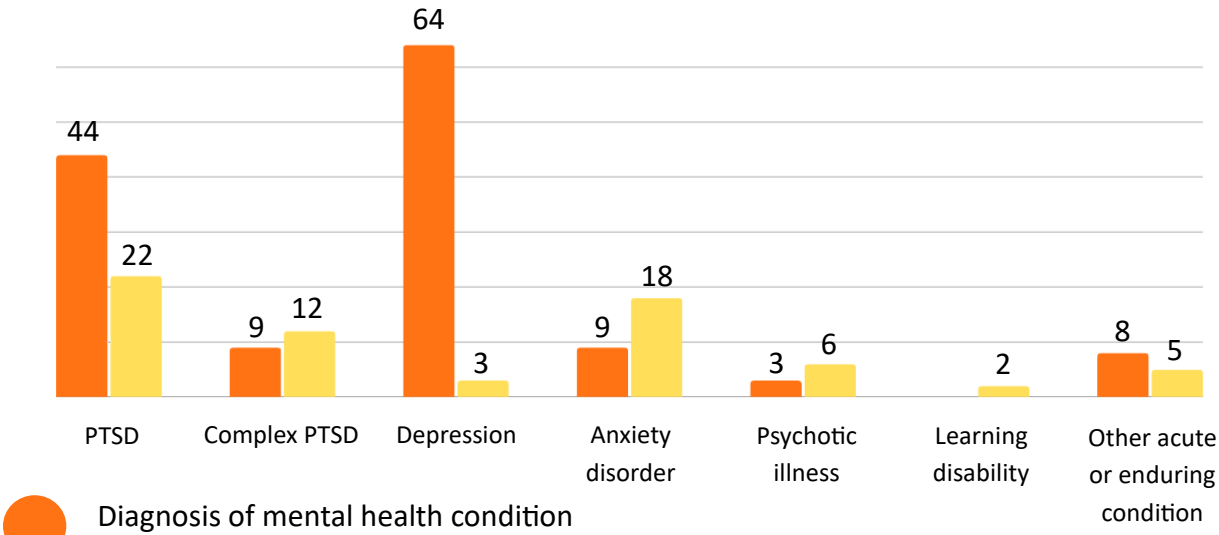
Where disclosure did take place, it was mostly during a Rule 35 appointment though it also took place at the initial healthcare screening, Rule 34 appointment or during a mental health team appointment.

[32] Home Office Guidance, Adults at risk: Detention of potential or confirmed victims of modern slavery
[33] The average (median) time taken from referral to conclusive grounds decisions made in 2024 was 637 days: Modern slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary 2024 - GOV.UK
[34] See Medical Justice, Abuse by the system p.12, October 2022
[35] The Taskforce on Victims of Human Trafficking in Immigration Detention, Briefing NABB Lords Second Reading,

Mental health diagnoses

99% of the clients in this case set had a diagnosis of at least one mental health condition, according to the Medical Justice clinician. 60% had PTSD.

Mental health diagnoses of the 73 clients by Medical Justice clinicians in 2024



The harm and suffering caused in immigration detention

Immigration detention is harmful. In addition to compounding existing vulnerabilities, Medical Justice continues to find that it can also trigger the onset of new health conditions, causing further harm and suffering.[36]

Mental health deterioration in detention

Medical Justice clinicians assessed that detention harmed and caused deterioration in 97% of our clients' mental state. For the other 3%, detention was likely to cause them harm and deterioration of their mental state if they remained in detention.

[36] M. von Werthern, K. Robjant, Z. Chui, R. Schon, L. Ottisova, C. Mason & C. Katona, The impact of immigration detention on mental health: a systematic review, December 2018

Suicidality in detention

Medical Justice continues to find that a large proportion of its clients' risk of suicide increases in detention.

There was also a similarly high proportion of clients (73%) who were detained for forced removal to Rwanda who expressed they would or will take their own life if forcibly sent to Rwanda.[37]



Witnessing suicide in detention

The level of suicidality in detention is such that in addition to those having suicidal thoughts, self-harming or attempting suicide, there are also those in detention that witness or know of the suicide or suicide attempts of other detained people, causing distress and deterioration in their mental state.

In this case set, one person witnessed the suicide of their cellmate and two people witnessed the suicide attempt of another detained person.

Piotr came back to his room to find his cellmate had taken his life. Piotr found it difficult to breathe and had a feeling of pressure on his chest, *"I was having a panic attack"*. Rather than being cared for following this traumatic incident, Piotr was taken to the segregation unit and put in a cell. He found the noise in the segregation unit distressing and was moved out of segregation after a few hours. Piotr's mental health deteriorated in detention and he was put on a Vulnerable Adult Care Plan. Piotr had insomnia and flashbacks of his cellmate's suicide, was prescribed sleeping pills and offered psychological support in detention. He saw a psychologist one month later. Healthcare records show that healthcare did not consider writing a Rule 35 (1)

[37] See Medical Justice, *"You'll see the outside when you're in Rwanda": Mistreatment in UK detention and mass round ups for forced removals* 8.3, September 2024

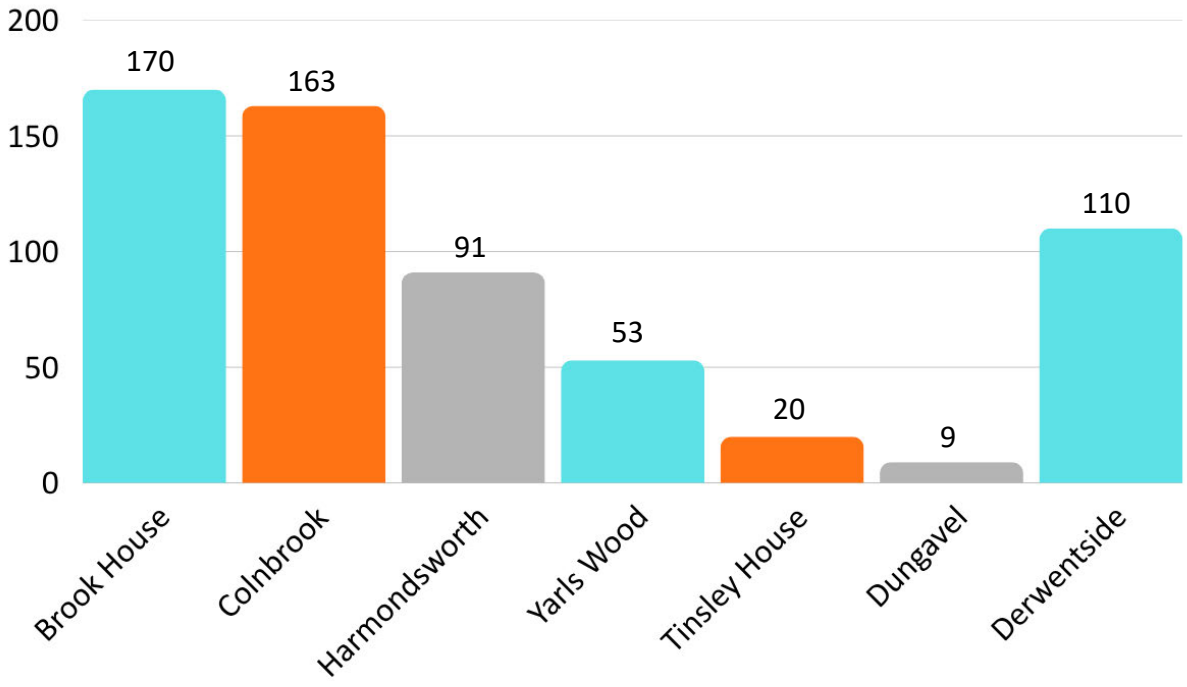
report at the time. However, an external support group supporting Piotr in detention requested one and it was belatedly completed by an IRC GP. Piotr was later diagnosed with PTSD and depression by the Medical Justice clinician. He told Medical Justice: "*I am feeling trapped in detention* [which is] *just like prison… Being in detention reminds me of that night…I just want to be released".*

Home Office statistics on self-harm in detention

The concerning numbers of clients in this case set who self-harmed, attempted suicide and/or had suicidal thoughts in detention are reflective of the overall situation in detention, with the Home Office's own statistics showing that 616 self-harm incidents were recorded to have taken place in IRCs in 2024.[38]

Home Office Statistics: Self-harm in detention 2024:

Number of self-harm incidents recorded



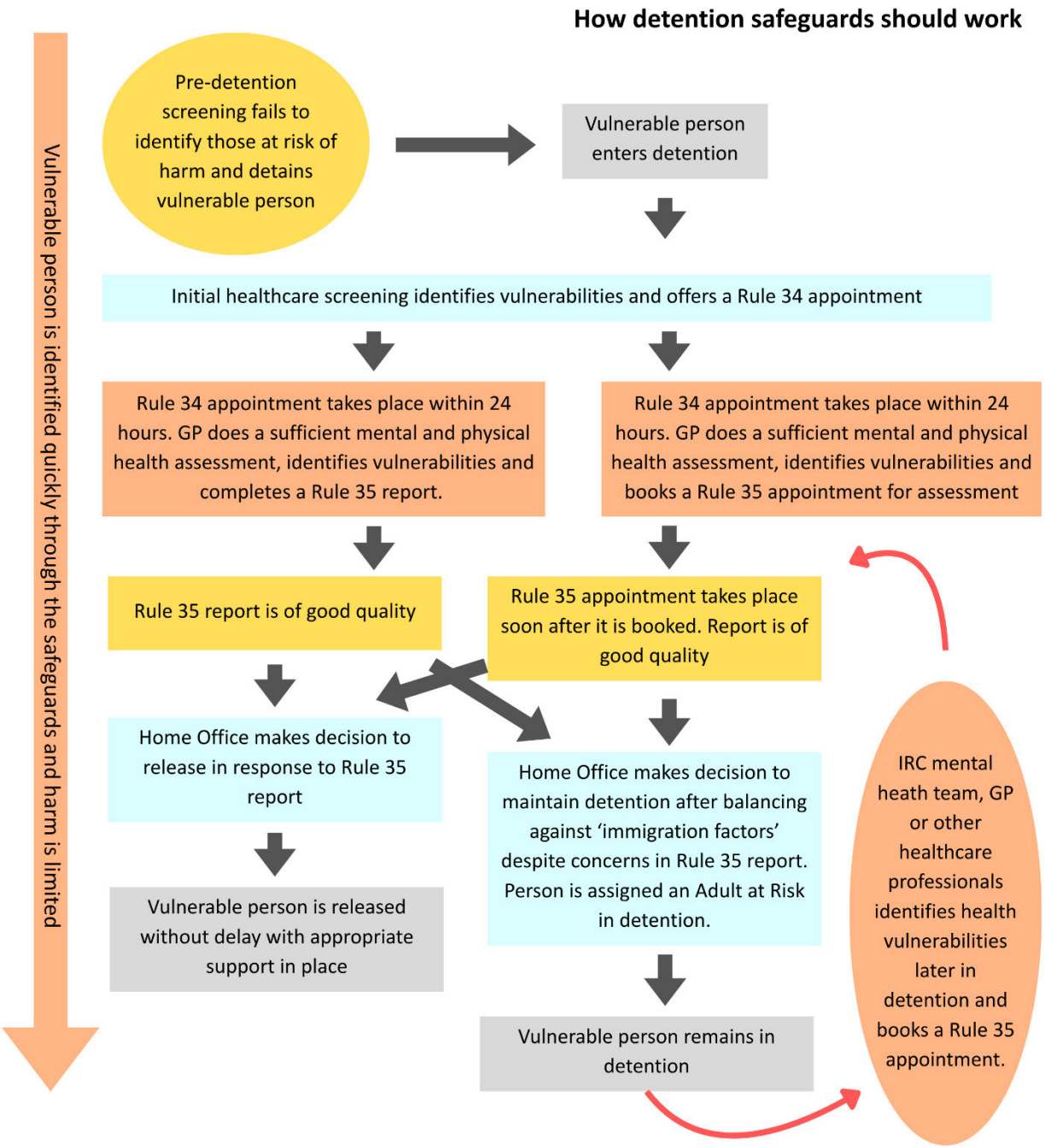
At least 371 of the self-harm incidents reported by the Home Office required "on-site" treatment at the IRC. [39] At least 42 incidents required the person to be transferred to hospital for treatment.

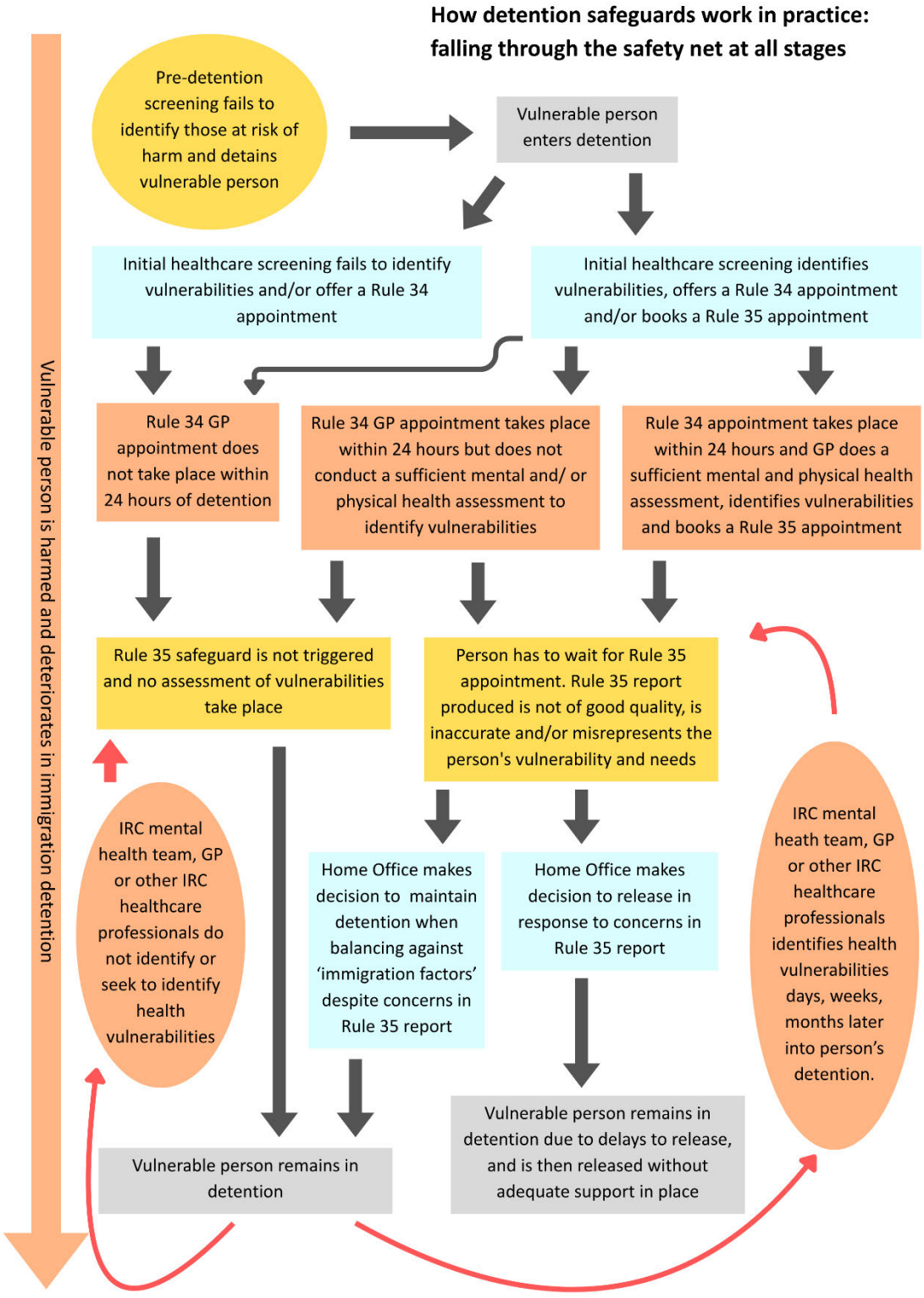
[38] Statistics broken down by IRC was provided in FOI 2025/05227 response to Medical Justice staff member

[39] The Home Office does not provide exact figures if it relates to less than five people (<5). Wherever the statistics provided is <5 it has been counted by Medical Justice as one incident and "at least" has been added to reflect that it may be more.

How vulnerable people are failed by detention safeguards

In 2024, vulnerable people were routinely failed by detention safeguards that are supposed to identify their vulnerabilities and route them out of detention, if the risks associated with these vulnerabilities are considered by the Home Office to outweigh 'immigration factors'.




How detention safeguards work in practice: falling through the safety net at all stages
Pre-detention screening fails to identify those at risk of harm and detains vulnerable person
Vulnerable person enters detention
Initial healthcare screening fails to identify vulnerabilities and/or offer a Rule 34 appointment
Initial healthcare screening identifies vulnerabilities, offers a Rule 34 appointment and/or books a Rule 35 appointment
Rule 34 GP appointment does not take place within 24 hours of detention
Rule 34 GP appointment takes place within 24 hours but does not conduct a sufficient mental and/ or physical health assessment to identify vulnerabilities
Rule 34 appointment takes place within 24 hours and GP does a sufficient mental and physical health assessment, identifies vulnerabilities and books a Rule 35 appointment
Rule 35 safeguard is not triggered and no assessment of vulnerabilities take place
Person has to wait for Rule 35 appointment. Rule 35 report produced is not of good quality, is inaccurate and/or misrepresents the person's vulnerability and needs
IRC mental health team, GP or other IRC healthcare professionals do not identify or seek to identify health vulnerabilities
Home Office makes decision to maintain detention when balancing against 'immigration factors' despite concerns in Rule 35 report
Home Office makes decision to release in response to concerns in Rule 35 report
IRC mental heath team, GP or other IRC healthcare professionals identifies health vulnerabilities days, weeks, months later into person's detention.
Vulnerable person remains in detention
Vulnerable person remains in detention due to delays to release, and is then released without adequate support in place
Vulnerable person is harmed and deteriorates in immigration detention

Defective initial healthcare screening

As part of the Rule 34 appointment, the IRC GP is required to identify pre-existing vulnerabilities or relevant history that make a detained person more at risk in detention, such as suicidality or a torture history. However, in practice, someone entering detention is asked in the initial healthcare screening whether they have a history of torture and this question is rarely re-asked in the Rule 34 appointment.[40] Disclosure of symptoms suggestive of a history of trauma do not routinely trigger exploration of whether the person has experienced torture.

We know from our clients that the experience of being arrested and taken by force to detention is a shocking, traumatizing and tiring experience in and of itself. The initial screening does not take place in an environment that is conducive to disclosure of sensitive or traumatic information. Lack of interpretation and late-night screening can also explain the lack of identification or disclosure of vulnerabilities or relevant history.

77% of torture survivors in this case set did not disclose or have identified their history of torture in the screening.

89% of trafficking survivors in this case set did not disclose or have identified their history of trafficking in the screening.

71% of those who had self-harmed, attempted suicide and/or had suicidal thoughts prior to this detention episode did not disclose this or have it identified in the screening.

Interpretation issues at screening

29 people who needed an interpreter did not have one at their healthcare screening.[41]

Most medical records noted “interpreter not needed” or stated that the client spoke English, when they only spoke very limited English. There were also examples where the nurse conducting the screening identified an interpreter was “needed” but the interpreter was “not available”, including during late night appointments, “not present” or google translate being used instead of an interpreter.

No or insufficient Rule 34 GP appointment

The Rule 34 appointment is the first opportunity to see a GP in detention. It is a key component of the detention safeguards to identify any mental or physical health vulnerabilities that a

[40] See Rule 34 for further exploration of this

[41] All 29 required an interpreter for their MLR assessment and some had an interpreter for other IRC medical appointments. For a small number there was no mention of an interpreter being used at the screening so it is unclear if one was used.

detained person has that put them at risk in detention. Early identification by the GP is crucial to trigger the Rule 35 safeguard to protect the individual from further harm.

Only 48% of the clients in the case set had a Rule 34 GP appointment within 24 hours of entering detention.

Only 23% of the clients in the case set had a sufficiently detailed mental health assessment conducted by the GP to qualify as a Rule 34 appointment.

IRC GPs tended to focus more on assessing physical health than mental health, though some assessed neither. There were multiple examples of GPs prescribing medication for a mental health condition without probing the condition itself and how it may be an indicator of a vulnerability that requires further assessment and potentially documentation in a Rule 35 report.

35 Rule 34 appointments took place within 24 hours of arrival at an IRC. One was conducted over the telephone, the other 34 were face to face.

Mental health assessments

- 17 had a sufficiently detailed mental health assessment to fulfil the safeguarding function of Rule 34.
- Six had a mental health assessment but it was insufficiently detailed to fulfil the safeguarding function of Rule 34.
- 11 had no mental health assessment. This includes clients who disclosed a mental health condition or a history of torture at screening and clients who were prescribed medication for a mental health condition by the GP without any assessment or probing taking place of the client's mental health.

Physical health assessments

- In 26 of the 35 Rule 34 appointments, the client had no physical health examination conducted and/or no detailed questions recorded about their physical health or possible symptoms.
- Most clients had vital signs, including blood pressure and heart rate, checked by the nurse in the screening, prior to seeing the GP. Further physical examination was undertaken by the GP in nine cases; these physical examinations were all focused on an identified physical health issue.
- The GP recorded in several cases that no complaints were raised, but beyond this, no detailed questions about physical health or possible symptoms were recorded in 18 cases.

- 20 clients had no physical examination beyond the vital signs. A further four had a single brief observation recorded, such as “stable” or “looks well”. In these four cases, no questions asking about physical health were recorded.
- In 20 cases, medication was re-prescribed, or plans were made to confirm and then prescribe medication, but for 14 of these individuals no detailed questions about physical health or physical examination was recorded.
- The group of clients who received no detailed health assessment included two individuals for whom significant pre-existing health issues were missed. This included one person for whom significant issues had been picked up in the nurse screening but were not addressed by the GP.

38 clients did not have a Rule 34 appointment within 24 hours. Of those: 31 saw a GP for the first time in detention between two days and almost five months into their detention. **For seven clients, the first time they saw a GP was at their Rule 35 assessment.**

Two clients did not see a GP for the entirety of their detention period and five did not see a GP for the period of detention where medical records were available.

Of the 38 people who did not have a Rule 34 appointment within 24 hours:

- For 14, no appointment was offered, booked or took place. For some, a referral to the mental health team is done instead which shows that healthcare was concerned enough about the person’s mental health that a referral is made but a Rule 34 appointment is not also booked.
- Nine “declined” the Rule 34 appointment during their healthcare screening, six of whom did not have an interpreter in their screening when it was needed.
- Three had the appointment within 48 hours.
- 12 did not attend the appointment. Of the 12, IRC healthcare attempted to or did rebook five clients’ appointments.
- One client was given the wrong time of their appointment by healthcare so it did not happen within 24 hours.

Non-attendance of Rule 34 appointments

Another failing of detention safeguards is the non-attendance of the Rule 34 appointment.

This could be explained by a number of factors. In particular, none of the clients’ healthcare screening noted that individuals were provided with an explanation of what the Rule 34 appointment was or the safeguarding purpose of it.

There were other reasons explaining the recorded non-attendance in the case set including a lack of interpreter in the screening meaning that those who speak limited English would not have been able to understand that a Rule 34 GP appointment had been made for them.

Of the 12 clients who did not attend the appointment, four required an interpreter in their screening but did not have one.

One client went to healthcare to attend their Rule 34 appointment but the healthcare records note that the "GP [was] not on site" when they arrived. The client was nonetheless marked down as "did not attend". No follow up was made by healthcare to rebook the appointment and the client did not see a GP for another three weeks.

Disconnection between safeguards: healthcare screening and Rule 34

Where the screening identified vulnerabilities that could put the individual at increased risk of harm in detention, this was not always followed up on by the GP in the Rule 34 appointment.

In 13 cases, relevant information relating to vulnerability picked up in screening was not followed up on or noted by the GP at the Rule 34 appointment. This included disclosure in the screening of a history of torture and/or trafficking, a mental health condition or symptom, a physical health injury and a history of self-harming.

Disclosure or identification of relevant information such as a history of torture and/or trafficking was rare in the Rule 34 appointments that took place; only 12% disclosed their history of torture and 6% disclosed their reported trafficking history to the GP.

43% who had a mental health condition did not disclose this or have it identified by the IRC GP.

Poor identification of vulnerabilities and insufficient Rule 34 appointments:

Of the 35 Rule 34 appointments that took place within 24 hours:

- Only three of the 26 torture survivors disclosed their history of torture.[42] Five others had already disclosed a history of torture in the screening, though only three of those were referred for a Rule 35 assessment in the screening.

[42] Survivors of torture often find it difficult to disclose and the detention environment is not conducive to disclosure. See Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention, p.8.

- Only one person who reported a trafficking history disclosed this and one disclosed an indicator of trafficking.[43] Three others had already disclosed trafficking in the screening.
- All of the 35 clients had at least one mental health condition diagnosed by a Medical Justice clinician. Only 20 of the 35 disclosed mental health symptoms or conditions at the Rule 34 appointment.
- 11 of the 15 who did not disclose mental health symptoms or conditions did not have a mental health assessment in their Rule 34 appointment. Four had an insufficient assessment. It is concerning that this includes clients who had disclosed a mental health condition or symptom at screening or was on medication for a mental health condition that the GP prescribed without recording the condition it is used for.
- 24 disclosed or had identified physical health symptoms or conditions. Seven did not disclose or have these identified in their Rule 34.[44] All seven had no detailed questions recorded by the GP about their physical health or possible symptoms though the GP may have noted in the records that no health complaints were raised.

There is a clear link between the quality of the GP's mental health assessment and disclosure or identification of vulnerabilities in this appointment. For all clients where the GP either did not conduct a mental health assessment or it was insufficient, they did not disclose or have their vulnerabilities identified.

There was also a correlation between the GP's physical health assessment and disclosure or identification of physical health issues. All of the clients who did not disclose a physical health issue or condition to the GP had no detailed questions recorded about physical health or possible symptoms though the GP may have notedin the records that no health complaints were raised.

Broken link between safeguards: Rule 34 and Rule 35

Despite the clear requirements of the DCR, the IRC GP does not always consider completing a Rule 35 report or booking a Rule 35 appointment where a safeguarding need engaging the requirements of Rule 35 is identified in the Rule 34 appointment.

A safeguarding need relating to the clients' disclosure of torture and/or serious mental or physical health issue was noted and identified in 10 of the Rule 34 appointments. This should have triggered the GP to assess and consider whether this meant the person would likely be harmed by detention, requiring consideration of a Rule 35 assessment.[45] Of those:

[43] Survivors of trafficking often find it difficult to disclose and the detention environment is not conducive to disclosure. See Limited disclosure of trafficking histories

[44] The client later disclosed this to healthcare or Medical Justice

[45] For five additional people, the need was not identified by the GP but they had already been put on the waiting list for a Rule 35 (3) appointment in the screening.

- The IRC GP booked a Rule 35 appointment for three clients.
- The IRC GP failed in four cases to assess whether the client would be likely to be harmed by detention and to consider a Rule 35 assessment. This includes clients who disclosed a serious mental health condition or a serious physical health condition requiring the client to be on a VACP.

Rule 35 safeguarding reports

Rule 35 is a critical safeguard for the IRC GP to communicate relevant information about a client's vulnerability and risk of harm in detention to the Home Office.

Yet, Medical Justice continuously finds the Rule 35 safeguard to be extremely flawed in terms of the lack of completion of Rule 35 (1) and (2) reports (on those at risk of being injuriously harmed by detention or at risk of suicide), the quality of information in the Rule 35 report and waiting times for a Rule 35 appointment.

Where Rule 35 reports are completed, we continue to see IRC GPs giving inaccurate information about the individual's needs being met in detention via interventions such as referrals or care under the mental health team, providing assurances that individuals are "stable" or even, "fit for detention", in cases where our clinicians have identified serious and deteriorating mental health issues, or not providing or giving limited information relating to the client's vulnerabilities to the Home Office for them to fully consider whether the person's detention should be maintained.

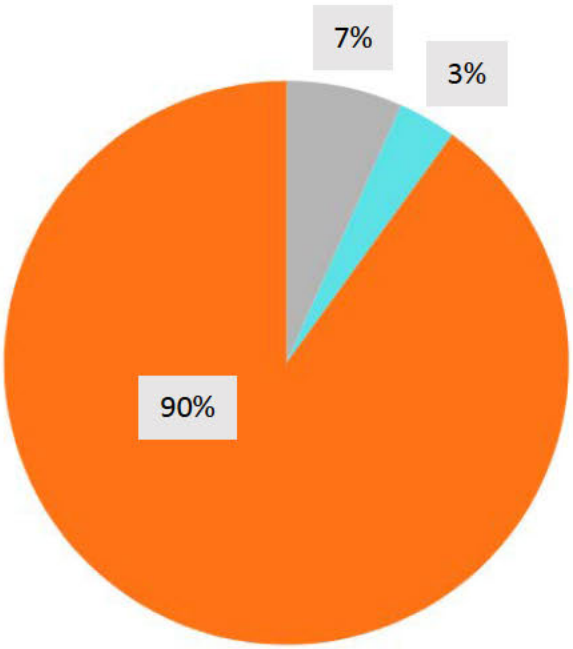
Numbers of Rule 35 reports completed: Medical Justice case set and Home Office data

In the Medical Justice case set, Rule 35 (3) reports were frequently completed by IRC GPs in detention to alert the Home Office that the individual may have been a victim of torture. However, Rule 35 (2) and (1) reports were very rarely completed. 60 Rule 35 reports were completed for 52 clients, 54 of which were Rule 35 (3) reports.[46]

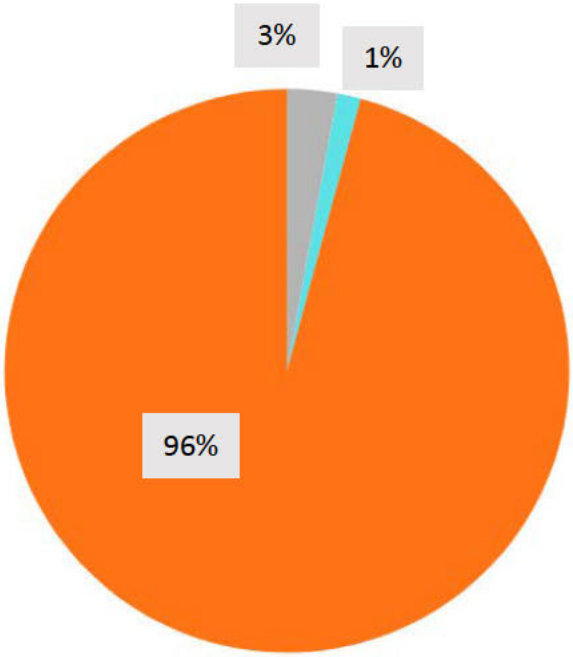
These findings reflect the Home Office's own data on the number of Rule 35 reports completed in detention in total in 2024. [47]

[46] Seven clients had two Rule 35 reports during their detention. In the case set, one client had a Rule 32 (3) report also completed in the Short-Term Holding Facility they were detained in before transfer to an IRC.
[47] Home Office Immigration enforcement statistics Q1-4, Immigration Enforcement data: Q1-Q4 2024 table DT_04

Medical Justice 2024 case set:
Numbers of Rule 35 reports completed



Home Office 2024 data:
Numbers of Rule 35 reports completed





Failure to complete Rule 35 (1) and (2) reports for clients that required them

Failure to complete a Rule 35 report can have life or death consequences, as illustrated in the inquest into the death by suicide of Frank Ospina in 2023..[48] Very few Rule 35 (1) and (2) reports were completed for the clients in this case set that required them..[49] This included clients whose Rule 35 (3) report included information from the IRC GP that should have triggered a Rule 35 (1) report in addition.

[48] Prison and Probation Ombudsman, *Independent investigation into the death of Mr Frank Ospina, a detainee at Colnbrook Immigration Removal Centre, on 26 March 2023,* May 2024

[49] Four of the 71 clients for whom Medical Justice clinicians assessed were being harmed by detention had a Rule 35 (1) report completed

Only 6% of Medical Justice clients who were harmed by detention and should have had a Rule 35 (1) report completed did. 94% did not.

96% of clients who had suicidal thoughts in detention did not have a Rule 35 (2) completed and 60% of clients who were on constant supervision ACDT did not have a Rule 35 (2) completed.

Medical Justice is concerned that there is a large difference in numbers of clients who had a Rule 35 (2) report completed and those who had suicidal thoughts, some of whom would likely meet the threshold for a Rule 35 (2) report, and those on constant supervision ACDT, a large proportion of whom would likely meet the threshold of 'suspicions of suicidal intent'.[50]

A significant larger proportion of this client set did have a safeguarding Rule 35 (3) report completed.[51]

78% of Medical Justice clients who should have had a Rule 35 (3) report did.

In 12 Rule 35 (3) reports, IRC GPs describe the harm and/or deterioration the client has, could, may or is likely or will endure in detention but does not also complete a Rule 35 (1) report.

Delays in release causing harm documented in Rule 35 (1) report

Three of the four clients who had a Rule 35 (1) completed had already been granted bail many weeks before and there are strong arguments that they should have been released prior to the completion of the report. [52]

The Home Office continued to detain these clients **between almost three weeks and four months after receiving bail** and in the meantime, the harm detention caused resulted in a Rule 35 (1) report being completed.

[50] See also ACDT and constant supervision disconnected from safeguards.
[51] The number of Rule 35 (3) reports amongst the case set (54) is different to the number of torture survivor clients who had a Rule 35 (3) report (47). Two clients had more than one Rule 35(3) report and some had a Rule 35 (3) report completed who did not have evidence of torture in their MLR but had, for example, reported a history of torture, trafficking or other trauma.
[52] See also Home Office accommodation delays having an impact on release of individuals following a Rule 35 report.

Waiting times for Rule 35 appointments

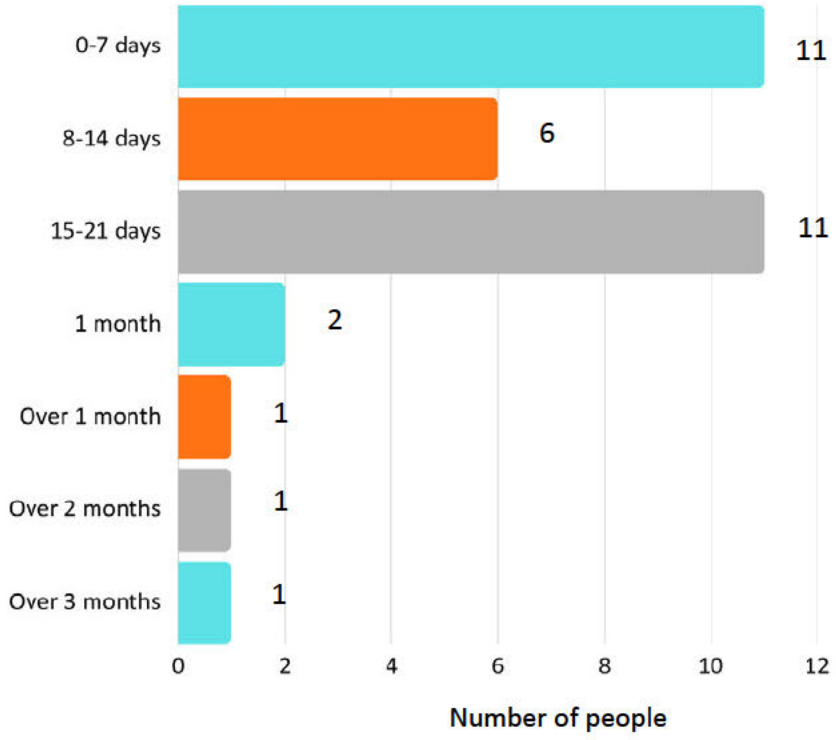
Ongoing delays to the Rule 35 appointment remain highly concerning and can have life or death consequences..[53] When questioned by the Senior Coroner in October 2024 at the inquest into Frank Ospina's death in 2023 as to why a Rule 35 (2) report had not been completed after his first suicide attempt, the head of healthcare at Colnbrook IRC pointed to the long waiting list for Rule 35 which at the time was four weeks and "the number has only increased"..[54]

During the wait for an appointment, the Home Office may not be aware of the risk to the person in detention and therefore not be reviewing their detention.

Waiting times for the Rule 35 appointment varied in this case set. For most, it was a short wait, but others waited for months.

The longest waiting time between identification of need in the medical records and the appointment taking place was over three months. The shortest waiting time for a Rule 35 appointment was the same day as the need was identified..[55]

Waiting times for Rule 35 appointments



[53] Medical Justice, *Frank Ospina killed himself following multiple clinical safeguarding failures that contributed to his death,* October 2024

[54] Liberty Investigates, *Migrants in detention 'faced month long wait for mental health assessments' when man took his life*, October 2024

[55] This does not necessarily equate to when the client is added to the waiting list. It could be for example when someone is identified in the medical records as a "victim of torture" but no Rule 35 appointment is booked.

Even when Rule 35 assessments are carried out, there are shocking examples of delayed appointments for those requiring one urgently including those who self-harmed and attempted suicide in detention. For example, one person had to wait over two weeks for a Rule 35 (2) report to be completed after their suicide attempt in detention.

Quality of the safeguarding Rule 35 assessment and report

With higher numbers of Rule 35 (3) reports being completed and very few other reports being completed, in practice, the Rule 35 (3) report is the only real way a client's healthcare needs are communicated to the Home Office. Whilst Part Cs are also used in practice, Rule 35 is the only reporting mechanism which requires the Home Office to respond and review detention.[56] With this in mind, it is therefore crucial that the IRC GP accurately reflects and communicates the client's health situation in detention and whether their needs are being or can be met.

Medical Justice continues to find examples of inaccuracies and misrepresentation of their needs and health in detention by IRC GPs in the Rule 35 report. This can lead to harmful consequences.

Inaccurate representation of clients' management in detention under the IRC mental health team and needs being met:

IRC GPs inaccurately represented clients' mental health team referral history in detention in 11 clients' Rule 35 reports.[57]

- In the 11 reports, GPs either stated that the client will be referred to mental health but did not do so, stated the client had not been referred to the mental health team when they had in fact already been referred or seen by the mental health team, or did not include information that the client had already been referred to the mental health team.
- GPs also stated that clients will be referred to mental health but they had already been referred prior to their Rule 35 appointment, or that the client had been referred or met the mental health team but they had not.
- In three of the 11 cases, the IRC GP provided inaccurate information to the Home Office about their mental health referral history which contributed to an inaccurate assessment that their needs were being met in detention. For one person, the IRC GP stated that the client will be referred to the mental health team and for two stated the clients had already met the mental health team and/or is under regular review by the mental health team – all of which were not accurate according to the medical records. The GP then concludes that the client's needs are being met in detention**.**

[56] For an explanation of Part C and the Brook House Inquiry finding it to be used inappropriately, see Medical Justice, *"If he dies, he dies": What has changed since the Brook House Inquiry?*, December 2023

[57] See also mental health referrals

- For two of the three clients, their detention was maintained by the Home Office in response to their Rule 35 report.

Not including relevant or comprehensive information relating to their increased mental or physical health vulnerability in detention:

In six cases the IRC GP did not include relevant information in the Rule 35 report that warranted enough concern from healthcare or IRC staff that the client was put on ACDT, constant supervision, and/or on a VACP.

In 15 cases, the IRC GP did not include relevant information relating to the client's history of self-harming and/or suicidal thoughts in detention, their mental health symptoms and diagnoses, and/or physical health issues previously recorded in the medical records.

Inaccurate assurances of clients' mental and physical health in detention:

In 20 cases, the IRC GP provided assurances that the client is "stable", "fit for detention" and/or their health is "well managed in detention" or having "no current concerns in terms of acute deterioration or severity in relation to" … their "mental" and/or "physical health".

Medical Justice is very concerned that when comparing these assessments with our clinicians' assessment or concerns recorded by healthcare in the medical records prior to the Rule 35 appointment, the GP's assessments do not accurately reflect the clients' mental or physical health.

Misleading statements about scarring documentation in the Rule 35 report:

In five cases, the GP states that there are "no scars" when scarring was documented by the Medical Justice clinician. This statement misleadingly implies that a full examination has been carried out, when it has not.

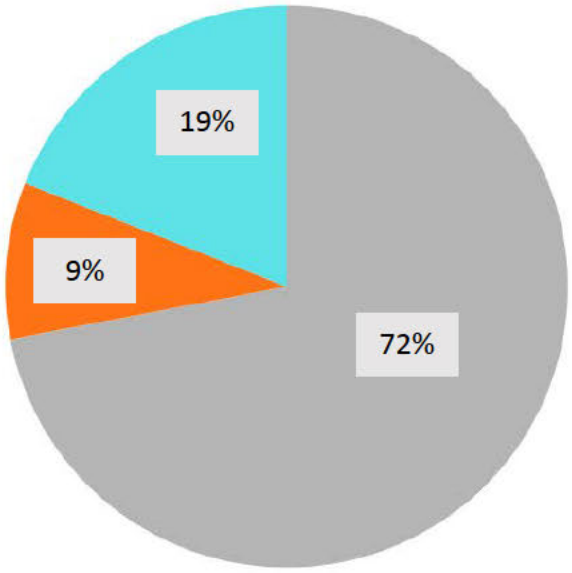
Brief Rule 35 assessments

Some clients in their MLR described the Rule 35 appointment as brief or short assessments, which may explain the poor quality of the report.

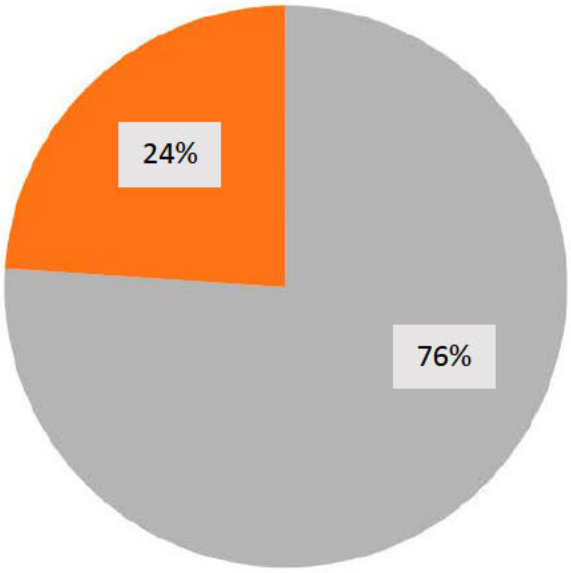
What did the Home Office decide in response to the Rule 35 reports?

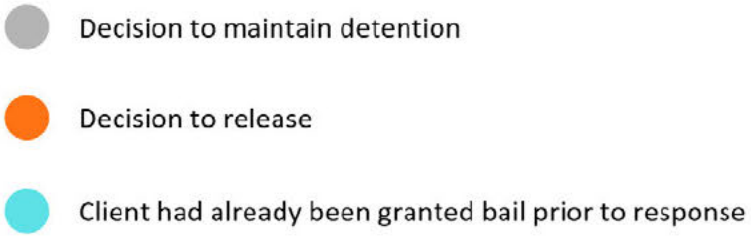
The Home Office made the decision to release very few people (9%) in response to their Rule 35, whilst accepting that they were all 'Adults at Risk' and that the majority had evidence of torture. The findings of Medical Justice clients is similar to the statistics released by the Home Office for the wider detained population.

Medical Justice data: Decision by Home Office in response to Rule 35 reports



Home Office data: Decision by Home Office in response to Rule 35 reports





Of the 46 Home Office responses Medical Justice had access to (for 43 clients):

- The Home Office 'accepted' that 28 clients had evidence of torture and 11 did not. The 11 clients include those who had a Rule 35 (3) report that did not include any detail of their torture account or who were too distressed to detail their account as noted in the report by the IRC GP.
- Two were assigned AAR evidence level 1, 29 were given level 2, and 15 were given level 3 (the highest evidence level that detention is likely to cause them harm).

Of the Home Office responses where the client was assigned AAR level 3(the highest level of evidence of likelihood of harm):

- Seven had their detention maintained by the Home Office and two were released on the basis of their Rule 35 report. **For one person who was granted release, they were detained for over three more months after the Home Office's response.**
- Six other responses related to clients who had already been granted bail prior to their Rule 35 decision and this was stated in the response. One client was released within a day of the decision. **The five other clients were released between three weeks and two and a half months after being assigned AAR level 3**.

Rule 35 safeguard not having an impact: Vulnerable people harmed by delayed release

Medical Justice is concerned that the ongoing Home Office accommodation delays result in Rule 35 assessments not having any real impact in terms of routing particularly vulnerable people out of detention. If someone at Adult at Risk level 3 remains in detention due to accommodation delays and no additional actions are taken to swiftly address those delays, that renders the safeguarding function of Rule 35 meaningless. It does not appear that there is any process by which a Rule 35 report being completed for someone who already has bail leads to additional action being taken to resolve any barriers to release, even if the person is found to be highly vulnerable with an AAR level 3.

This finding goes beyond Medical Justice's case set. The Independent Monitoring Board (IMB) found that in 2024 "many people…remained in detention for months after a doctor had assessed that they would be at risk of harm from detention, despite the Home Office having decided that the risk of harm outweighed immigration control considerations and that they should be released."[58]

After **Anthony** had a Rule 35 (3) report completed in detention, he had to wait over a month for the Home Office to respond. During that time, he had separately been granted conditional bail. In its response, the Home Office assigned him Adult at Risk level 3 – the highest level of evidence of likelihood of harm – and stated that he had already been granted bail. Anthony, however, remained in detention for a further four months due to delays related to probation and Home Office accommodation issues . During that time his mental health significantly deteriorated to the extent that an IRC GP completed a Rule 35 (1) report. In its response, the

[58] IMB, National Annual Report 2024 P.29, June 2025

Home Office again assigned him Adult at Risk level 3. Despite twice being assigned the highest AAR evidence level indicating a high level of risk of harm to him in detention and having had been granted bail months previously, Anthony remained in detention a further month before he was actually released.

Delays in Home Office Rule 35 responses:

The Home Office must send its response to the Rule 35 report within two working days of receiving the report.[59] In this case set, 14 out of the 46 responses were delayed more than two working days following receipt of the report by the Home Office.[60] One was delayed more than 20 working days and four others more than 10 working days.

The Home Office assigned seven of the 14 as AAR level 3 in their response and made the decision to release seven either through the Rule 35 or confirming that they had already been given bail by the time the response was sent. The delay to this group of clients is important to note as those assigned the highest AAR level and were to be released, could have been released sooner and these delays in risked further harm occurring in the intervening period in detention.

Medical Justice is also concerned that eight clients faced delays between having the Rule 35 report appointment and the Home Office stating that they received the report, one of whom had a delay of over 10 working days.

Suicide watch: ACDT and constant supervision failing people in detention

Medical Justice has long documented the failures and unsuitability of having ACDT as a non-therapeutic tool used by IRC staff to "manage" detained people at risk of self-harm and/or suicide..[61] The findings on the use of ACDT, including constant supervision – the most frequent level of ACDT observations – in this case set show that its use remained deeply concerning in 2024.

IRC staff did not always use the ACDT processes for individuals that required them. When the processes were used, clients remained in a distressed state and at risk of self-harm or suicide. In some cases, constant supervision caused clients further harm; clients described constant supervision as highly stressful and intrusive.

In reviewing the 2024 case set, Medical Justice also found a disconnect between these processes and clinical safeguards as a Rule 35 report identifying the client's suicide risk was rarely completed, resulting in this risk not being communicated to the Home Office.

[59] Home Office Guidance on Detention centre rule 35 and Short term Holding Facility rule 32 process
[60] For two, it was unknown if there was a delay due to the limited access to that response.
[61] See 4.2.4 Medical Justice, *"If he dies, he dies": What has changed since the Brook House Inquiry?*, December 2023

Failure to use ACDT and constant supervision as required

In this case set, clients were put on ACDT in response to self-harming in detention, thoughts of self-harm, suicidal thoughts and disclosing a history of attempting suicide. Clients were put on constant supervision in response to the individual self-harming or attempting suicide in detention.

Whilst 57 clients had suicidal thoughts in detention, 17 clients self-harmed and three attempted suicide,[62] only 29 clients were put on ACDT, with five on constant supervision.

Clients remain in distressed state and at risk of self-harm or suicide despite ACDT process

Clients were moved on and off ACDT and constant supervision, remained on ACDT for long periods during their detention, and/or self-harmed or attempted suicide whilst on ACDT. These clients remained in a distressed state and at risk of self-harm or suicide, despite the ACDT process.

- Nine clients were put on ACDT more than once and one was put on constant supervision more than once.
- Clients were on ACDT between one day and over two months. Five clients were on ACDT for over one month.
- Clients were on constant supervision for between several hours to three days.
- Several people self-harmed while on ACDT, including one client who self-harmed to a level requiring medical treatment in A&E.
- Whilst on ACDT, two people were found with items they were planning to use for suicide, according to their medical records.

ACDT and constant supervision disconnected from safeguards

When comparing the numbers of Rule 35 (1) and (2) reports with the number of people put on ACDT, the difference is stark. High numbers of individuals have been identified as warranting observation for suicide or self-harm risk, but in all but a few cases, the clinical assessment and reporting process for risk of deterioration and risk of suicide has not been followed.

A Rule 35 (1) or (2) report was only considered by an IRC GP for three of the 29 clients put on ACDT. However for two clients, it did not appear to be linked to the process of opening the ACDT and took place several days or weeks later after further deterioration whilst still on ACDT. Only two of the five clients on constant supervision had a Rule 35 (2) appointment booked and/or report completed. [63]

[62] See above Suicidality in detention

[63] See also Failure to complete Rule 35 (1) and (2) reports for clients that required them

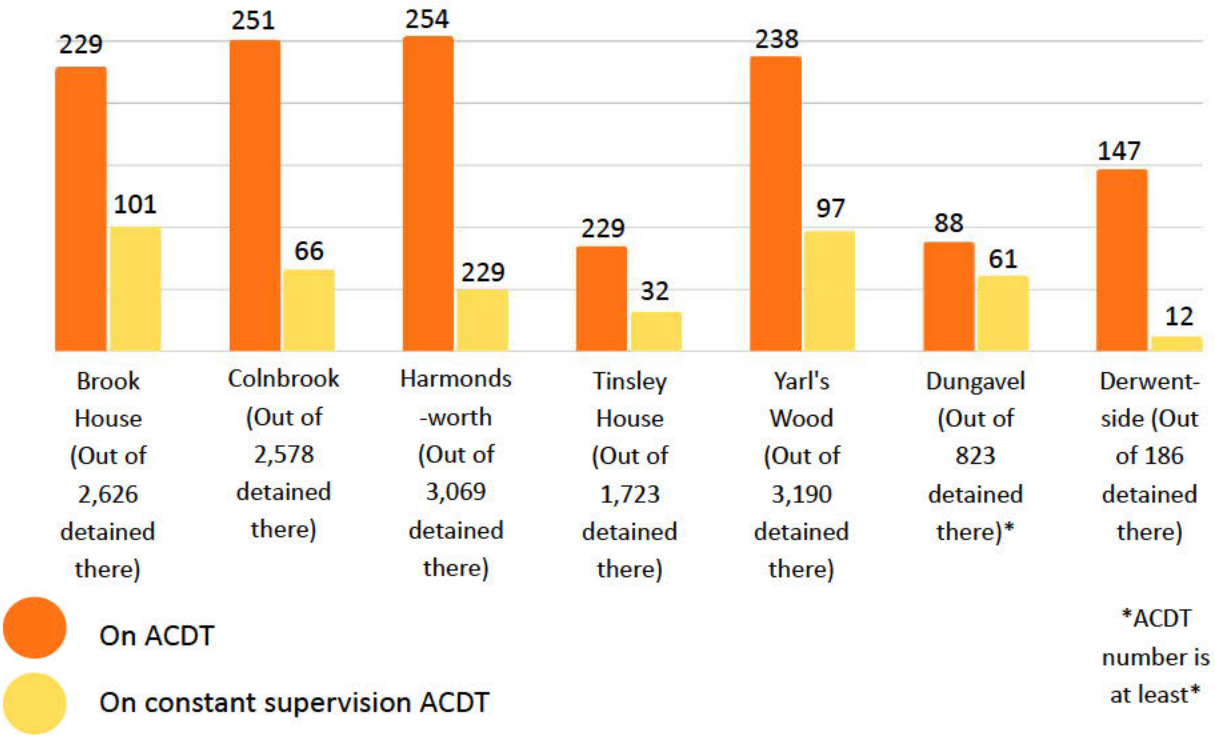
For one client, IRC healthcare failed to consider a Rule 35 (1) or (2) report at the point of putting a client on ACDT and again after the client self-harmed whilst on ACDT.

This is despite the healthcare provider giving evidence in the Brook House Inquiry in April 2022 that interim measures have been introduced requiring that a Rule 35 (2) appointment will be undertaken for all patients on constant supervision and that when an ACDT is opened, a Rule 35 (1) appointment will be booked the same or following day..[64]

Home Office statistics on ACDT and constant supervision

Medical Justice's findings reflect the use of ACDT, including constant supervision in the wider detained population as found in the Home Office's own statistics. 1292 ACDTs and 419 constant supervision ACDTs were opened in 2024..[65]

Home Office data: Number of ACDT and constant supervision ACDT opened in 2024



The Home Office's own statistics show that while 1292 ACDTs and 419 constant supervision ACDTs were opened in 2024, only 74 Rule 35 (1) reports and 35 Rule 35 (2) reports were completed in detention.

[64] Third witness statement of Sarah Bromley to the Brook House Inquiry, paragraph 3, PPG000205.
[65] FOI 2025/05227 response to Medical Justice staff member. Graph on next page uses data from Home Office statistics, Detention summary tables, year ending December 2024.DET_02a

The state of healthcare in detention: are needs being met?

Quality of healthcare in detention

In addition to concerns that vulnerable people are not safeguarded and routed out of detention, Medical Justice continues to find issues with the quality of healthcare in detention. This includes the inability to provide certain treatment in a detention setting such as for those with PTSD, the missed diagnoses of mental health conditions and not providing the quality of healthcare that is equivalent to that in the community.

Missed diagnoses

47 clients were diagnosed by the Medical Justice clinician with a new mental health condition that was not already recorded on their medical records.

For 31 clients, PTSD was missed or not explored by healthcare in detention and for six, complex PTSD was not diagnosed. Other missed conditions included depression and anxiety disorder.

It is well-recognised that symptoms of PTSD are likely to worsen in immigration detention so identifying those with PTSD in detention is crucial to safeguard the individual from further harm caused by detention.[66] Medical Justice continues to see from medical records that IRC GPs and mental health nurses rarely proactively seek to screen for trauma-related symptoms, as recommended by NICE guidelines.[67]

Treatment not offered and/or available in detention for PTSD

Although effective and safe implementation of trauma-focused therapy recommended for PTSD is not possible in detention,[68] a small number of clients were referred for psychological therapy in detention.

- Four clients who were diagnosed with PTSD or had trauma-related or PTSD symptoms were referred for trauma-based Cognitive Behaviour Therapy (CBT) in detention.[69]
- 16 others were referred for psychological therapy such as talking therapies and trauma focused psychological therapy.
- 37 were not referred for any therapy.

[66] Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21.
[67] National Institute for Health and Care Excellence (August 2022) Post-traumatic stress disorder: When should I suspect post-traumatic stress disorder (PTSD)?
[68] Royal College of Psychiatrists (April 2021) Position Statement: The Detention of people with Mental Disorders in Immigration Detention PS02/21, page 3
[69] Nine had insufficient medical records to decide if they were referred for therapy in detention.

__Amin__, who was diagnosed with PTSD by the Medical Justice clinician had asked the mental health team whilst detained under immigration powers in prison for a PTSD assessment. The psychologist is recorded in the medical records telling him there was "no psychiatrist in post [in prison] [so] it would not be possible for him to have the assessment." The psychologist told Amin he "would have to seek one in the community".

Amin told Medical Justice: "I told them I don't know when I'm going to be in the community. The person said there's no-one. She did manage to get me to see one after a couple of months. For those two months, I wasn't able to see anyone. Healthcare didn't care about what I was talking about. It felt like I was talking through them and not to them. My words were going in one ear and out another. They're not compassionate or understanding."

The absence or lack of psychological therapy means that for many detained people the only treatment they are offered is medication, which fails to address clients' needs holistically and is unlikely to sufficiently address their symptoms in isolation. In this case set clients diagnosed with depression were prescribed anti-depressants in detention in what appeared to generally be the sole intervention.

Lack of action by GPs in response to Medical Justice clinical letters

As Rule 35 reports (1) and (2) reports are routinely not written and diagnoses of mental health conditions are routinely missed or not explored by IRC GPs, Medical Justice clinicians write to healthcare to inform them of clinical findings and recommendations for individual clients. Clinicians wrote 71 clinical letters in this case set.[70] Medical Justice had access to 29 clients' medical records that covered the period where the clinical letter was sent.[71]

Only 10 of the clinical letters were noted by IRC healthcare staff in the medical records as having been received, despite all having been sent in accordance with the processes agreed with the relevant IRC healthcare unit. Of the 10:

- Action was taken for three clients by healthcare following the letter.
- Action was partially taken for four clients; some recommendations such as organising an appointment with a GP or mental health team, or reviewing the client's medication were implemented, but other recommendations such as considering a Rule 35 (1) report or organising physical health tests were not.
- For three, no action was taken by healthcare and one GP disagreed with the Medical Justice clinician's assessment.

[70] Two clients' appointments took place after the client was released from detention so a clinical letter was not sent to healthcare.

[71] For 43 clients, it is unknown what action is taken or whether the clinical letter is noted in the medical records as medical records available to Medical Justice do not cover the period that the letter was sent.

For 16 clients, the Medical Justice clinician recommended the client be assessed or considered for a Rule 35 (1), (2) and/or (3) report appointment. However, in none of the 16 cases did healthcare consider and/or book such an appointment.

The lack of action by healthcare for the majority of clients after receiving Medical Justice's clinical findings and recommendations for vulnerable clients is deeply concerning.

Mental health referrals

65 out of the 73 clients were referred to the mental health team in detention.

However, being referred to the mental health team did not always mean the clients received an assessment or treatment and some experienced a long wait to receive an assessment.

11 were referred to the mental health team but did not receive an assessment and were discharged .

- This included one person who decided they did not require the appointment and one person who did not attend the appointment and the decision was made to discharge them without any follow up.

- Three clients' medical records show the clients were discharged without being assessed but added to the psychology waiting list. However, these clients never saw the psychologist while in detention.

- It took between two and seven more referrals for six of those clients to be assessed by the mental health team. For the others, they never received an assessment by the mental health team.

Referral to mental health team does not mean care is provided and needs are met

These findings highlight that statements in Rule 35 reports that the person has been referred to the mental health team are often falsely reassuring.[72]

The Home Office may infer that appropriate care is available and the individual's needs are being met in detention. In such cases, if the evidence is considered to meet AAR level 2, this should be reviewed after the mental health assessment. Yet, there is no process to ensure the mental health assessment takes place, nor for the AAR level to be reviewed and informed by the mental health assessment. Accordingly, this did not occur for any of our clients in this case set.

[72] See Quality of the safeguarding Rule 35 assessment and report

Waiting times for mental health triage assessments and treatment

Some clients saw the mental health team quickly for a triage assessment after the referral and for some it was much longer. Clients were put at risk of further harm while waiting for a mental health appointment. One client self-harmed while waiting several days to be triaged by mental health.

Appointments for mental health triage took between two days and several weeks from the point of referral.

Clients waited up to four months before they saw a psychologist and started any treatment. There were also examples of clients who did not see a psychologist as they were released before an appointment took place.

Clients waited between one and nine days to see a psychiatrist.

In some cases individuals remained under the mental health team for several months with no further communication to the Home Office of their ongoing significant mental health needs.

Use of segregation in detention

Segregation of those held in immigration detention has long been documented by Medical Justice and others to be over-used, misused and harmful.[73]

DCR 40 and 42 allow segregation to be used only in the interest of safety or security or to manage actively violent detained people. It should not be used on those "with serious psychiatric illness or presenting with mental health problems"[74] and those at risk of suicide or self-harm must only be put in segregation in "exceptional circumstances…as a last resort".[75] A detained person can be held in segregation for up to a maximum of three days under Rule 42 and 14 days under Rule 40.[76] While a fresh authority can be sought to continue holding someone under Rule 40 for more than 14 days, the guidance clearly states that: "Every effort must be made to keep the time for which a detained individual is subject to restrictions as short as possible."[77]

[73] This includes the Brook House Inquiry findings. See Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.6 page 113 para 22 and 24-26, page 125 para 56, pages 118-121 para 34-44, and pages 121-125 para 45-55.
[74] Home Office Guidance on Removal from Association (DCR 40) and temporary confinement (DCR 42), Para 83.
[75] Home Office Guidance on Removal from Association (DCR 40) and temporary confinement (DCR 42), Para 85.
[76] Rule 40(3), Rule 40(4) and Rule 42 Detention Centre Rules 2001 (SI 2001/238)
[77] Home Office Detention Services Order 02/2017 Removal from Association and Temporary Confinement, January 2025, Para 35.

Despite these restrictions, nearly all those held in segregation in the 2024 Medical Justice case set had a mental health condition and a large proportion had an increased risk of suicide in detention.

19 clients were put in segregation during their detention. Of those:

- 18 had at least one diagnosed mental health condition and one had symptoms of a mental health condition, according to a Medical Justice clinician.
- 13 had an increased risk of suicide in detention according to a Medical Justice clinician.
- Four clients were on ACDT at the time of at least one of their segregation periods.
- Six were put in segregation two or three times during their detention.
- The time that clients were put in segregation ranged from several hours up to several weeks.

It is also extremely alarming that Medical Justice clients were put in segregation for purposes other than those allowed under the DCR and associated guidance. It was used in relation to mental health deterioration, in response to protesting or resisting, in order to facilitate a forced removal attempt and as a form of punishment. Segregation should not be used as a form of punishment.[78]

Segregation was used for a variety of reasons according to the medical records. This included:

- Altercations with others in detention
- For the person's safety
- After witnessing a suicide
- For resisting restraints and refusing to share a room
- Going on the safety netting
- Due to deterioration in their mental state
- To facilitate a forced attempted removal

One client told the Medical Justice clinician that they were threatened with segregation for refusing to share a room.

The IRC GP is required to see those held in segregation on a daily basis. However, very few clients were seen daily by a GP.[79]

[78] Rule 40 and Rule 42 cannot be used as a punishment, as set out in Rule 42(1) and the DSO para 29

[79] For six clients, it is unknown if they were seen by a GP on a daily basis in segregation as the medical records available to Medical Justice do not cover that period of time.

10 clients were not seen by a GP on a daily basis:

- Some clients were seen only by a nurse or psychiatrist.
- Some were seen by a GP but not daily.

Three clients were seen daily by a GP. However for one client, this did not apply for all times they were put in segregation and for another, the GP spoke to the client behind the closed door of the room which puts into question whether this was adequate.

Home Office statistics on use of segregation

Home Office data shows that *at least* 1,340 people were held in segregation under Rule 40 and *at least* 25 under Rule 42 in 2024.[80]

Use of force in detention

Rule 41 of the DCR and Home Office guidance puts restrictions around the use of force in detention. It can only be used if it is "necessary", "reasonable" and "proportionate to the threat being faced or the intended aim".[81] While the guidance explicitly states that "excessive use of force is unlawful"[82] yet there is evidence of force being used by officers as a first, not last resort[83] and using it in an unlawful and inappropriate way. There have also been multiple examples of force used "routine[ly]… in response to incidents of self-harm".[84]

Medical Justice clients continued to be subjected to use of force in 2024 including disproportionate, unnecessary and inappropriate use of force. Force including restraints were used in the context of arrest for detention,[85] transfer to another IRC, forced removal to an airport, in response to the client self-harming, attempting to self-harm and being distressed, restraining clients for transfer to and during hospital appointments. Force was used on individuals with a history of trauma, self-harm and/or attempting suicide and those with a serious physical health issue which puts them at high risk of harm.

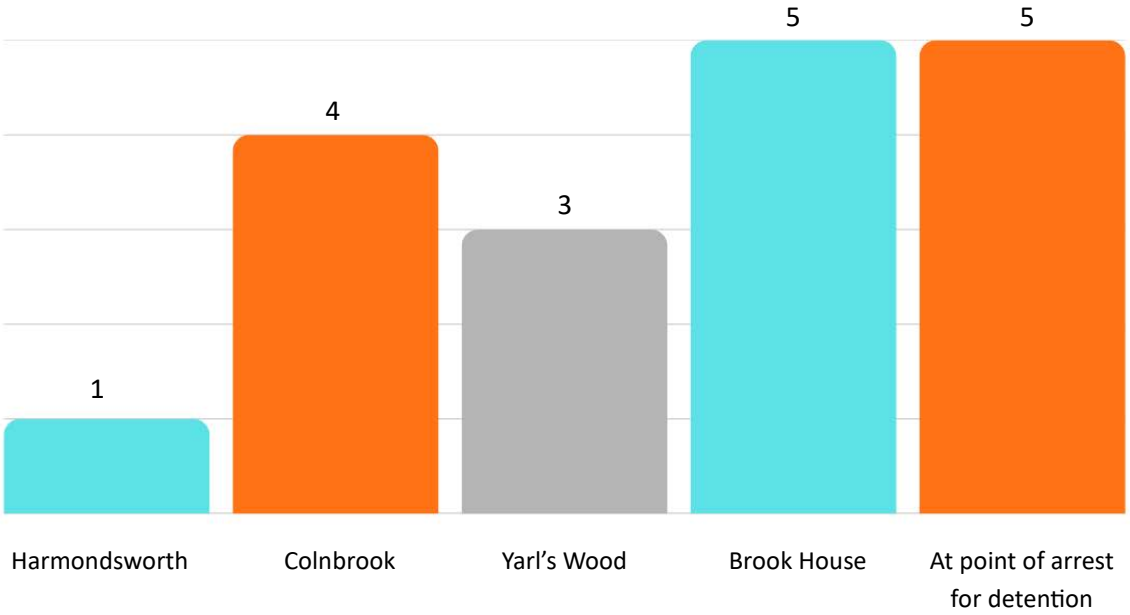
[80] FOI 2024/6818, 2025/00211 and 2025/05337 responses to Medical Justice staff member. The Home Office does not provide exact figures if it relates to less than five people (<5). Wherever the statistics provided is <5 it has been counted by Medical Justice as one incident and "at least" has been added to reflect that it may be more.
[81] Home Office (2022) Use of force: Guidance for Immigration Enforcement Officers Version 3.0
[82] Ibid
[83] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II,, HC 1789-II, Chapter D.7 page 142 paragraphs 26-33.
[84] Kate Eves, Chair of the Brook House Inquiry (19 September 2023) The Brook House Inquiry Report Volume II, HC 1789-II, Chapter D.7 page 155 paragraph 58.
[85] See case study of "Ahmad" in Medical Justice, *"You'll see the outside when you're in Rwanda": Mistreatment in UK detention and mass round ups for forced removals,* September 2024

18 incidents of force on 16 clients were documented in MLRs and/or medical records. Of these:

- Force was used on one woman.
- 10 of these clients were torture survivors.
- Five took place at the point of arrest for detention, including in preparation for forced removal to Rwanda.

Home Office data: Number of ACDT and constant supervision ACDT opened in 2024

Number of incidents of force used



The types of force used included "guiding holds" and use of handcuffs, heavy force applied to their limbs, and, for two of these 16 clients, highly concerning use of force applied to their head and neck.

Our clinicians heard descriptions of physical pain, feeling unable to breathe, fear, confusion and desperation.

Medical Justice clinicians documented lasting physical injuries sustained by one client, and psychological consequences sustained by eight including lasting distress, ongoing fear, intrusive memories and nightmares.

Use of force for hospital appointments

Clients were subjected to being handcuffed by escorting officers in the journey to and during external medical appointments. This included clients who were very unwell, requiring urgent care and transfer by ambulance.

For one client, Aaron, the medical appointment did not take place as the hospital doctor refused to treat the client while he had handcuffs on. Guards escorting him refused to remove the handcuffs. Aaron told Medical Justice: *"I don't know why they treated me like that. I was vulnerable. They know I suffer from mental health as well; I'm a vulnerable adult. I feel mistreated."*

Home Office statistics on use of force

In 2024, there were 715 Use of Force incidents at Brook House, 188 at Colnbrook, 43 at Derwentside, 34 at Dungavel, 156 at Harmondsworth, 76 at Tinsley House and 151 at Yarl's Wood.[86]

Deaths in detention

One person died in detention in 2024.[87] Theophile Kaliviotis, a 26-year-old French national died at Brook House IRC in October 2024. An inquest into the cause of his death is ongoing.[88]

In October 2024, the inquest jury into the death of Frank Ospina on 26 March 2023 found that he killed himself in a locked cell at Colnbrook IRC after three incidents of self-harm or attempted suicide.[89]

Forms of protest or resistance in detention

People in detention protested or resisted Home Office processes and the IRC and escorting officers in various ways and for different reasons.

Forms of protest included clients who went on hunger strike or went on the safety netting.[90] Forms of resisting the IRC and escorting officers or Home Office processes in detention included refusal to share a cell with another detained person, to move between locations in detention, and resisting being taken to segregation and to board a removal charter flight.

People resisting IRC and escorting officers in detention often had force used on them and were put in segregation.[91]

Eight clients were documented in their MLR to have protested or resisted Home Office processes or the IRC or escorting officers in detention. Five were then subjected to force and put in segregation.

[86] FOI 2025/03265 response to Lewis Kett at Duncan Lewis.
[87] INQUEST Casework and Monitoring, Deaths of immigration detainees Table 1
[88] The Argus, Inquest into death of man at Brook House opens in Brighton
[89] Medical Justice, Frank Ospina killed himself following multiple clinical safeguarding failures that contributed to his death
[90] An example of what the safety netting looks like can be seen in Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (HMIP000702), HMIP, September 2022, p1
[91] See also Use of segregation in detention and Use of force in detention

In addition to hunger strikes, four clients did not eat food in the IRC as they told the clinician they did not trust the food hygiene in the IRC, potentially a sign of deteriorating mental health. Loss of appetite or inability to eat relating to poor mental health was also common amongst clients in the case set but this was not always carefully distinguished from food refusal protests by healthcare staff.

There were also examples where actions were interpreted by healthcare or IRC staff as protesting when, for example, clients were in fact suicidal or too unwell to eat.[92] One client was taken to segregation as a consequence.

The state of detention under immigration powers in prison

At the end of 2024, a total of 107 people were detained in prisons under immigration powers in the UK.[93]

In this case set, eight clients were detained under immigration powers in prison following the completion of a prison sentence. For these clients, their detention in prison under immigration powers ranged from one day to almost five months before they were transferred to an IRC.

One client told Medical Justice about their experience being detained in prison:
"In prison under immigration powers, they know you're not there for a sentence but, for me, it was carrying on my [prison] sentence. I had no other reason to give myself why I was still there".

Disruption of continuity of healthcare

In addition to the harm caused by detention outlined above, detention itself can also disrupt the individual's continuity of healthcare.

In this case set, clients' pre-planned care in the community was disrupted due to them being transferred to IRCs. In addition, new medical appointments made in detention were disrupted both while still in detention and upon release, and vulnerable people were released in medically unsafe ways.[94]

Disruption of continuity of care by being detained

20 clients had their pre-planned existing external care interrupted or delayed by detention.

For six people, care was disrupted when they were transferred from prison to an IRC. This included missing a hospital appointment, and no longer having the access they had in prison to physiotherapy, counselling, psychiatric support and a drug rehabilitation programme.

[92] See also Mental health deterioration in detention
[93] Home Office national statistics, How many people are detained under immigration powers in the UK?
[94] Medical Justice, Detained and Discarded, March 2022

For 14 clients, being detained from the community disrupted the care they were receiving. This included:

- Missing hospital, GP and psychiatrist appointments in the community and missing hospital investigation appointments as they were detained before the scheduled date of the appointment.
- Not being able to keep external referrals made by their community GP as they were now in detention. This included referrals for physiotherapy, x-rays and scans.
- Not being able to access medication prescribed in the community or taken away from them when detained, leading to delays in being prescribed and/or receiving that medication in detention.
- Not being able to continue to have regular counselling.
- Not being able to continue with the physiotherapy they were receiving in the community.

Disruption of new appointments made in detention

Two clients' new external hospital appointments were disrupted by detention. For one person, their care was disrupted due to the use of handcuffs for the appointment.[95]

Unsafe release and disruption of continuity of care when released or forcibly removed

Four clients' care was disrupted upon their release from detention or forced removal. This included missing medical appointments, hospital investigations and scans.

Vulnerable clients were also released from detention in a medically unsafe way with no continuity of care. No support was given by healthcare in registering with a GP or referrals to the local safeguarding or mental health teams in the community when they were released.

Conclusion

Medical Justice clients were subjected to unnecessary harm, suffering and poor-quality healthcare in immigration detention in 2024.

We know from our daily casework with people in detention that the findings in this report goes beyond this case set. Indeed, the IMB makes similar findings to Medical Justice about those detained in all IRCs and Short-Term Holding Facilities in 2024. Its key findings include an "increase in the use of force", "vulnerable people were exposed to unnecessary harm", and "a concerning proportion of people detained in IRCs experienced acute and complex mental health

[95] See use of force for hospital appointments

issues and centres were not equipped to provide the care they required." The IMB also found that "people were detained for exceptionally long periods, with no real prospect of removal".[96]

The detention system is broken beyond repair. Vulnerable people languish in detention for months, sometimes years. Once in detention, the safeguarding system in place does not effectively identify and route vulnerable people out of detention.

It is too often only by good fortune and the power of word of mouth that clients are able to reach out to support organisations like Medical Justice and others to help them navigate the labyrinth-like system and signpost them to the safeguards or advocate on their behalf for their health rights. Without good support, good interpretation and good legal representation, there is very little chance that a vulnerable person who is at risk of harm in detention will be released.

Monitoring of the application and effectiveness of these safeguards by the Home Office and its contractors is limited and not transparent. Scrutiny from a Public Inquiry clearly is not enough for the government to take action to strengthen and implement the safeguards in practice.[97] In 2024, following the inquest into Frank Ospina's death, the Home Office stated it "welcome[s]…scrutiny" and is "committed to continuous improvement in relation to the safeguarding and wellbeing of detained individuals and committed to embedding changes from the identification of learning from internal audits, 'near-miss' incidents and deaths in detention."[98] It also stated the Home Office is conducting a review of the Adults at Risk policy, Rule 34 and Rule 35 in response to the inquest's finding that the failure to complete a Rule 35 (2) report prior to Frank Ospina's suicide "deprived him of the opportunity of a detention review".[99] However, this report demonstrates that we are yet to see any improvements in safeguarding or completion of Rule 35 (2) reports Medical Justice clients detained in 2025.

This is why reports like this one which scrutinise the effectiveness of the safeguards and provide statistical and clinical findings are important. Being able to compare this 2024 snapshot of the state of harm and healthcare in immigration detention with subsequent years should enable scrutiny of how the system is working year on year.

We are already experiencing what 2025 will bring - more people will be swallowed by the detention machine, more people will be rushed through an already broken and dysfunctional system, allowing for more vulnerable people to not be identified and protected by the

[96] IMB, National Annual Report 2024 P.26, June 2025

[97] In addition to the case set in this Annual review, see also: Medical Justice, *"If he dies, he dies": What has changed since the Brook House Inquiry?*, December 2023

[98] Angela Eagle response letter to the Senior Coroner for West London's Regulation 28 Report to Prevent Future Deaths, 16 December 2024

[99] Liberty Investigates, *Migrants in detention 'faced month long wait for mental health assessments' when man took his life*, October 2024

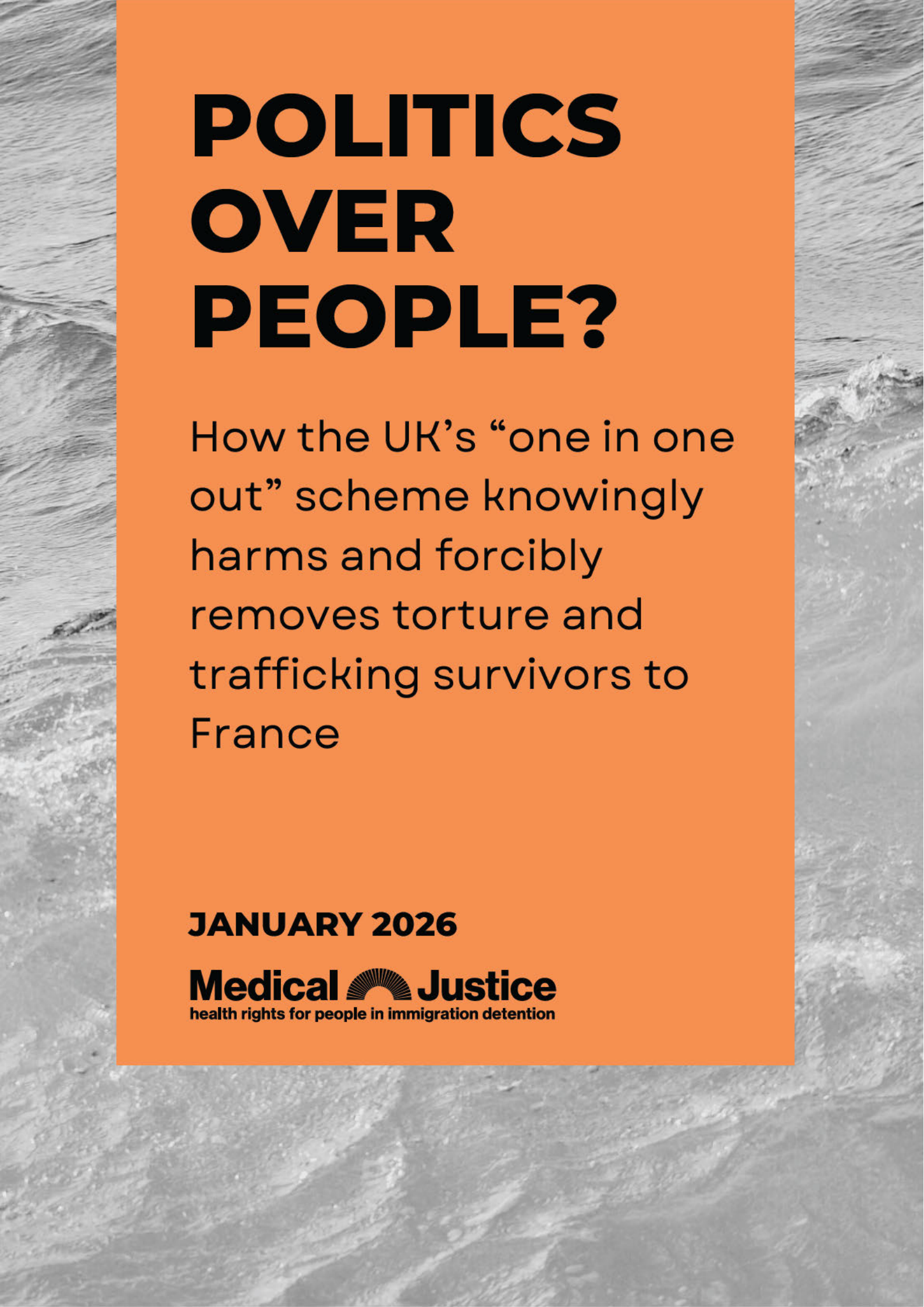
safeguards. They will be subjected to further harm in detention and potentially forcibly sent to a country where their life is in danger.

Recommendations

In light of the evidence in this report, Medical Justice sets out the following recommendations to the government and the Home Office in particular:

- Rather than expanding the use of detention, the only humane solution is to phase out detention. The government should also consider community-based alternatives. This must be done urgently.
- In the interim, promptly implement all 33 recommendations of the Brook House Inquiry. This is the only meaningful way to reduce the risk of mistreatment and abuse, including the breaches of Article 3 ECHR, from happening again.
- Make sure the Adults At Risk Review strengthens, not weakens, the protections provided to those at particular risk of harm in detention. To be effective, the policy framework has to be able to consistently identify those particularly vulnerable, ensuring their prompt release. Any policy intended to prevent instances of inhuman and degrading treatment contrary to Article 3 ECHR needs to be capable of also protecting those with past criminal conviction or adverse immigration histories.
- Abandon the use of former military barracks to accommodate those seeking asylum, and abandon plans to re-open and expand Haslar and Campsfield IRCs.
- Recalling the previous government's response to the Shaw report on the welfare in detention of vulnerable persons,[100] commit to taking measures aimed at reducing rather than increasing the number of people held in immigration detention.
- Cease mass round ups into immigration detention for enforcement and return flights. This causes 'surges' which risk including those with a history of trauma and fear of the country they will be forcibly sent to and overwhelm any capacity to operate safeguarding systems.
- Abandon consideration of any plans to offshore the processing of asylum claims to third countries.
- Stop using divisive and xenophobic language when talking about those in the immigration system or attempting to seek safety in the UK.

[100] Minister of State for Immigration, Immigration Detention: Response to Stephen Shaw's report into the Welfare in Detention of Vulnerable Persons, 14 January 2016



POLITICS OVER PEOPLE?

How the UK's "one in one out" scheme knowingly harms and forcibly removes torture and trafficking survivors to France

JANUARY 2026

Medical Justice
health rights for people in immigration detention

Medical Justice

Medical Justice is the only charity in the UK to send independent clinicians into all the Immigration Removal Centres (IRCs) across the UK. Our medical reports document the physical and mental scars of torture and trafficking, serious medical conditions, deterioration of health in detention, injuries sustained during use of force incidents and challenge instances of medical mistreatment. We help clients access competent lawyers to harness the strength of the medical evidence we generate. We receive over 500 referrals for people in detention each year. Our evidence is unparalleled, based on thousands of cases and growing.

Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused by these shortcomings, as well as the toxic effect of immigration detention itself on the health of people in detention. Our casework evidence guides our advocacy work and strategic litigation to secure lasting change.

Medical Justice was designated core participant status in the Brook House Public Inquiry. The Inquiry was set up to investigate mistreatment of those detained in Brook House IRC, as uncovered by BBC Panorama. In September 2023, the Inquiry found that the dangerous use of force, a wholesale failure of safeguards and a culture of dehumanisation led to 19 incidents in which there was credible evidence of acts or omissions that were capable of amounting to inhuman or degrading treatment in breach of Article 3 of the European Convention on Human Rights (ECHR), within a five-month period at Brook House IRC.

Medical Justice continues to witness many of the issues uncovered in the Brook House Inquiry across all IRCs as well as an inadequate healthcare provision. Detention continues to be dangerous and severely harmful. Medical Justice believes that the only way to eradicate endemic healthcare failures is to end immigration detention. Similarly, the British Medical Association believes that the use of detention should be phased out and abolished.

Acknowledgements

Medical Justice is grateful to its caseworkers for their invaluable knowledge and insights and to its clinicians for their tireless and essential work completing medico-legal reports for Medical Justice clients. Medical Justice would like to thank all of its clients whose data was reviewed as part of this research project and those that gave their time and allowed their experiences to be included as a case study in this report.

Contents

Executive Summary 4

Introduction 6

Medical Justice key findings and concerns 7

Methodology 9

Glossary of terms 10

Individuals' backgrounds and health vulnerabilities 13

Individuals' accounts of experiences in France 13

The detention and removal process 14

Trafficking and torture survivors in detention for removal to France 16

Impact and harm caused to those put through the detention and removal process 18

High levels of suicidality 18

Impact of anticipated removal to France documented by clinicians 19

Impact of forced removal to France described by clinicians 19

Failing clinical safeguards in detention 20

Initial healthcare screening 20

Rule 34 appointment 21

Rule 35 appointments and reports 21

Home Office decisions in response to Rule 35 reports 22

Removal attempts, use of force and segregation 23

Conclusion 25

Recommendations 26

Executive Summary

Based on clinical and other documentary evidence from 33 Medical Justice clients detained for forced removal to France under the "one in, one out" UK-France Agreement since the beginning of August 2025, our research findings show the arbitrary nature of how the policy is being implemented and the harm it is causing to highly vulnerable men, women and age-disputed young people.

With vaguely defined selection criteria, people with serious mental health conditions and experiences of trauma who have arrived by boat to seek safety in the UK are being detained under the scheme. Their claims for protection are not being considered, nor are their risks of harm in detention.[1]

Survivors of torture and trafficking are being harmed by detention, by the anticipation of forced removal to France and during forced removals themselves.

Clinical safeguards in detention are failing to protect these vulnerable people, with alarmingly high levels of suicidality among this group of clients. Many people have not been able to access adequate and timely legal advice.

The report also explores the accounts of many individuals' experiences of highly traumatic events in France and their fear of returning there.

Medical Justice has documented worrying clinical consequences of the use of force on and segregation of individuals to 'facilitate' removals.

Medical Justice found:

- Our 33 clients include three women and two age-disputed young people. Their nationalities include Eritrean, Iranian, Palestinian and Sudanese.
- All 20 individuals assessed by our independent clinicians have clinical evidence of a history of torture, ill-treatment and/or trafficking.
- All 20 have at least one serious mental health condition, distressing symptoms, or warranted further mental health assessment.
- Almost all people detained under this scheme experienced complete dysfunction of clinical safeguards in the immigration removal centres (IRCs). Of the 20, only two had an appointment with a GP from the IRC within 24 hours of arrival there - as required by 'Rule 34' of the Detention Centre Rules - and in neither case was the mental health assessment sufficiently detailed to qualify as a Rule 34 appointment.
- Only three individuals had a Rule 35 (1) report by the IRC GP identifying those who are likely to be injuriously affected by detention as they should have done. Those who didn't have such a report included individuals whose health had already deteriorated in detention, and one person who required transfer to hospital. People had to wait for up to two months for a Rule 35 assessment.

[1] In 2024, His Majesty's Chief Inspector of Prisons found that some of those detained at Harmondsworth IRC "were at imminent risk of harm". See BBC News, *Immigration centre shocking and dangerous – watchdog*, July 2024.

- There were alarmingly high levels of suicidality. 12 out of 20 had suicidal thoughts, one person attempted to take their own life and two self-harmed in detention. Five individuals were identified to be at risk of self-harm and/or suicide by the IRC, with one put on constant supervision due to suicide risk, yet only one had a Rule 35 (2) report as required to flag suspected suicidal intentions.
- People are being detained for at least one month and in some cases for over three and a half months under this Treaty. 16 of the 33 clients were released in the UK, with several subsequently re-detained for removal. 14 have been forcibly removed to France.

Medical Justice client, **Hamid**,[2] was detained under this Treaty and had clinical evidence of a history of torture. He describes excessive force and the violence he was subjected to during a removal attempt to France. Hamid told Medical Justice:

"*The belt that was tied around my shoulders got stuck in my throat. I started screaming and saying I want to die, untie the belt from my neck, but they thought I just wanted to be let go. After a few minutes, I became dizzy, and my voice became weak and my strength was limited to just tears. They saw me struggling for air and honestly, my eyes were turning white and my breathing was difficult. I said in a low voice, I can't breathe, and I thought to myself, Oh, my God*."

Following the attempt to remove him from the UK, a Medical Justice clinician documented evidence of Hamid's physical injuries and psychological harm. He has since been removed.

Medical Justice is alarmed that it is receiving proportionately more referrals from age-disputed young people detained for forced removal to France than in any other cohort subject to immigration detention.

The failures of safeguards in detention are not new. However, for this cohort, there is a near-total disregard for identified vulnerabilities in decisions to maintain detention – and what appears to be active decision-making to detain and remove vulnerable people. While almost half of clients detained under this scheme have been released after being granted bail by a Tribunal Judge, only one was released by the Home Office in response to safeguarding reports completed by GPs within the IRCs.[3] Although historically the Home Office only releases a low number of people in response to Rule 35 reports,[4] the number for this cohort is particularly low. Keeping vulnerable people from this cohort in detention despite clear evidence that they are at risk and with few 'immigration factors' to justify the decision is difficult to reconcile with the Home Office's Adults At Risk policy and effectively renders the safeguarding system a futile exercise.

We call for an end to yet another cruel and harmful scheme, and for the Home Office to release all detained under this scheme, and to reverse any inadmissibility decisions made on individuals' asylum

[2] Hamid's real name has not used to protect his identity

[3] The others were released after being granted Tribunal bail.

[4] See Home Office statistics since 2015 (published November 2025) Immigration Enforcement data: Q3 2025 table DT_03.

claims and allow them to enter the asylum process in the UK. Medical Justice continues to defend the right to territorial asylum.

Introduction

Following the ratification of the Hillmore Treaty ("the Treaty") between the governments of the UK and France on 29 and 30 July 2025,[5] the UK began detaining individuals seeking protection in the UK who arrive by small boat with the intention of removing them to France, whilst accepting an equal number of people from France to seek asylum in the UK. A stated aim of the scheme is to act as a "deterrent" for people taking "unsafe" routes to the UK. However, it is unclear how that will be achieved and it is hard not to see it as a form of punishment for people who are desperate enough to take a perilous journey to the UK in a dinghy. The only published criteria for inclusion in the "out route" to France are not being an unaccompanied child, security considerations and that any asylum claim has been declared inadmissible and any human rights claim concluded by the time of transfer to France.[6]

Under the reciprocal nature of the agreement, individuals in France can apply for entry to the UK via the "in route". Again, the criteria are very broad and exclude those considered to pose a national security or public order risk to the UK, those who have previously been removed from the UK and unaccompanied minors.[7] As the numbers accepted by the UK is dependent on the numbers removed to France, the availability of each place on this so-called "safe" route to the UK is predicated on someone else taking an "unsafe" route.

The government is well aware that "safe" routes to reach the UK are non-existent for the vast majority of people seeking asylum. Yet, it has chosen to implement a scheme where the decision on whether the asylum claims of individuals arriving by small boats are admitted into the asylum system or are treated as inadmissible and the individuals immediately detained for removal to France is apparently arbitrary.

Individuals' health vulnerabilities or histories of trauma are not taken into account in the selection process. Yet, immigration detention can cause those with pre-existing vulnerabilities such as a mental health condition or history of trauma to deteriorate, putting them at particular risk of harm.

Medical Justice has consistently warned consecutive governments about, and exposed the cruelty and harm involved in, the mass round ups of people for forced removal to third countries. In a similar scheme in 2022 and again in 2024, we saw the detrimental impact the Rwanda scheme had on people seeking asylum in the UK, with high levels of distress, fear and suicidality identified by our clinicians.[8]

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[5] Agreement presented to Parliament August 2025, Agreement between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the French Republic on the Prevention of Dangerous Journeys.

[6] Ibid

[7] Ibid

[8] Medical Justice, *Who's paying the price? The human cost of the Rwanda scheme,* September 2022 and "*You'll see the outside when you're in Rwanda" Mistreatment in UK detention and mass round ups for forced removals*, September 2024

Medical Justice began receiving referrals from individuals detained under the UK-France Treaty from mid-August 2025 and started providing support through casework and clinical assessments. Our access to clinical and other evidence has allowed Medical Justice to document and draw insights from individuals' experiences before arriving and during their journey to the UK, their experience and treatment in UK detention, and during removal or attempted removal to France. This is the basis for our key findings below.

Medical Justice key findings and concerns

Between mid-August and 31 October 2025, Medical Justice had 33 clients - men, women and age-disputed young people - who were detained for removal to France under the Treaty.

- They include nationals of Afghanistan, Eritrea, Ethiopia, Sudan, Syria and Palestine.
- Individuals claimed asylum upon arrival in the UK and had their asylum screening interview in the day or nighttime following their arrival. Some described taking part in this interview feeling weak and confused and having not slept or eaten for several days.
- People spent at least 30 days and in some cases over three and a half months in detention.
- Some have been removed to France and some were released. Of those released, some were then shortly re-detained for removal.

20 individuals detained for removal under the Treaty had a Medico-Legal Report produced by a Medical Justice clinician. Of these:

- All 20 are extremely vulnerable. Those detained include **age-disputed young people, survivors of torture and/or trafficking, and those with serious mental health conditions**, such as Post-Traumatic Stress Disorder, depression and anxiety disorder.
- **Many described having experienced severe violence and highly traumatic events in France**. This included witnessing the violent death of another person at the hands of traffickers and being threatened by traffickers that they would be killed if they returned to France.

Clinical safeguards in UK immigration detention – including Rules 34 and 35 of the Detention Centre Rules 2001, and the Adults at Risk policy – did not operate as intended and failed for almost every person in this cohort:

- **The Home Office failed on multiple occasions to identify vulnerable people and age-disputed young people unsuitable for detention.**
- There was a concerning lack of access to interpretation during the healthcare screening, which is the only opportunity for individuals to be offered a GP appointment within 24 hours at the IRC. This appointment is crucial to identify vulnerabilities and trigger a safeguarding Rule 35 report to be undertaken by an IRC GP and provided to the Home Office to communicate if individuals are at risk in detention and to review if they should continue to be held in detention.
- Very few saw a GP within 24 hours of arriving in detention as required by the Detention Centre Rules. Where they did, none had a sufficiently detailed mental health assessment conducted by the GP to qualify as a Rule 34 safeguarding appointment.

- IRC GPs only completed one Rule 35 safeguarding report identifying suspected suicidal intentions of an individual in detention, whereas many others who should have had this report, did not including an individual who attempted suicide in detention. Four other people put on Assessment Care in Detention and Teamwork (ACDT) by the IRC to monitor their risk of suicide or self-harm did not have a Rule 35 (2) report completed. There was a clear disconnect between Rule 35 (2) and those put on ACDT.
- **IRC GPs missed almost all cases of harm and health deterioration caused by detention.**
- Even where vulnerabilities were identified by IRC GPs through these safeguards, **the Home Office maintained all but one person's detention** in response.

These are not new failures. Medical Justice has repeatedly raised concerns that detention safeguards are unsafe.[9] The recent experiences of individuals detained under the UK-France Treaty indicate they remain as dysfunctional and dangerous as they were during the attempted removals to Rwanda in 2022 and 2024 and during the period examined by the Brook House Inquiry.[10] **Indeed, the number of people released in response to safeguarding reports in this cohort is so low that it risks rendering the whole process of clinical safeguards meaningless.**

As a result of being detained for removal under the Treaty, **the mental health of all 20 Medical Justice clients deteriorated**.

Suicidality was alarmingly common. One client attempted to take their own life and two individuals self-harmed in detention. Several people described having suicidal thoughts when thinking about being returned to France and expressed intent to die by suicide if they were to be removed**.**

Medical Justice clinicians found that **deteriorating mental health, fear, and erosion of trust in authority left many individuals unlikely to access help they might need to avoid further exploitation or destitution if they were returned to France and/or onward in Europe**.

Medical Justice is alarmed that it is **receiving proportionately more referrals from age-disputed young people detained for forced removal to France than in any other cohort** subject to immigration detention**.**

[9] Medical Justice: *Medical Justice Annual Review: The state of healthcare and harm in UK immigration detention in 2024*, July 2025*; "If he dies, he dies" What has changed since the Brook House Inquiry?*, December 2023.
[10] Kate Eves, Chair of the Brook House Inquiry, *The Brook House Inquiry Report* Volume II, HC 1789-II, Chapter D.1 page 3 paragraph 2, September 2023 and Medical Justice, *Who's paying the price? The human cost of the Rwanda scheme*, September 2022; and *"You'll see the outside when you're in Rwanda" Mistreatment in UK detention and mass round ups for forced removals*, September 2024.

Methodology

Medical Justice analysed 33 individuals' demographic information and information about their immigration and detention status and/or removal to France.[11] Twenty-eight of these individuals had a clinical assessment by a Medical Justice clinician which took place between mid-August and mid-October 2025.[12] Where the client's detention or removal status and status of reasonable or conclusive grounds decision on their trafficking claim within the National Referral Mechanism (NRM) had changed between data collection on 31 October and the time of writing on 15 December 2025, this has been included in this report.

The organisation conducted a more comprehensive analysis of clinical and other evidence of 20 individuals who also had a Medico-Legal Report (MLR) completed by a Medical Justice clinician at the point of data collection (31 October 2025). MLRs were completed between mid-September and end of October 2025. More clinical assessments and MLRs have since been completed by Medical Justice but are not included in the scope of this report.

Where available, supplementary information from the 20 clients' documentation was also analysed. This included further documentation produced by Medical Justice clinicians such as clinical letters and clinical opinions, as well as the client's asylum screening interview records, MLR instructions from the client's individual's legal representative, IRC healthcare records, Rule 35 reports and Home Office response letters to Rule 35 reports. Other relevant Home Office case information was also reviewed such as bail documentation, NRM documentation, Notices of Intent, inadmissibility decisions and removal documentation.

Since data collection on 31 October and the time of writing on 15 December 2025, Medical Justice has since taken on 12 more clients who have been detained under this scheme.

[11] Medical Justice received additional referrals from people detained under the Treaty who were removed, released or referred elsewhere before we were able to begin work on their case. Since the point of data collection of 31 October, Medical Justice has taken on further clients detained under the Treaty, however their data has not yet been analysed and is therefore not included in this report.

[12] Some follow up clinical assessments for those clients took place after this date.

Glossary of terms

'Adults at Risk' (AAR) Policy | Statutory Guidance and policy on determining whether a person is vulnerable (an 'Adult at Risk') and whether they ought to be released from detention because they may be at increased risk of harm in detention. The guidance states that vulnerable individuals should not normally be detained and can only be detained when 'immigration factors' outweigh their evidence of risk. Indicators of risk include those with histories of torture, trafficking and/or sexual violence, those suffering from a mental health condition, and those suffering from PTSD.

The AAR policy contains three levels of evidence. Level 1 is a declaration by the detained person about their medical or other aspects of their history that they had an indicator of risk. Level 2 is where a professional provided information that the detained person had an indicator of risk. Level 3 is evidence from a professional that the person has an indicator of risk and detention would be likely to cause them harm.

Assessment Care in Detention and Teamwork (ACDT) | A process used in IRCs intended to reduce the risk of self-harm and/or suicide. It is a custodial process involving regular reviews, with observations and/or periods of constant supervision carried out by custodial staff, and not trained clinicians, for risk-management purposes rather than for a therapeutic role.

Constant supervision | This is the highest level of observation under ACDT for those at immediate and acute risk of suicide or serious self-harm. A detained person can be put on constant supervision "to reduce a serious risk of them carrying out acts of self-harm or other behaviours which could lead to them accidentally or intentionally killing themselves". It is a member of custodial staff, not healthcare, who remains with the detained person.

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

Healthcare screening | Initial screening by a nurse or healthcare assistant which should be conducted within two hours of arriving at the IRC. The screening should identify immediate healthcare needs and risks relevant to their detention. Everyone should be offered a Rule 34 GP appointment in addition to this screening.

IRC Healthcare | The healthcare team is responsible for the provision of healthcare for those held in IRCs. Healthcare is commissioned by NHS England, usually from private companies. These companies employ healthcare staff to work in the IRCs and there may be further tiers of sub-contracting or use of bank staff. The IRC healthcare team provides primary care and some secondary mental healthcare. Psychiatrists are not always available in every IRC.

Medical Justice Medico Legal Reports (MLRs) | These are detailed reports written and peer- reviewed by independent clinicians at Medical Justice, which provide evidence for asylum cases and other legal decisions. This may include details of the person's physical and mental health, examination findings, forensic assessment of scars and psychological consequences of ill-treatment, torture and trafficking, documentation of injuries sustained during use of force incidents, consideration of the impact of detention on the person's health, and identification of unmet health needs.

Medical Justice Clinical Letters | These are letters written by independent clinicians at Medical Justice to raise immediate concerns about a client with the IRC healthcare unit within 24 hours of a medico-legal report assessment in detention.

National Referral Mechanism (NRM) | This is the UK's framework for recognising and supporting survivors of modern slavery and trafficking. When someone has indicators of trafficking, they should be offered referral into the NRM. Once referred, there are two stages of decision-making. Firstly, they receive a decision which states whether or not there are 'Reasonable Grounds' to believe that they are a victim of trafficking. This decision should be made within five days of a referral. Secondly, they will receive a 'Conclusive Grounds' decision, which will accept or not accept the person as a victim of trafficking on the balance of probabilities.

Rule 34 (of DCR 2001) | This is the requirement that detained people are given an appointment for a physical and mental examination with the GP within 24 hours of arrival. Rule 34 has a dual function: (1) to promptly identify healthcare needs so that appropriate healthcare can be provided; and (2) to enable early identification of vulnerabilities so that those at risk of suffering harm in detention can be referred to the Rule 35 mechanism.

Rule 35 (of DCR 2001) | This is the key statutory safeguarding mechanism which aims to identify those with particular vulnerabilities and bring them to the attention of the Home Office who has sole responsibility of reviewing whether the person should remain in detention or be released. Under Rule 35, IRC GPs have specific reporting obligations to the Home Office if an individual is identified as falling under the following three Rule 35 limbs: they are likely to be injuriously affected by detention (Rule 35(1)); they may have suicidal intentions (Rule 35(2)); or they may have been a victim of torture (Rule 35(3)).

Rule 35 response letter | The Home Office is required, within two working days following receipt of a Rule 35 report, to review the person's detention in light of the information contained in the report. The Rule 35 response letter is then sent to the person (and copied to the healthcare unit at the IRC to communicate the outcome of the review). The response usually summarises the information contained in the Rule 35 report, determines what the AAR evidence level (1, 2 or 3) is, summarises how this has

been balanced against any 'immigration factors', and the outcome of the review (to maintain detention or release).[13]

Rule 40 (of DCR 2001) | Under Rule 40, "removal from association", a form of segregation, may be used in the interest of safety or security. A detained person can be held in segregation for the minimum time necessary to maintain safety/security, for an initial period of up to 24 hours, but this may be extended to a maximum of 14 days.

Rule 41 (of DCR 2001) | Rule 41 provides parameters around the use of force. Force shall not be used "unnecessarily", and "no more force than is necessary shall be used". The detail of the use of force must be recorded and reported to the Secretary of State.

Rule 42 (of DCR 2001) | Under Rule 42, "temporary confinement", another form of segregation, may be used to manage an actively violent detained person. They can be held in segregation for as long as they pose a risk, for up to 24 hours and this may be extended for up to three days after written direction from an officer of the Secretary of State.

[13] 'Immigration control factors' encompass the following factors: Timescale for removal, compliance such as breaching immigration rules or non-compliance with conditions, and risk to the public such as criminal convictions.

Individuals' backgrounds and health vulnerabilities

The nationalities of the 33 Medical Justice clients detained under the Treaty are Afghani, Eritrean, Ethiopian, Iranian, Libyan, Palestinian, Somali, Sudanese, Syrian and Yemeni.

Three are women, 28 are men and two are age-disputed young people.

All 20 individuals who had a Medical Justice MLR are either an age-disputed young person and/or exhibited vulnerability in line with the criteria of the Home Office's own Adults at Risk policy.[14]

All 20 people have clinical evidence of a history of torture, ill-treatment and/or trafficking. Of those, 18 have evidence of torture and 14 of trafficking.[15] Thirteen people have evidence of both torture and trafficking.

All 20 individuals had at least one serious mental health condition, distressing symptoms, or warranted further mental health assessment. Medical Justice clinicians identified:

- 15 individuals with Post-Traumatic Stress Disorder (PTSD), including three with symptoms of complex PTSD;
- Two individuals with acute stress reaction and four with significant trauma-related symptoms, all of whom were at risk of development of full PTSD;
- Eight individuals with depression;
- Four individuals with an anxiety disorder or significant and distressing anxiety.

Individuals' accounts of experiences in France

Medical Justice clinicians explored individuals' accounts of their experiences in France. Many described facing severe violence, intimidation, and death threats, from traffickers and people smugglers, border forces, police, and organised gangs. Two described witnessing the violent death of another person at the hands of traffickers or organised gangs.[16]

Some, including young women, spoke of feeling unsafe in France and having been hungry, cold, destitute, and frightened. Two had witnessed another person die by suicide during their journey.

Individuals also described to clinicians how they were videoed or photographed by traffickers who threatened to use this to find and kill them if they returned to France.

[14] Home Office Guidance (Published May 2024) on Adults at Risk in immigration detention.
[15] These individuals have clinical evidence of a history of torture or trafficking documented in their MLR.
[16] Other organisations have documented other forms of violence at the UK-France border. See: Humans for Rights Network, *"You can't stay and you can't go" - State Violence at the UK-France Border*, December 2025

Many described facing severe violence, intimidation, and death threats in France from traffickers and people smugglers, border forces, police, and organised gangs.

The detention and removal process

All 33 Medical Justice clients arrived in the UK by small boat between 6 August and 29 September 2025. Upon arrival, they were detained and transferred to Manston Short-Term Holding Facility (STHF) in Kent.

Asylum screening interviews at Manston STHF

All 33 clients claimed asylum and had their asylum screening interview the same day or night as their arrival, or in the early hours of or during the following day.[17] Eleven people had their asylum screening interview between midnight and 5.30am.

The asylum screening interview is one of the Home Office's first opportunities to identify people with vulnerabilities that could impact their suitability for detention. For Medical Justice's clients, these vulnerabilities - such as mental health symptoms, indicators of a history of torture, ill-treatment and/or trafficking - were rarely identified in the asylum screening interview.

Clients have told Medical Justice that they were under the impression that the asylum screening interview was only a very preliminary interview and that they would have further opportunity to explain their history, their fears, and their reasons for seeking protection in the UK and hence they limited their answers to brief points. However, those detained for removal to France do not receive a further asylum interview if their asylum claim is deemed inadmissible by the Home Office.

Some people described to the Medical Justice clinicians how their asylum screening interview took place when they had not eaten or slept for up to several days, and felt tired, weak, and confused.

Two people were not provided with an interpreter who spoke their dialect and one had part of their asylum screening interview conducted in English when they did not speak sufficient English to have a detailed conversation.

[17] Medical Justice had access to 30 clients' asylum screening interviews. It is unknown for three people where their interview took place, but it is likely they were detained and had their interview at Manston STHF like the other 30 clients who arrived in the same way (small boat).

Detention at Yarl's Wood, Brook House and Harmondsworth IRCs

Medical Justice's female clients were taken from Manston STHF to Yarl's Wood IRC, while male clients – including age-disputed young people – were taken to either Brook House (19) or Harmondsworth (11) IRCs.

Two to four days after arriving in the UK, our clients received a written Notice of Intent, informing them that the Home Office was considering treating their asylum claim as inadmissible and remove them to France. The Notice of Intent also informed clients that they had seven days to make any representations to the Home Office as to why they their asylum claim should not be treated as inadmissible.
Many people went on to receive an inadmissibility decision on their asylum claim around one to two months into their detention and were then issued with notices of planned removal with details of a flight to Paris. Individuals who had been released before an inadmissibility decision was made were re-detained very shortly after receiving the decision or were re-detained and then given an inadmissibility decision shortly afterwards.

At the time of publication (21 January 2026), the Home Office had decided to remove five clients from the inadmissibility procedure, and they are now able to process their asylum claim in the UK.[18] A sixth client, an age-disputed young person, is also no longer part of the UK-France scheme.

Length of time in detention, and numbers of clients released, re-detained and/or removed to France

Under the Treaty, the UK and French governments have agreed to work towards an end-to-end process not exceeding three months from arrival in the UK to removal to France.

At the time of writing Medical Justice clients had spent at least 30 days and in some cases over three and a half months in detention.

16 of Medical Justice's 33 clients including one age-disputed young person were released, seven of whom were subsequently re-detained after reporting to a Home Office reporting centre, in compliance with their bail conditions.

At the time of writing (15 December 2025), 14 had been removed to France and five were still in detention, at risk of forced removal to France.

Three more age-disputed young people have been referred to Medical Justice at the time of writing, bringing the total now to five, including the two age-disputed young people in the larger 33-client cohort. Medical Justice is alarmed that it is receiving proportionately more referrals from age-disputed

[18] Medical Justice is not aware why some clients have been removed from the inadmissibility procedure as part of the UK-France scheme, whilst others have not.

young people detained for forced removal to France than in any other cohort subject to immigration detention.

The following information and statistics relate to the 20 clients who had a Medical Justice Medico-Legal Report (MLR):

Trafficking and torture survivors in detention for removal to France

Immigration detention can cause severe mental and physical suffering for survivors of torture or human trafficking. It impedes recovery and increases the risk of re-traumatisation[19] which occurs when a person is exposed to new experiences of powerlessness or threat that echo their original trauma, provoking and exacerbating psychological symptoms.

Medical Justice and other medical bodies have repeatedly described the severe impacts of immigration detention on survivors of torture and/or trafficking.[20] 90% of Medical Justice MLR clients who were detained under the UK-France scheme have clinical evidence of torture and 70% of trafficking.[21]

None of those with clinical evidence of trafficking were identified by the Home Office as potential victims of trafficking prior to detention. Once in detention, identification of trafficking survivors solely through the National Referral Mechanism (NRM) continues to be very rare. Referrals into the NRM of our clients while in detention (17 in total) mostly came about as a result of representations by their legal representative to the Home Office.

When they do disclose a trafficking history, disclosures have been criticised by the Home Secretary as being 'last minute' and treated less credible as a result.[22] However, trafficking survivors face multiple barriers to disclosure such as being afraid of sharing their experiences of trafficking and exploitation for a multitude of reasons, including shame and fear of stigmatisation.[23] Detention adds further barriers to disclosure, including mistrust arising from the fact that the Home Office is both the First Responder

[19] Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention; and Royal College of Psychiatrists (2021) Position statement PS02/21 Detention of people with Mental Disorders in Immigration Removal Centres

[20] Royal College of Psychiatrists (2021) Position statement PS02/21 Detention of people with Mental Disorders in Immigration Removal Centres; Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention; and British Medical Association (2017), Locked up, locked out: Health and human rights in immigration detention

[21] At the time of data collection (31 October 2025)

[22] Yahoo News UK, Home Secretary vows to fight 'last-minute claims' against UK-France deportations

[23] See Helen Bamber Foundation, ATLEU, FLEX and Medical Justice, *Abuse by the system: Survivors of trafficking in immigration detention*, October 2022. Many of the barriers are also included in the Modern Slavery: statutory guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and non-statutory guidance for Scotland and Northern Ireland

Organisation[24] -– which in the detention setting has sole statutory responsibility for referral into the NRM – and the authority that is holding the person in detention.

Beyond barriers to disclosure, even when MLR clients detained under the UK-France scheme did disclose a history or indicators of trafficking to the IRC's healthcare unit, this did not necessarily result in the Home Office being informed, or the person being referred into the NRM process.

At the time of writing, four of the 17 individuals referred to the NRM received an initial positive reasonable grounds (RG) decision, indicating that the Home Office had found reasonable grounds to believe that the person has experienced modern slavery or trafficking.[25] For those that had received a negative RG decision, at least eight put in a reconsideration request.[26]

It is extremely concerning that the recent change to Modern Slavery Statutory Guidance removes some people's right to have a negative decision reconsidered.[27] In practice, this policy seems to be implemented inconsistently with some people in this cohort still receiving a reconsideration and some refused. Three Medical Justice clients went on to be recognised as potential victims of trafficking only after receiving a reconsideration of their initial and wrong negative decision.[28] One then went on to receive a positive Conclusive Grounds (CG) decision, meaning that they are formally recognised as a victim of trafficking and/or modern slavery, despite initially being given a wrong negative decision. This shows the importance of being able to seek reconsideration of a negative decision.[29]

Medical Justice very frequently see clients who have strong medical evidence in keeping with their account of Modern Slavery, but before the evidence becomes available they have already received a negative decision on the basis that the evidence threshold was not met. As people's claims to protection are not considered under this Treaty and the process for removal is therefore sped-up, and with the removal of the right to reconsideration of a negative decision from the NRM, this increases the likelihood that trafficking survivors will not be formally recognised as such and therefore are not able to access the statutory entitlements or support they need and would otherwise have, and are removed to France.

After receiving a positive RG decision, a person is entitled to targeted support during a 'Reflection and Recovery Period'. For those in Medical Justice's MLR cohort receiving this decision, however, this did not mean that they were released from detention. All of the clients with a positive reasonable grounds

[24] The organisation authorised to refer a potential victim of modern slavery into the NRM.
[25] The reasonable grounds decision for two clients was unknown at the point of data collection.
[26] For some it was unknown if a reconsideration request was made.
[27] In September 2025, the Home Office changed the Modern Slavery Statutory Guidance on the eligibility for reconsideration of negative Reasonable or Conclusive Grounds decision where the Home Secretary "intends to remove that individual to a country that is a signatory to the Council of Europe Convention on Action Against Trafficking in Human Beings (ECAT) and European Convention on Human Rights (ECHR)". See Modern Slavery: Statutory Guidance for England and Wales (under section 49 MSA) and non Statutory Guidance for Scotland and Northern Ireland. Updated 10 October 2025. Para 14.216
[28] At the time of writing (15 December).
[29] See further evidence here: Modern Slavery and Human Rights Policy and Evidence Centre, A second chance to be seen and protected: Analysis of policy and data on reconsideration requests for negative decisions from the National Referral Mechanism, December 2025

decision should have had a Modern Slavery Needs Assessment and consideration of whether their recovery needs could be met in detention. It appears none of the clients were released as a result of the Needs Assessment.
Seven who received a positive initial or reconsidered RG decision[30] remained in detention for between two and six weeks after this decision before being released. It is therefore unclear if a person's release is directly linked to receiving a positive RG decision. Two were later re-detained.

One person went on to receive a negative CG decision and five received a positive CG decision.[31] A positive CG decision means that they are therefore officially recognised by the UK government as being victims of trafficking and/or modern slavery.

Impact and harm caused to those put through the detention and removal process

Immigration detention is harmful. In addition to compounding existing vulnerabilities, Medical Justice clinicians find that it can also trigger the onset of new health conditions, cause deterioration and increase suicide risk, resulting in further harm and suffering.

Of the 20 people who had a MLR and were detained under the UK-France scheme, every individual was found to have deteriorated in their mental health while in detention. Medical records show that the IRC healthcare team referred the majority (16) to the mental health team in detention.[32] Sixteen people experienced additional harm as detention impeded their recovery and their access to appropriate healthcare.

Medical Justice clinicians identified that detention was likely to cause further harm to all 20 people.

High levels of suicidality

Suicidality was alarmingly common. A high proportion of our clients (75%) detained under the Treaty had an increased risk of suicide since they were detained.

Twelve of the 20 people in Medical Justice's cohort had had suicidal thoughts while in detention.[33] Six said they would take their own lives if removed to France. Two people self-harmed. One person attempted suicide.

[30] At the time of writing (15 December 2025)
[31] For one it was unknown.
[32] This is out of the number of Medical Justice clients for whom we accessed their medical records (16) and the number of clients where their Rule 35 report noted that they had been referred to the mental health team (3). One additional person is not included in the 16 as they declined the referral.
[33] Not everyone considered to be at risk of suicide had expressed suicidal thoughts. This is because clinical risk assessment goes beyond disclosure of suicidal thoughts, to consider clinical risk factors, including past behaviours and current symptoms.

For many, detention in the UK — not their past trauma — was described as the moment when they lost hope. From a clinical perspective, this is dangerous.

Although 15 people were assessed by a Medical Justice clinician as being at increased risk of suicide in detention, medical records show that only five people were put on ACDT in detention. This was in response to suicidal ideation or risk of self-harm, including after receiving removal directions for France. Clients remained on ACDT between three days and over a month.

Impact of anticipated removal to France documented by clinicians

Medical Justice clinicians documented the impact an anticipated removal to France had on people in the MLR cohort. For people already struggling with symptoms of post-traumatic stress disorder or depression, it impeded their recovery, eroded their trust in authorities and made engagement with healthcare and support services in the IRC much harder.

Before removal had taken place and irrespective of whether their fears would be realised, Medical Justice clinicians observed that individuals were highly distressed when discussing and contemplating being returned to France. Our clinicians noted destabilising impacts on mental health and that fear of return caused harm to people in the present.

Among other impacts and fears, individuals described nightmares, intrusive thoughts and other trauma-related symptoms directly linked to their experiences in France, including ill-treatment by traffickers or people smugglers. Several individuals described suicidal thoughts when thinking about being returned to France.

Medical Justice clinicians found that the threat of forced removal to France was a significant factor in provoking symptoms and mental health deterioration in this group.

Impact of forced removal to France described by clinicians

Medical Justice clinicians focus on health issues and are unable to comment on the French context or other legal matters. However, our clinicians were clear that, if returned to France and/or onward in Europe, many of the individuals in the MLR cohort would be too unwell or too distrustful to be able to access and utilise the support and therapeutic services, where available, that they might need to avoid further exploitation or destitution, and were therefore highly vulnerable.

For example, for trauma survivors, effective engagement in therapy to begin a process of recovery requires a sense of safety. Clinicians found that even if individuals were able to access mental health services in France, the impact on their sense of security would be likely to interfere with the effectiveness of any psychological treatment.

Clinicians also found that for some people their detention and removal to France would result in the removal of hope and impact on trust and engagement. If removed, it is likely that their mental health

would continue to deteriorate, and those who already had suicide risk factors would be at increased risk of suicide in France. Clinicians found that for some individuals, removal to France is likely to be harmful to their mental health and is likely to be retraumatising.

Removal of trafficking survivors, in particular, would put them at increased risk of harm, exploitation and abuse.

Failing clinical safeguards in detention

Medical Justice has long documented how clinical safeguards in detention very often fail to identify and route vulnerable people out of detention.[34] Like other cohorts, there continued to be very low numbers of Rule 35 (1) and (2) reports completed for those that should have had one amongst the UK-France MLR detained cohort.

Our evidence shows that these safeguards failed for almost every person in the cohort, as even when vulnerabilities were identified by IRC GPs, the Home Office maintained the detention of all but one client in response.

Initial healthcare screening

Within two hours of arriving at the IRC, detained people are given an initial healthcare screening with a nurse or healthcare assistant, which may take place at night.

There were many examples of people not having interpreters present in their screening despite this being needed. This was usually when they spoke some limited English, or no interpreter was available at the time. The majority of these people were noted to then 'decline' a Rule 34 GP appointment, which each newly detained person must be offered within 24 hours of arriving at the IRC. This is concerning because the Rule 34 appointment is a key opportunity for detained people to disclose to the GP any vulnerabilities that put them at risk of being harmed in detention, which the GP should then flag to the Home Office through the Rule 35 mechanism in order for them to consider release. It is unclear, however, how a person who needed interpretation could understand the purpose and significance of the appointment without that assistance.

Even in cases when an interpreter was used for healthcare screening or not required, it was rarely noted in individuals' medical records that the safeguarding purpose of the Rule 34 appointment was explained. When asked, clients told Medical Justice they could not recall having been offered the appointment.

During the healthcare screening, detained people are asked a question to elicit whether they have experienced torture in the past. Disclosing a history of torture should lead to an appointment with the

[34] See Medical Justice, *"If he dies, he dies" What has changed since the Brook House Inquiry?*, December 2023 and *Medical Justice Annual Review: The state of healthcare and harm in UK immigration detention in 2024*, July 2025.

IRC GP for a Rule 35 safeguarding report. However, it was rare for our clients with such a history to disclose this, or for it to be otherwise identified, in their healthcare screening.

For five clients, a broader question to elicit a torture history was recorded: "did anything bad happen to you on the way to the UK?" or "in your country of origin". Three of our clients disclosed ill-treatment and/or indicators of trafficking during their healthcare screening. However, none of their medical records noted whether they were then referred for a Rule 35 assessment.

It is concerning that clients who needed but did not have an interpreter present in their healthcare screening were also noted to have "discussed" Rule 35 with IRC healthcare who concluded "no further assessment [is] required".

Rule 34 appointment

The Rule 34 appointment is a key component of the detention safeguards to identify any mental or physical health vulnerabilities that a detained person has that put them at risk in detention. However, only two clients had a Rule 34 appointment with an IRC GP within 24 hours of arriving in detention.

Rule 34 stipulates that the GP must conduct a mental and physical examination. Yet, neither of the two individuals had a sufficiently detailed mental health assessment conducted by the GP to qualify as a Rule 34 appointment.

Rule 35 appointments and reports

Rule 35 is a critical safeguard for the IRC GP to communicate relevant information about a client's vulnerability and risk of harm in detention to the Home Office and triggers a review of the person's suitability for detention. For the safeguarding process to take place, detained people wait for a GP appointment to assess the need for a Rule 35 report. Waiting times for this varied from one day to two months following the identification of need. There was also a case of a five-day delay between the appointment taking place and the production of the Rule 35 report. Any delays to this process are of concern as it delays consideration of the individual's release and risks further avoidable harm in detention.

In a large number of our clients' cases (15), the IRC GP issued a Rule 35 report identifying them as an individual who may have been a victim of torture (Rule 35 (3)).[35] One of these reports documented torture of the client by traffickers in France. Four clients who have clinical evidence of a torture history did not have a Rule 35 (3) report completed.

Only three clients had a report identifying that their health is likely to be injuriously affected by detention (Rule 35 (1)). Medical Justice clinicians, however, found that all clients' mental health deteriorated in detention. The IRC GPs therefore had failed to complete a Rule 35 (1) report in almost all

[35] 14 people who had clinical evidence of torture and one person who had clinical evidence of ill-treatment had a Rule 35 (3) report completed.

cases where this was necessary due to the harm and health deterioration caused by detention. Individuals who were missed in this process included those whose health had already deteriorated in detention, and one person who required transfer to hospital. Further, one of the Rule 35 (1) reports that was completed communicated that the client had *already* deteriorated in detention, having surpassed the reporting threshold of being "at risk" of being injuriously affected in detention.

Only one Rule 35 (2) report was done by the IRC GPs in this cohort to communicate suspected suicidal intentions. Rule 35 (2) reports were not completed for those who were likely to have met this threshold, including those placed on Assessment Care in Detention and Teamwork (ACDT)[36] and cases where the person had been placed on constant supervision due to suicide risk, where they had attempted suicide in detention, those who had self-harmed, and those recorded to express suicidal thoughts or intentions.

Home Office decisions in response to Rule 35 reports

Medical Justice had access to 14 Home Office responses (for 13 individuals) to Rule 35 reports in this cohort.[37]

Only one client was released as a result of the reports, since the Home Office consistently gave more weight to 'immigration factors' than the evidence of risk related to the vulnerabilities identified.[38]

The 'immigration factors' cited by the Home Office were primarily in relation to the detained person's mode of arrival to the UK by small boat, which was interpreted as indicating a higher risk of absconding or breaching immigration rules. Other 'immigration factors' included "declin[ing] to leave the UK voluntarily", and having "no close family ties in the UK", both of which are unsurprising given that the individuals had just arrived in the UK and were seeking protection in the UK.

All 13 clients were considered by the Home Office to be an Adult at Risk in relation to their Rule 35 report. Only two were assigned Adult at Risk 'level 3', the highest evidence level to be weighed against 'immigration factors'. 'Level 3' evidence is defined in the Home Office's Adult at Risk policy as professional evidence "that the individual is at risk and that a period of detention would be likely to cause harm".[39] It is therefore concerning that 11 individuals who had professional evidence were assigned 'level 2', including one client who had medical evidence from multiple sources on the risk to their health in detention, including from the IRC GP and IRC psychiatrist in the Rule 35 report.

The vulnerability factors the Home Office gave when assigning other clients as 'level 2' were either their torture account and/or the GP's assessment of their mental health. Where the GP stated in certain terms

[36] ACDT is the process used in IRCs intended to reduce the risk of self-harm and/or suicide, with varying frequencies of observation depending on the perceived level of risk.

[37] For five clients, the Home Office response was delayed more than two working days as per its own policy.

[38] 'Immigration control factors' encompass the following factors: timescale for removal, compliance such as breaching immigration rules or non-compliance with conditions, and risk to the public such as criminal convictions. None of Medical Justice's clients detained under the UK-France Treaty had a history of absconding, any public protection concerns or a criminal conviction in the UK.

[39] Home Office Guidance (Published May 2024) on Adults at Risk in immigration detention

that the client was going to deteriorate if they remain in detention, the Home Office assigned them 'level 3'. Where the IRC GP stated that the client was *likely* to deteriorate if they remained in detention (the standard laid out in the Adults at Risk policy for level 3), they were assigned 'level 2'.

The number of clients with 'level 3' is similar to Medical Justice clients detained under the previous government's Rwanda policy[40] and very low when compared to other Medical Justice clients detained outside of the UK-France deal.[41]

The Home Office's decision to only release one person in this cohort based on the Rule 35 safeguard is deeply concerning. Clinical safeguards are in place to act not just as a process to identify individuals with health or other vulnerabilities in detention but as a means for the Home Office to review and route out those identified as at risk in or unsuitable for detention. If so few people are released from detention as a result of identification, this renders the Rule 35 safeguard meaningless. This low rate of release – 7% of MLR clients who had a Rule 35 report detained under the UK-France Agreement – mirrors the findings of Medical Justice's analysis of Home Office decisions following a Rule 35 report for MLR clients in 2024 when 9% were released as a result of the report.[42]

Removal attempts, use of force and segregation

Some individuals were subjected to force and segregation in detention, including during removal attempts to France. If this was done purely for administrative convenience it would breach the Detention Centre Rules.[43] Three people were put in segregation; for two of them this was in relation to removal to France. One person was subjected to force in relation to removal to France.[44]

A Medical Justice clinician documented the harm caused to an individual whose attempted removal and being put in segregation triggered a worsening of their mental health symptoms.

[40] One was assigned 'level 3' in this cohort. See Medical Justice, "You'll see the outside when you're in Rwanda": Mistreatment in UK detention and mass round ups for forced removal, 7.4, September 2024.
[41] In 2024, the Home Office assigned 15 Medical Justice clients as Adults at Risk 'level 3' out of 46 responses to Rule 35 reports. See p.40 *Medical Justice Annual Review: The state of healthcare and harm in UK immigration detention in 2024*,, July 2025.
[42] Medical Justice, *Medical Justice Annual Review: The state of healthcare and harm in UK immigration detention in 2024*, July 2025.
[43] Home Office, Detention Services Order 02/2017: Removal from Association and Temporary Confinement (November 2025), states that: "112. An individual must not be removed from association or placed in temporary confinement for administrative convenience in advance of an individual's removal from the UK. To do so would be a breach of the Rules. 113. If an individual does need to be removed from association or placed in temporary confinement ahead of their removal, it must be as a result of a thorough individual risk assessment where staff have balanced the interests of safety and security against any adverse effect on the individual and be for the shortest time possible. Any such assessments must be made on a case-by-case basis in accordance with the minimum acceptable standards outlined above."
[44] In addition to our evidence on this, Humans for Rights Network also documented the experiences of two men who spoke of experiencing or witnessing violence during their forced removal to France. See Humans for Rights Network, *'One in one out' summary of visit to Paris October 2025*.

TORTURE SURVIVOR SUBJECTED TO EXCESSIVE AND DISPROPORTION FORCE DURING REMOVAL ATTEMPT TO FRANCE

Hamid,.[45] a Medical Justice client who has evidence of a history of torture, was detained on arrival under the Treaty. His medical records note that in detention he was stressed and distressed, with symptoms of post-traumatic stress disorder. No Rule 35 safeguarding report to raise concerns that he might be a victim of torture was completed while he was detained.

The morning of Hamid's attempted removal, he was confused and unsure what was happening. He asked to talk to his lawyer with an interpreter but he could not get through as it was before 9am and he was not allowed to access his emails to check if there was any communication from his lawyer regarding his removal. Hamid told Medical Justice "I was not allowed to go to the toilet that day. I was not allowed to wash my face properly, they only gave me a wet wipe and told me to clean my face while standing there."

"Then they started to open their bags and take out four different belts and they started to forcefully use them and tie me. They banged my head against the wall several times while I was screaming in pain, but they were not kind to me." Hamid was tied very tightly.

"One of the women there was trying to pull my hair to make me feel pain, and one of them was bending my fingers backwards to make me feel pain. I was in a very serious situation. The belt that was tied around my shoulders got stuck in my throat. I started screaming and saying I want to die, untie the belt from my neck, but they thought I just wanted to be let go. After a few minutes, I became dizzy, and my voice became weak and my strength was limited to just tears. They saw me struggling for air and honestly, my eyes were turning white and my breathing was difficult. I said in a low voice, I can't breathe, and I thought to myself, Oh, my God."

On return to the detention centre, the medical records confirm that, in the presence of a medical escort, handcuffs, pain compliance techniques, restraint belts and leg restraints had been applied.

In Medical Justice's clinical assessment following the use of force, the clinician documented evidence of Hamid's physical injuries and psychological harm. These were in addition to evidence of physical injury and psychological harm attributed to prior experiences of torture in his home country. Hamid has since been removed to France.

[45] Hamid's real name has not been used in order to protect his identity.

Conclusion

The UK government has chosen to detain and forcibly remove torture, trafficking and other survivors of trauma to France, in full knowledge of the harm that this is likely to cause.

Many of the findings presented in this report are not new – highly vulnerable people are detained for an unlimited length of time, without working safeguards to protect and route them out of detention, some are subjected to excessive force and segregation and there is high suicidality amongst our clients. However, what is new is that those detained under the UK-France Treaty are all people who arrived having just gone through a traumatic journey to reach the UK to seek protection. Instead of receiving protection, many were immediately locked up for months, re-traumatised, harmed and forcibly removed to France. Not considering people's claims for protection and putting them through an accelerated removal process as a consequence has meant that many people have not been able to access adequate and timely legal advice.

Trafficking survivors have not been able to access the support required for recovery to which they are entitled. Instead, they spend their "recovery" time in detention and/or in fear of being returned to France where they report fearing traffickers who had threatened them.

It also has meant that people have been removed despite having expressed suicidal intent in relation to removal to France.

In a shocking move, the Home Office changed the rules for potential trafficking survivors, including all those detained under this scheme by removing their eligibility for reconsideration of negative reasonable grounds decisions. This move downgrades modern slavery protections in the UK and is extremely dangerous for trafficking survivors.

Additionally, the detention safeguards appear to have been rendered almost meaningless. All but one individual in the Medical Justice MLR cohort of 20 clients were either not identified through the appropriate Rule 35 safeguarding report or not released as a result of such a report. It appears that for those detained for removal to France failure of the detention safeguards – where evidence of vulnerabilities are trumped by 'immigration factors' – is now the norm.

Recommendations

In light of the evidence in this report, Medical Justice sets out the following recommendations to the government and the Home Office in particular:

- To phase out and end immigration detention which causes severe harm;
- In the interim, ensure clinical safeguards actually work as intended and ensure there are no unlawful actions or inactions regarding treatment of detained people;
- Cease the implementation of the France-UK Treaty immediately, release all individuals detained under this Treaty, reverse all inadmissibility decisions and allow individuals to enter the asylum process in the UK;
- Amend the Modern Slavery Statutory Guidance to ensure everyone is entitled to reconsideration of negative reasonable or conclusive grounds decisions;
- Ensure that NGOs are consulted when reviewing the implementation of the agreement, including on the criteria to be assessed.

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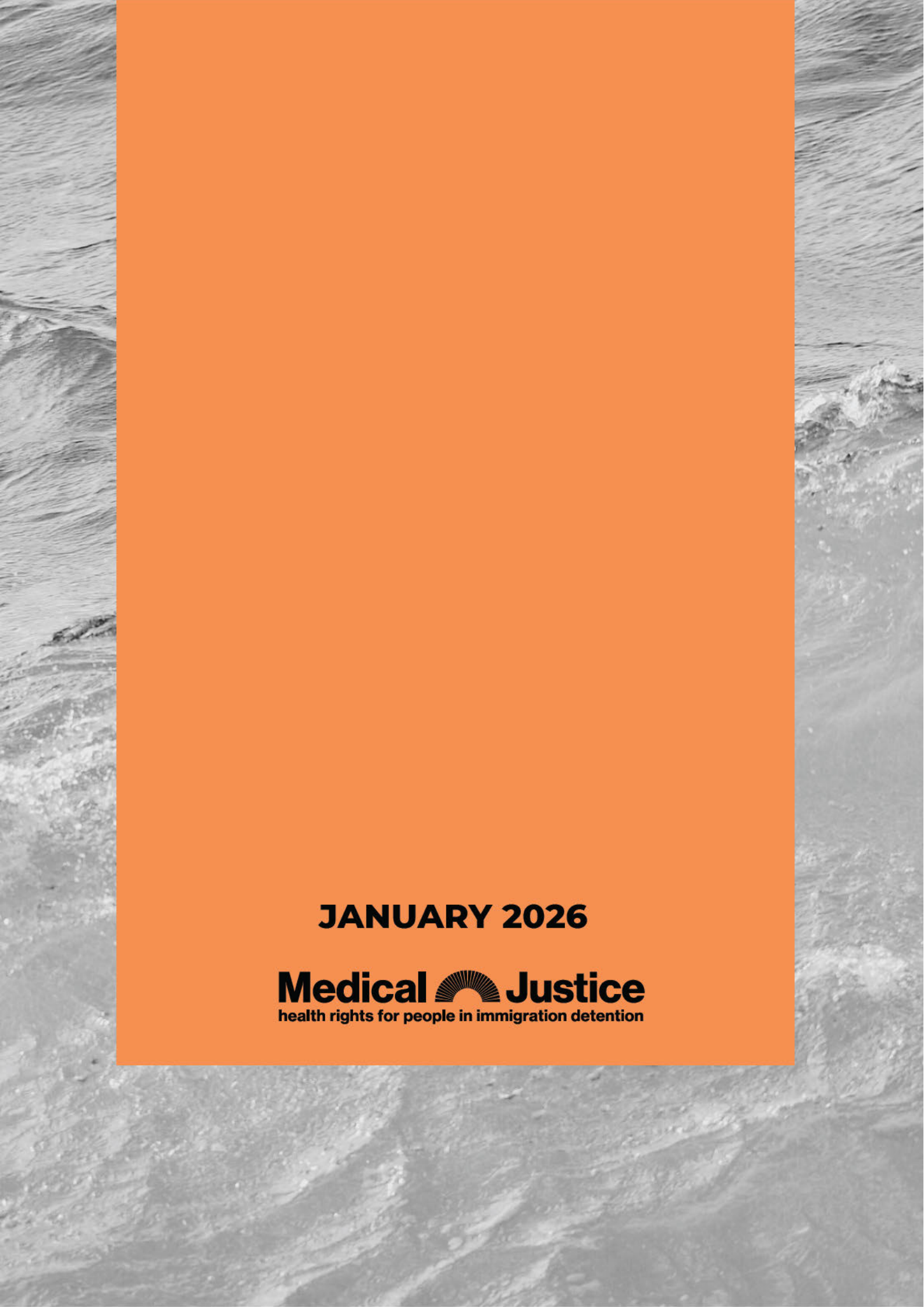
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