# Rethinking 'Vulnerability' in Detention: a Crisis of Harm

Report by the Detention Forum's Vulnerable People Working Group
July 2015

The Detention Forum

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Report by the Vulnerable People Working Group of the Detention Forum, convened by AVID (Association of Visitors to Immigration Detainees) and GDWG (Gatwick Detainees Welfare Group)

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Detention Forum is a network of organisations working together to challenge the UK's use of immigration detention.

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# Glossary

**ACDT** Accelerated Care in Detention and Teamwork

**AVID** Association of Visitors to Immigration Detainees

**BID** Bail for Immigration Detainees

**CEAS** Common European Asylum System

**DEPMU** Detainee Escorting and Population Management Unit

**DFT** Detained Fast Track

**DSO** Detention Service Order

**EHRC** Equality and Human Rights Commission

**EIG** Enforcement Instructions and Guidance

**HASC** Home Affairs Select Committee

**HMIP** Her Majesty's Inspectorate of Prisons

**HO** Home Office

**ILPA** Immigration Law Practitioners Association

**IMB** Independent Monitoring Boards

**IRC** Immigration Removal Centre

**JRS** Jesuit Refugee Service

**NGO** Non Governmental Organisation

**PTSD** Post Traumatic Stress Disorder

**SSHD** Secretary of State for the Home Department

**UKBA** United Kingdom Borders Agency

**UNCAT** UN Convention Against Torture

**UNHCR** UN High Commissioner for Refugees

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# Executive Summary

More people than ever before are now being detained without time limit in the UK for immigration purposes. The use of detention has become a core element of immigration policy for successive governments, despite mounting evidence that its use is both inefficient and enormously damaging to those detained.

In particular, increasing numbers of very vulnerable people are now held in detention. Despite repeated and severe criticism, the UK has been unable to find an effective way to prevent this. Monitoring bodies, academics, clinicians, NGOs, and those with experience of immigration detention themselves have all expressed their concern that the UK's immigration detention system is putting vulnerable people at risk. The High Court has found on no less than six occasions in a period of three years that the Home Office had breached its responsibilities under Article 3 of the European Convention on Human Rights (the right to freedom from torture, cruel and inhuman or degrading treatment)[1] for those who are in immigration detention. Most recently, the parliamentary inquiry into immigration detention called for radical reform of the entire detention system.

This report revisits the issue of vulnerability through a literature review and interviews and case studies of 31 vulnerable people. This exercise elicited three key observations which should inform a new approach to vulnerability in detention. Such a new approach would require that the Home Office think about vulnerability in a different way, in order effectively to *prevent* detention of vulnerable people.

1. that the Home Office has failed to follow its own guidance and continues to detain individuals they have recognised as members of 'vulnerable groups';

2. that detention centres are inadequate to meet the basic care needs of these individuals;

3. that reliance on the categories of vulnerability within the current policy guidance overlooks the dynamic nature of vulnerability, shaped by individual characteristics and changing over time. This means that detainees who do not fit within the pre-existing categories remain invisible and at risk.

The issue is not just that current policy is failing but that it is inadequate in its own terms. The current policy focuses the decision-maker's mind solely on whether a person fits straightforwardly into a specific category of vulnerability at the point at which a decision to detain is made. This creates an impression that those who do not fit neatly into the existing categories are not and will not be vulnerable in detention.

This narrow, static and category-based approach to vulnerability contrasts starkly with a holistic approach recommended and used by researchers and other specialists. Our literature survey shows that this more holistic approach to vulnerability acknowledges a range of personal, social and environmental factors which may affect or indeed cause a person's vulnerability. Such an approach also highlights the need to monitor how individuals' vulnerability may change over time.

While we were completing this report, the parliamentary inquiry into immigration detention published its report in March 2015. The inquiry panel concluded that 'detention is currently used disproportionately frequently, resulting in too many instances of detention' and urges the government to radically reform its detention system, starting with the introduction of a time limit of 28 days and the development of community-based alternatives to detention.

1 European Convention on Human Rights (ECHR) (1953) Available at http://www.legislation.gov.uk/ukpga/1998/42/schedule/1

Our case studies of vulnerable people in detention demonstrate what the inquiry panel called 'the enforcement-focused culture of the Home Office' – its narrow, static and category-based vulnerability assessment is used primarily to reduce as far as possible the number of people who cannot be detained, rather than to prevent vulnerability from happening in detention.

We propose that reform of detention should include the introduction of a more holistic approach to vulnerability so that the detention of vulnerable people for immigration purposes can be truly eliminated. This is likely to be a complex task, and we hope that the government initiates dialogue with practitioners and experts to overcome various shortcomings identified by this report and others.

With this in mind, we recommend the following:

- The government should implement the recommendations made by the parliamentary inquiry into the use of detention.

- The current policy on detention of vulnerable people is not working because of its narrow, static and category-based approach. We do not think this can be resolved by an expansion of the number of categories used to identify and describe vulnerability. The Home Office should develop a vulnerability assessment tool and practice which enable a more thorough approach to screening of individuals before detention but is also adaptable to changes over time in detention. This should be based on good practice developed by researchers and other practitioners. The primary purpose should be to prevent detention of vulnerable people and the occurrence of vulnerability in detention.

- The development of such a tool should be carried out in consultation with independent experts, including clinicians and mental health professionals, researchers and practitioners from other areas through the establishment of an independent expert working group. This working group should oversee both the development of a vulnerability tool and its implementation, which should be regularly reviewed and externally audited.

- Such a vulnerability tool should be engaged at regular intervals to enable changes over time to be reviewed. People identified as becoming increasingly vulnerable over time should be released immediately.

- As recommended by the parliamentary inquiry, community-based alternatives to detention utilising a case management model should be developed. This would enable a shift away from the current enforcement culture and significantly reduce the use of detention. Such a model should ensure that vulnerable and potentially vulnerable people can go through the immigration system without experiencing detention. The development of such a model is likely to take time and effort, as well as the participation of civil society organisations and other institutions, but the reduced use of detention will generate cost savings which can be reinvested into case working and support in the community.

# 1. Introduction

More people than ever before are now detained without time limit in the UK for immigration purposes. In September 2014 there were 4,270 residential bed spaces in the detention estate, over 800, or almost 20%, more than in September 2013.[2] This figure does not include former prisoners subject to immigration control and held in prison post-sentence, nor anyone held in holding rooms at the UK's ports or airports or in police custody suites. The use of detention has become a core strand of immigration policy for successive governments, despite mounting evidence that its use is both inefficient and enormously damaging to those detained.

The Detention Forum is a network of more than 30 NGOs, who have come together to challenge the legitimacy of immigration detention. We are united in our concern at the increasing numbers of very vulnerable people held in detention and the devastating effects this has on them. We are also united in our frustration that the UK has been unable to find an effective way to prevent this for far too long.

This report revisits the issue of vulnerability through interviews and case studies of vulnerable people collected through our member organisations and a literature review. It also summarises what we regard as key factors that should shape a new approach to vulnerability in detention. Our hope is that this report encourages the government to engage in dialogue with practitioners and experts in order to prevent the detention of vulnerable people. The report was prepared by a working group set up for this purpose.

We have concluded that, by routinely detaining vulnerable people on a large scale, the UK government is failing to follow its own policy. In addition, this policy as currently formulated is inadequate to protect these people from the damaging effects of being locked up indefinitely for purely administrative purposes. Needless to say, we are not alone in our critique of the detention of vulnerable people in the UK. As the scale of detention has grown, so the detention of those deemed to be vulnerable has become the subject of a growing body of international and national criticism. A diverse range of voices within the UK – statutory bodies such as Her Majesty's Inspectorate of Prisons (HMIP) and the Independent Monitoring Boards (IMBs); human rights mechanisms such as the Equality and Human Rights Commission (EHRC);[3] academics; clinicians; NGOs, and detainees themselves – have all expressed their concern that the UK's immigration detention system is putting vulnerable people at risk and failing in its duty of care. International bodies have also levelled criticism at the UK, for example the UN Committee Against Torture (UNCAT)[4] and the UN High Commissioner for Refugees (UNHCR).[5]

2 AVID (Association of Visitors to Immigration Detainees) (16th September 2014) Immigration Detention in the UK: 'residential' detention capacity

3 The Equality and Human Rights Commission (EHRC) has raised specific questions about the treatment of vulnerable people in detention. They identified immigration detention as one of their top ten human rights concerns in the UK in 2012, noting immigration removal centres do not always offer sufficient care for detainees with mental health conditions, or provide adequate mental health services.

4 In May 2013 the UN Committee Against Torture, in its concluding observations on the UK, expressed concern about the detention of survivors of torture, people with mental health conditions, children, and victims of trafficking. While making particular recommendations on the Detained Fast Track (DFT), UNCAT also recommended that detention be used only as a measure of last resort and that the 2010 version of the Enforcement Instructions and Guidance 'which allows for the detention of people with mental illness unless their mental illness is so serious it cannot be managed in detention' is amended.

5 Over the years, the UNHCR has raised numerous concerns about overuse of immigration detention in the UK and has criticised the Home Office for failing to fulfil its human rights duties. For example it noted that the Home Office has consistently exercised its detention powers purely for 'administrative convenience' and that 'the use of detention fails the necessity test required under international refugee and human rights law' .

These concerns have led to increasing parliamentary scrutiny of the detention system. For example, the Home Affairs Select Committee (HASC) has asked specific questions about vulnerable groups in detention and has questioned the Home Office repeatedly about the detention of torture survivors. In July 2012, the committee called for an independent review of the use of Rule 35 at Harmondsworth, the policy mechanism to review the detention and facilitate the release of torture survivors and others whose health may be harmed by detention. Most recently, the parliamentary inquiry into immigration detention called for a radical reform of the entire detention system.

The High Court has found that on no less than six occasions in a period of three years the Home Office breached its responsibilities under Article 3 of the European Convention on Human Rights (the right to freedom from torture, cruel and inhuman or degrading treatment).[6] These human rights breaches embarrass the UK internationally; they also demonstrate the systemic nature of the problem, the continuing failure to address the issue and the need for urgent action to prevent such abuses in the future.

Finally – and importantly – detainees themselves express concern about vulnerability in detention. A 2012 quantitative study of the quality of life in detention found that over half of those detainees interviewed felt that detention centres did not care for the most vulnerable.[7] Many individual testimonies and submissions made to the parliamentary detention inquiry panel also described their experience of vulnerability whilst in detention.

These criticisms have been mounting since 2010, when the guidance regarding the detention of vulnerable people[8] was amended without consultation. The Home Office subsequently argued that this effectively meant that detainees could be lawfully held in detention up to the point of requiring sectioning under the Mental Health Act, though in January 2014 the Court of Appeal rejected this interpretation.[9] Despite this, very little has changed on the ground.

Bearing in mind this background, we analyse interviews with, and case studies of, 31 vulnerable people who were detained in the UK. This exercise elicited three key observations.

1. that the Home Office has failed to follow its own guidance and continues to detain individuals they have recognised as members of 'vulnerable groups';

2. that detention centres are inadequate to meet the basic care needs of these individuals; and

3. that reliance on the categories of vulnerability within the current policy guidance overlooks the dynamic nature of vulnerability shaped by individual characteristics and changing over time. This means that detainees who do not fit within the pre-existing categories remain invisible and at risk.

Rather than suggest a new definition of vulnerability or an expansion of the number of categories used to identify and describe

6 European Convention on Human Rights (ECHR) (1953) Available at http://www.legislation.gov.uk/ukpga/1998/42/schedule/1

7 Bosworth, M. and Kellezi, B. (Feb 2012) Quality of Life in Detention: Results from MQLD Questionnaire Data Collected in IRC Yarl's Wood, IRC Tinsley House, and IRC Brook House, August 2010 - June 2011 Centre for Criminology, University of Oxford, available at [redacted]

8 UK Home Office Enforcement Instructions and Guidance, Chapter 55.10, available at: https://www.gov.uk/government/collections/enforcement-instructions-and-guidance

9 R (Das) v SSHD (2014) EWCA Civ 45

vulnerability, we will argue that all individuals are subject to becoming vulnerable within detention. Therefore, we believe that the Home Office should establish a new approach and process to prevent harm from detention in an on-going manner. This does not mean that there should be a weakening of existing safeguards against the detention of categories of vulnerable people. This new approach will require a re-conceptualisation of vulnerability that takes account of both individual characteristics and changes over time and sees vulnerability as dynamic, not static. It also requires a new attitude to vulnerability assessment; its objective should not be to reduce as far as possible the number of people who cannot be detained, but to prevent vulnerability from happening in detention.

Our study reveals the negative outcomes for those most at risk in detention, and proposes that alternatives to detention should be developed in the community for vulnerable and potentially vulnerable people so that they can go through the immigration system without experiencing detention. Here, we echo the recommendations made by the parliamentary detention inquiry panel and hope that the government takes steps to significantly reduce its use of immigration detention.

Our evidence gives a clear message that the detention of vulnerable people needs to be stopped, and we urge the government to act on our recommendations, so as to protect those in its care and to prevent further harm.

# 2. Methodology

## Background

The Detention Forum carried out qualitative primary research by collating case studies based on our daily contact with people in detention. This study is based on the findings of this primary research, complemented by a review of previous research by other NGOs, reports by national and international monitoring bodies, and a substantive review of recent case law on vulnerability in detention.

Our primary research is based on case studies of 31 detainees and former detainees. 24 of these were gathered from organisations that provide direct support for those detained. These were supplemented by seven qualitative interviews with detainees who agreed to participate in this way. The case studies were collated and analysed by a volunteer researcher, who also carried out the one-to-one interviews.

## Primary research: case studies

The sample for this research includes 31 detainees and ex-detainees held in UK Immigration Removal Centres (IRCs) in 2013. All were in contact with UK-based charities working in immigration detention support. Detainees were held in various centres up and down the country; some of them had been held in more than one. They were at various stages of the immigration process. Some had claimed asylum and others had not.

Some of these detainees had served a criminal prison sentence and were subsequently held under immigration act powers. Many of them had claimed asylum before or while serving their prison sentence. Such people are referred to in other literature as Foreign National Ex-Offenders or Ex-Foreign National Prisoners. We refer to them as ‘post-sentence detainees’.

## Case Studies

A call for case studies was sent to 30 organisations in the Detention Forum. Nine responded. A total of 24 case studies were gathered, via a proforma which asked a series of questions regarding wellbeing, length of time held, screening, response by the Home Office/IRC staff, and legal process. These case studies provided a means of gathering information on a wide range of vulnerability issues across several detention centres. A definition of vulnerability was avoided in the questionnaires, in order to broaden the scope of our study and include cases that did not fall into the categories of vulnerable individuals recognised in Home Office policy guidance.

The case study questionnaire is attached in the Appendix.

### Interviews

An additional seven detainees were included through interviews. All were contacted through the support organisations, who introduced the topic of the research and provided contact information when detainees expressed interest in participating. The interviews were conducted over the phone in all cases, and were recorded and transcribed, or recorded through detailed notes. Interviews provided the opportunity to discuss individual experiences in more detail, and thus highlighted factors that were not as apparent in the more structured questionnaires. The findings from the interviews are presented in the same format as the case studies.

### Ethical Considerations

Ethical considerations were central to this project. Because many of the participants were in detention or recently released, we chose to approach them through organisations which they already trusted rather than approaching them directly. The use of questionnaires meant that detainees did not have to re-tell their story to a stranger, but talked to someone from an organisation with which they already had a relationship.

The seven interviewees were approached first by organisations and then contacted by the researcher. In all cases at least one conversation was held between the detainee and the researcher prior to conducting the interview. Information and consent forms were also sent in writing to each of the interviewees. Participants were encouraged to ask questions, and assured that they could withdraw participation at any time. Two detainees decided not to participate following the preliminary discussion.

Data was collected and stored in a secure environment and pseudonyms were used in all cases. Unless otherwise agreed, all identifying information was removed.

### Limitations

The majority of the findings presented here are based on self-reporting by detainees or visitors' groups/NGOs involved in their case. Without reviewing all the medical and detention records it is impossible to cross-reference each of the stories, and some interviews include more information than others. Nevertheless, many of our findings are corroborated by previous research, by the recommendations of national and international monitoring bodies, and by recent case law Where this is the case, we have pointed it out.

The sample is limited to detainees who were known to or receiving support from a visitors' group or detention NGO. They probably represent a mere fraction of those who may be vulnerable, given the difficulties detainees

experience in contacting external support agencies from inside detention. It is also likely that our sample does not include the most vulnerable as they may not be in contact with support organisations.

On a more general note, our case studies were taken only from those who were held in IRCs and not from those held in prisons upon expiry of their sentence. There are understood to be up to 1000 such people at any one time. People held in prison are more likely to become vulnerable than those in IRCs due to the lack of safeguards such as Rule 35 of the Detention Centre Rules, difficulties in accessing legal advice and representation, lack of access to email and telephones, restricted visiting arrangements, and the more punitive environment and regime.

## Secondary evidence and case law

In addition to our primary research of case studies, we reviewed relevant UK case law and undertook a systematic review of literature on the issue of vulnerability in detention, including secondary evidence from other NGOs, the reports of international and national monitoring bodies and human rights mechanisms, and academic research.

# 3. Current policy and practice

Our case studies must be viewed within the current legal and policy context under which vulnerable people in the UK are detained. The primary policy guidance for officers dealing with immigration enforcement matters at the Home Office is Chapter 55.10 of the Enforcement Instructions and Guidance (the EIG), which is outlined below.

In addition, the Home Office has a duty to take into account the wider issues of vulnerability under the 'Hardial Singh principles', which require the Home Office to ensure that detention complies with the implied limits on the statutory power to detain. These state that detention should only be for the purposes of removal or deportation and only for a reasonable period. They were first handed down by Mr Justice Woolf 1983, and subsequently endorsed and explained by the senior courts in a number of cases, including R (I),[10] R (M),[11] and R (Das)[12], all in the Court of Appeal, and (R) Lumba[13] in the Supreme Court. All these judgments made the point that factors of harm, in these cases to a person's mental health, should be taken into account when assessing the *reasonableness* of detention.

## Home Office Policy

The Home Office frequently refers to detention as an integral part of effective immigration control, though according to Chapter 55.10 of the EIG the presumption should be to *favour release or temporary admission*, using detention only:

i. to effect removal;
ii. to initially establish a person's identity or basis of claim; or

10 R (I) v SSHD (2003) INLR 196 at para 48

11 R (M) v SSHD (2008) EWCA Civ 307

12 R (Das) v SSHD (2014) EWCA Civ 45 at para 16

13 R (Lumba) v SSHD (2011) UKSC at para 218

iii. where there is reason to believe that a person will fail to comply with conditions attached to the grant of temporary admission or release.

(The exception to this is the Detained Fast Track (DFT), when these presumptions do not apply).

In addition to the presumption in favour of release, the Home Office has outlined certain groups which should only be detained under *very exceptional circumstances*. These include families with a minor under the age of 18, and unaccompanied minors. The guidance states that unaccompanied minors who are to be returned to a European Union Member State may be detained to facilitate removal, but only on the day of the planned removal and not overnight.

Other groups listed as unsuitable for detention except in very exceptional circumstances are:

i. the elderly
ii. pregnant women
iii. those suffering from serious medical conditions
iv. those suffering from serious mental illness
v. those with independent evidence of a history of torture
vi. persons with serious disabilities
vii. persons identified as victims of trafficking.

In 2010 the Home Office pushed through changes to Chapter 55.10 without consultation. It now states that, while those suffering with *serious* mental illness and *serious* health conditions should not ordinarily be detained, this only applies if their conditions '*cannot be satisfactorily managed within detention*'. This new guidance has worried organisations that support people in detention[14], both because it appears to reverse the presumption against the detention of very ill people, but also because it does not define 'satisfactorily managed'. This leaves room for concern that the guidance will be applied arbitrarily, and our evidence bears this out.

This significant revision to the policy guidance was questioned by the Immigration Law Practitioners Association (ILPA) and other NGOs. In response, the Home Office (then UKBA) noted that the qualifier 'satisfactorily managed': *'is not defined, nor do we consider it necessary to do so. The phrase is intended to cover the broad basis on which a person's healthcare, mental health or physical needs might need to be met if they were to be detained, with the expectation being that where these needs cannot be met the persons concerned would not normally be suitable for detention.'* [15]

The policy change has also attracted criticism from judges, with one describing it as a '*seismic shift from the previous policy*.'[16] In 2012, in the case of R (HA)[17], the Court reviewed the legality of the changes to 55.10. It found that the 'reformulation' of the policy without conducting an equality impact assessment constituted a breach of the public sector equality duties under the Disability Discrimination Act 1995 and the Race Relations Act 1976 and, accordingly, declared the changes unlawful. It remains unclear how this policy change fits with the Home Office's positive duty of care towards those deprived of their liberty.

In early 2014 the Court of Appeal overturned an earlier High Court decision that had ruled in the Home Office's favour, when they argued that the definition of 'satisfactorily managed' equated to 'not requiring sectioning under

14 ILPA (Immigration Law Practitioners Association) (October 2010) Letter to UKBA re Enforcement Instructions and Guidance available at [redacted]

15 ILPA (Immigration Law Practitioners Association) (December 2010) Written response from Alan Kittle, Director of UKBA Detention Services to ILPA

16 R (AK) v SSHD (2011) EWHC 3188 at 16

17 R (HA) v SSHD (2012) EWHC 979 (Admin)

the Mental Health Act', even though the term 'satisfactorily managed' has no clinical meaning. Despite the Court of Appeal's judgement though the policy remains in place, and the ambiguity about what it actually means in practice remains.[18]

Chapter 55.10 applies equally to both non-offenders and post-sentence detainees. The cases of the latter, however, are subject to a risk assessment which takes into account the likelihood of reoffending and the harm this might cause to the public.[19] The HO maintains that there is a presumption in favour of temporary admission in all cases.

Once a person has been routed through detention, which can be anywhere in the UK, their access to family, friends, resources, outside organisations and legal advice are severely curtailed. This increases their level of vulnerability.

## Current safeguards in Detention

The EIG stipulates that a risk assessment should be conducted prior to detention or as soon as possible afterwards. The first handling authority should complete the IS91R form and serve it on each detained person. This form describes six reasons for detention based on 14 deciding factors. The guidance notes that risk assessment is an on-going process. In the case of a change in circumstances, information should be forwarded to the Detainee Escorting and Population Management Unit (DEPMU) using the IS91RA form part C. It also notes that it is important for a detainee to understand the contents of the IS91R once it has been served. Translation, when necessary, is obligatory, as a failure to provide this could lead to a successful challenge under the Human Rights Act Article 5(2) of the ECHR.

According to published Home Office policy, the IS91RA is the only risk assessment undertaken prior to detention. Unless a detainee explicitly refers to previous incidences of torture, mental health problems, or other vulnerabilities, they may be placed in detention.

The statutory provisions governing immigration detention, the Detention Centre Rules 2001, provide other rules and safeguards. One of the most strongly worded is Rule 35, which refers to those already detained, whose health may be 'injuriously affected' by continued detention. This includes any detained person suspected of suicidal intentions or who may have been a victim of torture. The stated purpose of Rule 35 is to '*ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention*'.

Under Rule 35, a report on the person at risk should be passed directly from a medical practitioner to the HO Case Owner to consider. They must then undertake a full review of the person's suitability for detention and respond within two working days. Those with vulnerabilities and past experiences of harm, which do not constitute torture, require particularly sensitive handling. Through this Rule 35 report, the medical practitioner may declare whether they think further detention will harm the detainee. If the practitioner believes that the response to their report is inadequate, the onus rests on him or her to pursue the matter through the management chain.[20]

Rule 9 of the Detention Centre Rules requires the monthly review of every detainee, to

18 R (Das) v SSHD (2014) supra

19 See the Home Office Enforcement Instructions and Guidance Chapter 55.1.3 for more detail on the risk assessment for post-sentence detainees, available at https://www.gov.uk/government/collections/enforcement-instructions-and-guidance

20 This is outlined in the Detention Service Order (DSO) 17/2012: Application of Detention Centre Rule 35', available at https://www.gov.uk/government/publications/application-of-detention-centre-rule-35

evaluate whether their detention is still justifiable. Chapter 55 also contains this requirement. Failure to conduct a monthly review has resulted in detention being deemed unlawful, for example in the case of Kambadzi (2011)[21], where the Supreme Court held that the breach of Chapter 55 rendered the claimant's detention unlawful.

In 2012, when the detention NGOs AVID and BID expressed concerns about mental health, the Home Office responded that from that date medical reports would be included in the monthly review.[22] This addition constituted a positive move forward, but the guidance is not listed explicitly on the Home Office website. And many of our case studies reveal that mental or physical illnesses were not included in the monthly report or detention review, even when well-known or very serious.

Our evidence suggests a picture of widespread failure to implement these supposed safeguards, leaving the most vulnerable at risk. The policy safeguards are no longer fit for purpose.

21 Kambadzi (2011) UKSC 23

22 AVID and BID (13th August 2012) Letter from Colin Punton, Director, Returns Directorate Crime and Enforcement Group to Ali McGinley (AVID) and Adeline Trude (BID)

'Mental health problems were evident for detainees in many centres, and some had reported significant trauma or torture. However the process intended to provide safeguards to detainees who were not fit to be detained, or had experiences of torture, did not appear to be effective.'[23]
**HMIP Annual Report 2010-11**

'We are concerned that the cases outlined above may not be isolated incidents but may reflect more systemic failures in relation to the treatment of mentally ill immigration detainees.'[24]
**Home Affairs Select Committee 2012**

'People simply deteriorate – suicide attempts and sectioning are common. The stress of being in a chaotic environment with the constant threat of deportation for many months is devastating for people with pre-existing vulnerabilities.'[25]
**Detention Action 2011**

'Vulnerable adults, such as those with mental health needs, continue to be held in each of the 11 Immigration Removal Centres around the UK. This is despite statutory obligations and UKBA's own stated policy guidance, which purports to prevent these groups from being detained. This leaves people with mental health needs at risk, without access to the services and supports they would otherwise have.'[26]
**Association of Visitors to Immigration Detainees (AVID), 2011**

'The practice of some states of transferring persons with serious psychological illnesses or those exhibiting serious signs of trauma or stress to provincial jails in lieu of any better alternatives ought to be considered a bad faith implementation of human rights obligations, and raises issues around violations of one's right liberty and security of person and against inhuman or degrading treatment.'[27]
**UNHCR 2011**

23 HM Chief Inspector of Prisons for England and Wales (2011) Annual Report 2010-11, available at http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hmip-annual-report-2010-11.pdf

24 Home Affairs Committee (HASC) (2012), The work of the UK Border Agency April-June 2012, available at [redacted]

25 Phelps J, Detention Action, cited in in MIND (2011) A Civilised Society: mental health provision for refugees and asylum seekers in England and Wales, p 9 [redacted]

26 AVID (Association of Visitors to Immigration Detainees) (2011) Parliamentary Briefing: Mental Health, available at [redacted]

27 Edwards A. (2011), Back to Basics: the right to liberty and security of person and 'alternatives to detention' of refugees, asylum-seekers, stateless persons and other migrants, UNHCR available at [redacted]

# 4. Findings

## 4.1 Introduction

This research stems from the premise that all detainees are vulnerable as a result of their detention. Research by UNHCR and the Jesuit Refugee Service, amongst others, has shown that the conditions of detention, especially prolonged detention, have negative impacts on every detainee's wellbeing.[28] In the UK, as outlined above, policy guidance on detention recognises that certain categories of people are exceptionally vulnerable and should not be detained.

In spite of this, many vulnerable people still suffer in detention every day. Our study includes people who met the criteria set out in the Home Office's own policy, yet continued to be detained. We also found evidence of broader vulnerabilities that did not fit within the criteria of the current policy. This suggests that not only is the current policy failing, it is also inadequate and leaves many at risk. We outline examples below.

### Cases

Thirty-one detainees participated in this research: five women and 26 men. Twenty-one of the 31 had made claims for asylum. Of these four had been granted refugee status by the time the case studies were gathered. The large majority of them had been held for prolonged periods, averaging 13 months. The shortest period was nine days, and the longest was 65 months. At the end of the research period, only two of the detainees had been removed from the country, eight remained in detention, and 21 had been released into the UK. Of those who had been released, three were in the process of making unlawful detention claims, and a fourth had been settled outside of court. Many had been released only after Judicial Reviews were submitted challenging their detention.

28 See, for example: Robjant K, Hassan R and Katona K (2009), Mental Health Implications of Detaining Asylum Seekers: systematic review British Journal of Psychiatry, Mar 2009, 194 (4) 306-312 194; McGinley A and Trude A (2012), Positive Duty of Care? The mental health crisis in immigration detention (AVID and BID), available at [redacted] Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project'), available at [redacted]

## 4.2 Detention in contravention of stated Home Office policy

### 4.2.1 Serious mental illness

'Immigration removal centres do not always offer sufficient care for detainees with mental health conditions.'[29]
**Equality and Human Rights Commission, 2012**

The most striking finding in our study is the high proportion of detainees who told us they had experienced mental ill health: 77%, or 24 people. The mental health needs of detainees have long been ignored, but in recent years they have come under increasing scrutiny through six cases where the detention of very seriously ill people were judged to constitute the breach of their Human Rights. Mental health is assessed on arrival in detention, but in our experience these assessments are often inadequate to establish the very complex range of needs of many detainees. Despite the policy safeguards in place to prevent those with very serious mental health needs from being detained, time and again our case studies reveal that many in detention are dealing with very serious mental health issues and are not

29 Equality and Human Rights Commission (2012) Human Rights Review 2012 p 25 available at [redacted]

receiving the care that they need. Further, a growing body of evidence substantiates that as detention continues, untreated mental health can deteriorate quite rapidly. Clearly the mechanisms currently used both to identify mental health needs prior to detention and to manage mental ill health in detention are grossly inadequate and put many people at risk.

## Our findings

An overwhelming majority of the detainees in our case studies (24, or 77%) had experienced a mental health issue. This number was no surprise to us as detention NGOs and visitors' groups; we have observed the negative impact of detention on mental health, and it is also well documented. The highest profile examples of this relate to the six breaches of Article 3 of the European Convention on Human Rights referred to above. Our research suggests that these cases are not isolated, but the tip of the iceberg, and that the problem is systemic.

In our research, eight (26%) of the detainees expressed suicidal ideations, and four of those were on ACDT (Accelerated Care in Detention and Teamwork), a form of self-harm prevention plan used in detention.[30]

In all cases, mental health worsened as detention continued. Concomitant with previous research,[31] detainees in our study who had previously considered their mental health to be good reported increasing symptoms of depression and in some cases more serious diagnoses, suggesting that detention may both exacerbate and cause mental health problems. Our evidence suggests that far from being 'satisfactorily managed', detainees' mental health issues are often ignored, up until the point that they become unmanageable. This may manifest in suicide attempts, hunger strike, or in some cases violence.

Nine of our cases involved detainees with mental health conditions that were clearly unmanageable in detention. Four of these detainees were held for over two months even though they were too unwell to communicate enough to allow for representations to be made on their behalf by visitors' groups or solicitors. In two further cases, depression and confusion severely diminished the detainees' desire and capacity to engage with their ongoing legal matters. This suggests that negative effects on mental health often have implications for detainees' asylum and immigration cases. In a number of cases depression led to increasing forgetfulness or confusion, which limited the detainees' capacity to engage with documentation attempts or to communicate their cases to visitors' groups and solicitors.

The impact of Post Traumatic Stress Disorder (PTSD) on asylum claims is especially significant. Worsening PTSD often creates substantial problems with memory, but any inconsistencies in asylum-seekers' stories are taken as an indication of a lack of credibility.[32] This is particularly important in lengthy stays in detention, which leave detainees increasingly vulnerable as their tools for coping diminish.

Jacques's case below illustrates a common process of the escalation of poor mental health over time in detention. Warning signals were ignored, making legal advice difficult, and detention continued.

30 The Assessment Care in Detention Teamwork self-harm reduction strategy aims to create a holistic approach to self-harm and suicide reduction that focuses on prevention. It requires that staff undergo training for suicide awareness and prevention strategies, and that any detainee who is considered to be at risk be placed on a plan and consistently monitored by staff. See Detention Services Order 6/2008 available at https://www.gov.uk/government/collections/detention-service-orders

31 See footnote 27 above.

32 See, for example, Kagan, M (2003) Is Truth in the Eye of the Beholder? Objective credibility assessment in refugee status determination, Georgetown Immigration Law Journal, 17, 367-415; Thomas, R (2006) Assessing the Credibility of Asylum Claims: EU and UK approaches examined, European Journal of Migration and Law, 8, 79-96

## Jacques

Jacques was detained for the purposes of removal to Denmark where he had previously claimed asylum. He had a traumatic history as a child soldier and was severely impacted by PTSD. Despite being visibly unwell, and despite anecdotal evidence of staff feeling unable to manage the situation, he was detained for over two months before being removed to Denmark.

During detention, Jacques suffered periodic blackouts and dizziness, which at least once led to injury. He was unable to communicate with staff or other detainees and exhibited erratic behaviour, at times running naked out of his room or speaking in what was understood by staff as gibberish. In response, Jacques was regularly placed in isolation, which appeared to exacerbate his confusion and paranoia.

The local visitors' group made efforts to raise concerns with the detention centre staff, but got no response from the healthcare centre. Attempts to support Jacques were made by a fellow detainee who spoke the same language as well as a solicitor who was willing to represent him for a temporary admission application and for unlawful detention. Jacques' paranoia made him unwilling to enter the room with the solicitor, and so it was impossible to represent him. Communication was so difficult that his fellow detainee was unable to do much to support him either.

In five cases, detainees had been diagnosed with severe mental illnesses prior to entering the detention centre. One detainee reported that his medication was changed when he arrived, without a consultation with a psychiatrist. He was not in fact seen by a psychiatrist until he began hunger strike, after six months of deteriorating mental health.

Five (16%) of the detainees in our study told us that requests to see psychiatrists were often ignored for months. In many cases, detainees were only seen and assessed following a suicide attempt or hunger strike. In these instances, attempting suicide and refusing food were a means of responding to extreme desperation and the enduring decline of mental health. A number of detainees suggested that they stopped attempting to access medical care because they knew it was hopeless.

*'Almost one month, without seeing the psychiatrist, I am totally mentally confused and I didn't see the psychiatrist before. I wanted to ask him because I can't sleep at night, I am forgetting things, and I wanted to ask him how I can improve, how can I help with my mental problems?'*
**W from Pakistan**

Insomnia is often reported as a common reaction to lack of activity and stimulus within detention centres. But research suggests that sleep should be taken as an important indicator of mental health, as it is significant in its impact on both cognitive capacities, and emotional imbalances.

### Case law

Recent case law substantiates our findings, demonstrating a consistent pattern of failures. Their seriousness can be best evidenced with reference to the six cases that were ruled to have amounted to 'inhuman and degrading treatment', breaching Article Three of the European Convention of Human Rights (the 'ECHR').[33] In all six cases, detention was

33 R (BA) v SSHD (2011) EWHC 2748 (Admin), R (HA (Nigeria)) v SSHD (2012) EWHC 979 (Admin), R (S) v SSHD

## Syed

Syed had pre-existing mental health conditions that were exacerbated by fleeing trauma in his home country. He was granted asylum with temporary leave to remain in another European country, but travelled to the UK to join family who helped him cope with his mental health issues. Although he had been documented as having a history of trauma and mental health issues, Syed had been detained for five months at the time of this study.

His engagement with his own asylum case diminished over his time in detention, and he reported feelings of extreme hopelessness, which led to suicidal ideations. Aware of his suicidal thoughts, the detention centre placed him in isolation units under constant supervision, which exacerbated his stress and led to increased incidences of self-harming.

Although Syed had family in the UK who supported him and helped him to handle his mental illness, he was refused bail on the grounds that removal was imminent (despite being detained for five months). Medical notes suggested a belief that he would not follow through on his suicidal thoughts, limiting the impact of the Rule 35. As a result of his ongoing separation and feelings of hopelessness, Syed had a diminished sense of agency in dealing with his case, and focused instead on regaining hisautonomy through suicide.

*'It's my life, I should be able to do what I want with it. I have no hope… you are trying to give me hope but I know it is hopeless.'*

maintained despite the Home Office being aware that the individuals had a history of mental illness. The psychiatric reports conducted prior to or during detention indicated, in each case, that the detainee's condition was likely to deteriorate if detention continued.

For example in the case of S, the Court found that: '*The defendant failed here to have in place measures which were designed to ensure that S was not subjected such treatment. Such procedures which were in place were not utilised to deal effectively with S's condition nor sufficient to ensure a timely response to it. Further, the procedures in place were not such that they were treated with an appropriate level of seriousness or urgency and the attention to S's condition was inadequate, as the successive reviews of S's detention all too clearly illustrate.*'[34]

Similarly, in R (HA), it took five months to provide the detainee with hospital treatment, even though the medical report advised 'urgent' hospitalisation. In another, the case of R (BA), continued detention was authorised, despite the fact that a psychiatric assessment stated a risk of death if detention continued.

These cases demonstrate very serious failings on the part of the Home Office to adequately identify and treat mental illness or to act upon the recommendations of medical professionals. This was most clearly described by Deputy Judge Laing QC in R (BA). She referred to a '*callous indifference to BA's plight*' and a '*deplorable failure, from the outset, by those responsible for BA's detention to recognise the nature and extent of BA's illness.*' She concluded that the breach of Article 3

(2012) EWHC 1939 (Admin), R (D) v SSHD (2012) EWHC 2501 (Admin), R (Das) V SSHD (2014) EWCA Civ 45, R (S) v SSHD (2014) EWHC 50 (Admin)

34 R(S) 2012 at 215

occurred due to '*a combination of bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare.*'[35]

Similar findings were made in R (S) where, in the Court's judgment, the policy '*was not properly understood by those authorising detention and was certainly not properly applied*' and '*the decision and subsequent reviews failed to both understand and assess the impact of detention on S's mental condition.*'[36]

In several claims made by vulnerable detainees, UK case law has found detention unlawful on the grounds that the Secretary of State for the Home Department (SSHD) failed to follow her own policy contained in Chapter 55.10. Typically this was through lack of reference to the policy itself, even where Home Office staff were made aware of the mental health need.[37] In some instances, the Home Office failed to follow the guidance contained in Chapter 55.10 even where a clear deterioration in a detainee's health was observed and medical treatment provided.

Case law evidence also demonstrates that the initial decision to detain a person with a history of serious mental illness is often made automatically and without careful consideration of all relevant factors. The Court has emphasised, on numerous occasions, that the existence of 'exceptional circumstances' justifying detention under Chapter 55.10, demands both '*quantitative and qualitative judgment*', and that consideration must be given to the nature and severity of any mental health problem and how it may be impacted by continuing detention Despite this, decisions to detain continue to be made primarily on the basis of whether someone has a previous criminal conviction and with little regard to their condition or to medical evidence which suggests that it may be aggravated by detention.

In addition to the failure to consider pre-existing medical conditions on entry to detention, case law also substantiates our findings that detention staff routinely fail to act upon signs of deterioration in detainees' mental health. For example R (D), who was diagnosed with paranoid schizophrenia prior to his detention, was held without psychiatric medication or treatment for several months. In this time his symptoms worsened, eventually culminating in a psychotic breakdown and loss of capacity.[38] Like Jacques in our study, his deterioration did not result in release from detention. Similarly, in the aforementioned case of R (HA),[39] the response to a detainee with serious mental problems who was sleeping naked on the floor, often in a toilet area, and drinking and washing from the toilet, was to keep him in isolation for prolonged periods of time.

## Secondary evidence

Various academic and NGO research studies have responded to the increasing levels of mental illness in immigration detention. One of the few qualitative academic studies in this area examined the quality of life of 158 detainees in Yarl's Wood, Brook and Tinsley detention centres between August 2010 and June 2011. It found high levels of stress, with 82.9% of detainees (131 people) classified as suffering from depression.[40] This

35 R (BA) v SSHD At 236-238

36 R (S) 2012 supra at 182

37 R (LE (Jamaica)) v SSHD (2012) EWCA Civ 597, R (S) v SSHD (2012) EWHC 1939 (Admin), R (D) v SSHD (2012) EWHC 2501 (Admin), R (EH) v SSHD (2012) EWHC 2569 (Admin), R (Das) v SSHD (2013) EWHC 682 (Admin)

38 R (D) v SSHD (2012) EWHC 2501 (Admin)

39 R (HA) v SSHD (2012) EWHC 979 (Admin)

40 Bosworth, M. and Kellezi, B. (Feb 2012) Quality of Life in Detention: Results from MQLD Questionnaire Data Collected in IRC Yarl's Wood, IRC Tinsley House, and IRC Brook House, August 2010 - June 2011 Centre for Criminology, University of Oxford, available at http://border-

is a startlingly high statistic, but one which mirrors our own case study evidence.

A joint paper by the Association of Visitors to Immigration Detainees (AVID) and Bail for Immigration Detainees (BID) raises questions about the UK Home Office's duty of care regarding the detention of the mentally ill, describing a 'crisis' in detention and questioning whether individuals can be 'satisfactorily managed' in detention 'where the fact of detention is itself a trigger for mental distress'.[41]

A study into the impact of indefinite detention on mental health, by Detention Action, describes the impact on detainees' wellbeing of witnessing other detainees' attempts to harm or kill themselves. It also describes the mental anguish suffered by detainees, many of whom had no previously diagnosed conditions: hearing voices, talking to themselves, memory problems, problems sleeping.[42] Expert medical charities such as Medical Justice have also found that '*management of people with mental illness is inadequate... There are delays in arranging psychiatric assessments, delays in arranging transfers to hospital or releasing individuals found to be unfit for detention*'.[43] These delays in accessing secondary mental health care for detainees were referred to as 'unacceptable' by the Immigration Minister in 2011, yet they continued on his watch.[44] Clinical professionals add weight to this, for example the Royal College of Psychiatrists Working Group on Mental Health and Asylum has stated:

'*We feel that detention centres are not appropriate therapeutic environments to promote recovery from mental ill health due to the nature of the environment and the lack of specialist mental health treatment resources.*'[45]

This is reinforced by the recommendations and findings of UK statutory monitoring bodies. HMIP and the IMB have repeatedly raised concerns about the impact of detention on mental health. For example the IMB at Harmondsworth stated: '*We have seen no evidence in 2012 that the review of mental health provision in IRCs is underway. We continue to be shocked by the detention of those who are mentally ill.*'[46] HMIP have raised similar concerns on several occasions, commenting on the lack of staff training on mental health the limited provision available, and the inappropriate use of segregation to manage mental ill health. The Equality and Human Rights Commission has suggested that the government is not taking sufficient steps to safeguard the lives of those in its care; it describes the provision of mental health care in immigration detention as 'not always adequate' given the high levels of need.[47]

Academic studies add weight to this growing body of criticism. In a study monitoring immigration detainees over a nine-month period, 85% reported chronic depressive symptoms, 65% reported suicidal ideation, 39% experienced paranoid delusions, 21% showed signs of psychosis and 57% required

[redacted]

41 McGinley A and Trude A (2012), Positive Duty of Care? The mental health crisis in immigration detention (AVID and BID), available at: [redacted]

42 Detention Action, (2009) Detained Lives: the real cost of indefinite immigration detention

43 Medical Justice (2012) The Second Torture: immigration detention of torture survivors, p 95, available at [redacted]

44 HC Deb, 7 March 2011, C870W

45 Royal College of Psychiatrists (October 2013), Position Statement on detention of people with mental disorders in Immigration Removal Centres, available at [redacted]

46 Independent Monitoring Board for Harmondsworth (2013) Annual Report 2012, p5

47 Equality and Human Rights Commission (2012) Human Rights Review 2012, p440

systematic medication.[48] Another study reported that the estimated percentage of self-harming in Immigration Removal Centres (IRCs) during a twelve month period was 12.79%, compared with between 5% – 10% in the prison community.[49]

## 4.2.2 Victims of torture

Almost one third of our cases involved detainees with a history of torture. Due to the psychological and physical impact of torture, Home Office policy and international guidelines suggest that victims of torture should only be detained in very exceptional circumstances.[50] The primary policy safeguards against detention for victims of torture are Rules 34 and 35 of the Detention Centre Rules (2001). However, while official policy seeks to keep those who are victims of torture out of detention, the inadequacy of the Rule 35 process has been highlighted time and again by NGOs, the courts, and even in parliament. Home Office decision-making on detaining torture survivors has also been shown to be poor, many cases being overturned on appeal. Our evidence substantiates this.

### Our findings

Nine (30%) of our cases involved asylum applicants who had a history of torture. In three of the cases, the history of torture was declared in the substantive interview, but decision-makers did not follow it up. All three were subsequently detained and none of them were provided with medical review or Rule 35 reports to determine the validity of their claim. In three separate cases, Rule 35 reports were issued by detention centre medical staff, but initially disbelieved by the Home Office and, in one case, by the appeals judge, despite being substantiated by medical practitioners. One detainee was granted Indefinite Leave to Remain in 1994 on the basis of past persecution and torture, but in spite of this he was detained again for nine months in 2012 on a deportation order before eventually being released back to the UK.

48 Robjant K, Hassan R and Katona K (2009), Mental Health Implications of Detaining Asylum Seekers: systematic review British Journal of Psychiatry, Mar 2009, 194 (4) 306-312, p307

49 Cohen J. (2008), Safe in Our Hands? A study of suicide and self-harm in asylum seekers (2008), J Forensic Leg Med. 2008 May;15(4):235-44

50 UNHCR (2012) Detention Guidelines: guidelines on the applicable criteria and standards relating to the detention of asylum-seekers and alternatives to detention, p 33, available at [redacted]

## Tapiwa

Tapiwa fled his home country after being detained and tortured by the government in relation to his connection with the military. He was arrested in the UK for using false papers. While in prison he received news that colleagues had been killed in his home country, learned of the possibility of claiming asylum and made a claim. He was refused asylum and his claims of torture were disbelieved. Despite making these claims known, he was not provided with a medical review or Rule 35 report during his first detention and, because he was not aware that this was the necessary process, he did not ask for screening. He was released after three months.

Tapiwa pursued his asylum claim for six years and was re-detained after being found working in the community. During his second detention he was held for nine months and educated himself about the asylum process. He requested medical reports and two Rule 35 reports substantiated his claims of torture. He was also diagnosed with PTSD.

Tapiwa says his history in the military gave him the knowledge necessary to deal with the detention centre staff. He also describes the positive impact of being able to represent his own case and of using his educational background to help other detainees. In spite of this Tapiwa's mental health deteriorated during his second detention; he began getting panic attacks and had difficulty with sleep and appetite. Although he felt himself healthy prior to detention, his time in detention still affected him after release.

The HO refused Tapiwa's applications for bail under the claim that he constituted a risk to the public if released, despite having no history of violence and no criminal history other than working without documentation and using false papers in order to flee the danger of his home country.

Analysis of these cases suggests that detainees found it difficult to access medical services that should have provided screening to corroborate their claims of torture. This probably contributed to the long periods of detention they experienced. This is especially true for detainees who were transferred from prison to detention centres. In the majority of the cases involving torture, detainees were held for extended periods of time, even after Rule 35 reports were issued.

In all but two of these torture cases Rule 35 reports were issued during some point in the process (seven cases, 77%). However, several detainees faced significant barriers in accessing medical appointments to detail their claims of torture. Even those with obvious scarring were ignored until outside organisations got involved. Two detainees were not issued a Rule 35 until their second detention, despite making their claims clear during the first detention. Our case studies suggest that applicants may have to take the initiative in pursuing Rule 35 reports.

Several of these detainees said that nursing staff had ignored their requests for appointments with IRC doctors. In one case a Rule 35 was not initially issued because the health practitioners deemed the torture not to have been state-sponsored, a clear violation of protocol.

## Sam

Sam has a history of torture and imprisonment in his home country. He was detained in the UK for four months during which his mental health deteriorated rapidly. Outside detention, Sam's PTSD was manageable; but being held in a locked room reminded him of his experiences in his home country and this had a serious impact on his mental health. Before he was released, he was experiencing auditory hallucinations and had become suicidal.

At times Sam resorted to banging his head against the wall in order to quieten the voices he was hearing. Despite his visible indications of trauma, the majority of his claim was disbelieved. Rather than reporting on his poor mental health in detention, his Rule 35 report reiterated the Home Office's disbelief of his claims of past persecution. Although Sam was placed on an Assessment Care in Detention Teamwork (ACDT) suicide prevention strategy, medical notes suggested doubt of his hallucinations and suicidal ideation and claimed Sam was using the ACDT as a 'crutch'. This was despite entries in the same notes documenting Sam's reports of voices telling him to commit suicide.

In addition to Sam's attempts to tell the health care staff that he was unwell and unable to eat, concerns were raised to the Home Office by his solicitor, visitors' groups and the Helen Bamber Foundation. Despite these representations, it was two months before Sam was eventually released on bail.

Rule 35 provides one of the only safeguards for detainees who do not enter with independent medical evidence or who were too traumatised to describe their past experiences at the screening or substantive interview. Rule 35 should ensure that victims of torture like Sam are not detained, or that they are released once the history of torture is known. In seven of our cases, Rule 35 reports were issued that substantiated the claims for torture; five of these resulted in eventual release, following stays in detention ranging from one month to nine months. In May 2013, a High Court case found the detention of four victims of torture to be unlawful.[51] As these people were not part of our study, this corroborates the likelihood that the failures we found are endemic to the system.

Evidence suggests that detention is particularly damaging for individuals with a history of torture.[52] All nine torture cases in our study exhibited worsening mental health during detention. The majority were diagnosed at some point with PTSD, but only two detainees reported receiving psychological support, and they felt that the support they received was inadequate.

Although the mental health of all nine detainees got worse, their ability to cope with the stressors within detention varied substantially. After months of being detained without support for deteriorating mental health conditions, two detainees attempted suicide and one was reportedly on hunger strike for a total of 60 days. Tapiwa's case above suggests that without proper screening even a person who has strong coping mechanisms may find that their mental health deteriorates over time.

Two detainees with PTSD symptoms suffered lasting effects even after release. These included serious weight loss, lack of appetite, difficulty sleeping and flashbacks.

51 [redacted]

52 ECHR (2012) Submission to the UN Committee against Torture: list of issues on the UK's 5th Periodic Report, p28, available at [redacted]

[redacted]

## Case Law

The courts have found serious problems in the way that the Home Office has implemented its own policy towards torture survivors. In EO & Ors, R[53], a case which concerned five detainees who had experienced torture in their country of origin, the authorities had failed to conduct a medical examination within 24 hours of arrival in detention. This rendered the detention of three of the five unlawful. Similarly in R(RT) v SSHD[54] the High Court found that the failure to explain the purpose of a Rule 34 medical examination (within 24 hours) to a detainee who had suffered rape and torture rendered their detention unlawful from shortly after the time at which a proper medical examination should have taken place.

## Secondary Evidence

Research suggests that it is often difficult for those who have been traumatised to retell their experiences in a coherent manner, creating difficulties in assessing their cases. UNHCR advises that if torture victims are detained, both initial and periodic assessments are necessary to monitor the mental and physical impacts of detention.[55] Detainees with a history of torture who are detained in the UK have referred to the psychological and physical impact of detention as a 'second torture'. In 2012 the Medical Justice report, *The Second Torture: the immigration detention of torture survivors* highlighted the failures in Rule 35 processes, and referred to 'a lack of sympathy and professionalism of the staff' in their treatment of detainees who had survived torture.[56]

These findings have been echoed by HMIP. For instance, their 2010-11 Annual Report found that '*the process intended to provide safeguards to detainees who were not fit to be detained, or had experience of torture, did not appear to be effective.*'[57] They also stated that Home Office caseworker responses to Rule 35 reports were often 'insubstantial and dismissive'. This failure was 'an unacceptable state of affairs'.[58] Their individual inspection reports on detention centres also frequently find that Rule 35 safeguards are not implemented properly. Our case studies back this up.

Numerous NGOs have voiced concerns over many years regarding the application of Rule 35, and lobbied hard for an audit into its use. This was finally carried out by the Home Office in late 2009. The results, which were not published until February 2011, showed that just 9% of Rule 35 reports resulted in release, raising questions over the efficacy of the decision-making process.[59] Significantly the audit contained no analysis of the quality of decision-making. It drew widespread criticism from groups who work with detainees.[60]

A growing body of literature suggests that the process of identifying torture victims

53 EO & Ors, R (on the application of) v SSHD (2013) EWHC 1236 (Admin)

54 R(RT) v SSHD (2011) EWHC 1792 (Admin)

55 UNHCR (2012) Detention Guidelines: guidelines on the applicable criteria and standards relating to the detention of asylum-seekers and alternatives to detention, available at [redacted]

56 Medical Justice (2012) The Second Torture: immigration detention of torture survivors, p 51, available at [redacted]

57 HM Chief Inspector of Prisons for England and Wales (2011) Annual Report 2010-11, available at http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hmip-annual-report-2010-11.pdf

58 ibid

59 UK Border Agency (2011), Detention Centre Rule 35 Audit available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257174/det-centre-rule-35-audit.pdf

60 See for example Medical Justice press release 4th March 2011 at [redacted]

is particularly poor.[61] Even when expert medical evidence is available, wrong decisions are often made at the initial stage – as demonstrated by the rate of overturn on appeal.[62] Doctors and experts from Medical Justice examined 56 cases over a six-month period in 2007 and found that physical signs 'consistent with or typical of' torture (as defined by the Istanbul Protocol on the Reporting of Torture) were being ignored by the Home Office and that detainees with a history of torture were being held for lengthy periods.[63]

61 See for example Medical Justice (2012) The Second Torture: immigration detention of torture survivors,; Freedom from Torture (2011), Body of Evidence: treatment of medico-legal reports for survivors of torture in the UK Asylum Tribunal, available at [redacted] Amnesty International and Still Human Still Here (2013), A question of credibility: why so many initial asylum decisions are overturned on appeal in the UK, available at [redacted]

62 Freedom from Torture (2011), Body of Evidence: treatment of medico-legal reports for survivors of torture in the UK Asylum Tribunal, p36

63 Medical Justice (2008) 56 case-studies, available at [redacted]

## 4.2.3 Serious disabilities

Detainees with disabilities face additional and serious barriers to accessing basic provisions in detention. Guidance states that those with serious disabilities should only be held in exceptional circumstances and that individual care plans should be put in place for them. Despite this, detainees with disabilities were often not prioritised, and had to argue proactively for any additional provisions that were made. Our cases raise concerns about current safeguarding provisions, about Home Office standards for 'adequate provisions', and about decisions to detain.

### Our evidence

Four cases involved detainees with serious disabilities, three physical and one a learning disability. Home Office guidelines (Chapter 55.10) state that individuals with serious disabilities, which cannot be satisfactorily managed in detention, should only be detained in exceptional circumstances. Our case studies illustrate the difficulties in managing the needs of those with serious disabilities in detention, not least because of the lack of physical space.

The cases also raise concerns about the safeguarding provisions currently in place for disabled detainees, about Home Office standards for 'adequate provisions', and about decisions to detain. All three detainees with a physical disability were held for over seven months, despite having little to no possibility of imminent removal and limited liability as a flight risk. In one case, the detainee was only released when the High Court accepted their unlawful detention claim.

**The consolidated Detention Service Order (DSO) manual released in 2005 outlines the provisions necessary for disabled detainees:**

- The Centre must ensure that procedures are in place to prevent discrimination against detainees on the grounds of disability and that local arrangements are in place to reflect this.
- Arrangements must be made for an assessment of detainees' needs during reception. A record detailing specific communication and mobility needs of disabled detainees must be kept.
- Allocation of accommodation must be suitable to the needs of disabled detainees.
- Auxiliary aids or services as available in the community should be provided so that disabled detainees are able to make use of the centre's facilities.
- The Centre must provide appropriate services for detainees who have a hearing impairment.
- Detainees with disabilities must have access to education, library and, as far as practical, to physical education.
- There must be a system of monitoring the number of disabled detainees who are unable to participate in activities by reason of their disability.[64]

The cases we found suggest that contrary to the guidance above, special provisions are rarely personalised, and so do not meet the specific needs of individual disabled detainees. In three separate detention centres, the provisions offered to detainees was insufficient and resulted in limited access to basic services.

64 UKBA (2008), Detention Services Operating Standards Manual for Immigration Removal Centres (Consolidated version), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257352/operatingstandards_manual.pdf

## Osman

*'Every one of the adjustments that have been made so far, I have had to push for and this is primarily because no needs assessment was done for me upon arrival at the centre. This is despite the fact that I declared my disability immediately upon arrival to the centre.'*

Osman's leg was amputated as a result of bone cancer. Despite making this disability clear to the Home Office prior to detention, Osman was detained for over seven months. Upon arrival, he was housed in the health clinic for four weeks due to insufficient provisions in other areas of the detention centre. Contrary to detention policy, a needs assessment was not done until five months after his arrival and only after he had pressed for it himself and requested a meeting with the diversity manager.

Although he was eventually moved to the 'disabled room', Osman found that the toilet was the wrong height, which resulted in difficulties using it. He was accommodated on the ground floor for evacuation reasons, but this meant that he had to climb a flight of stairs to the shower. The descent afterwards was particularly dangerous because his crutches became slippery from the shower, creating a regular safety hazard. Osman relied on other detainees to bring him his food for six weeks before staff responded to his complaints and provided regular access to meals.

In response to these difficulties, Osman repeatedly self-advocated, engaging with caseworkers and detention centre managers in order to ensure his needs were met. He was often referred back and forth from Serco staff to Home Office staff, without seeing any improvements and with little accountability.

Osman's requests for bail were denied due to Home Office claims that his removal was imminent. The Home Office issued three separate removal directions despite the fact that the High Commissioner of his home country had refused to grant travel documents as a result of outstanding medical appointments.

Detention centre staff are often not aware of the daily needs of disabled detainees. In Osman's case, services were provided in an ad-hoc manner, often in response to complaints made by Osman himself. In another case, the Diversity Manager reportedly told the detainee that he had not even seen the disability manual, and that these manuals are often created but then not passed on to the relevant managers. This shows that even where provisions are put in place, the system is not designed to ensure that adequate action is taken. Detainees are left to push proactively for provisions to be made.

Although the adjustments Osman needed were eventually provided, most of these provisions were only made after persistent requests by Osman himself. A less empowered detainee, who lacked language and literacy skills, knowledge of basic rights, or support from outside organisations or solicitors, would find it even more difficult to access support – it is likely that their individual needs would not be met.

The UN Convention on the Rights of Persons with Disabilities states that failure to provide adequate services for disabled individuals amounts to discrimination and that a lack of basic services could amount to cruel, inhumane and degrading treatment.[65] Furthermore, under the Equality Act 2010 comprehensive protection for disabled detainees should be

65 Lawson A (2012), Disability Equality, Reasonable Accommodation and the Avoidance of Ill-treatment in Places of Detention: the role of supranational monitoring and inspection bodies, The International Journal of Human Rights, 16, 6, 845-864 Rights, 16, 6, 845-864

provided, including a duty to make reasonable adjustments.

Like Osman, Claire also experienced difficulties in accessing such basic provisions as meals and personal hygiene. In Claire's case the humiliations she experienced while in detention continued to impact her after her release.

A third detainee, with multiple physical disabilities and complicated HIV and Hepatitis C infections, was detained for over ten months despite medical reports finding him unfit for detention and unfit to fly. The IRC medical staff declared him unfit to attend interviews at his home country's embassy. His medication was repeatedly interrupted during his detention, because his limited mobility meant that he could not reach the medical centre without support from staff.

One detainee in our study was recognised as having a learning disability. Despite a long psychiatric report commissioned by his solicitor detailing various mental health issues and learning disabilities, he was detained twice, the first time for somewhere between six and eight months.

## Claire

Claire is paralysed on one side of her body as a result of a stroke and walks with the aid of a stick. She also has heart problems, which leave her feeling constantly tired. She was detained following a prison sentence in an attempt to deport her. Medical reports stated that she would never be fit to fly, even for short distances.

For the first six months of her detention, Claire had no access to breakfast, despite needing to take her morning pills with food. Her disabled room was on the ground floor. The cafeteria upstairs was accessible by lift, but no staff members were available to operate the lift at breakfast time. Following a written request to the Home Office, Claire was granted provision of breakfast in her room. Additionally, although she was in the disabled room, Claire was not provided with a shower seat, which limited her ability to wash for over a month.

Claire was finally released after 15 months when Home Office doctors reiterated previous medical reports that her conditions meant she would never be fit to fly. She is currently visiting a psychiatrist, but finds that her time in detention is too painful to discuss.

### Case Law

In 2011, the High Court considered the lawfulness of the detention of an Iranian man, BE.[66] The claimant suffered a degenerative condition that resulted in the amputation of his leg above the knee when he was young, leaving a deformed and painful stump. Having had his leave to remain in the UK revoked following a criminal conviction, he was detained pending deportation in progressively unsuitable conditions. After two years of detention, he was moved to accommodation that was so unsuitable that he could not access basic sanitation facilities without risk of injury. BE challenged the legality of his detention and claimed a breach of the Disability Discrimination Act (DDA). In an important judgment, the High Court found his detention to have become unlawful after 26 months. Moreover, while BE was not deemed to be entitled to compensation under the DDA, the High Court found that the Home Office had failed to have due regard to his needs because it had not ensured that he was held in suitable accommodation.

66 BE, R (on the application of) v Secretary of State for the Home Department (2011) EWHC 690 (Admin)

## 4.2.4 Victims of trafficking

Although the Home Office has a clear obligation to identify and protect victims of trafficking, many end up in detention, often after a prison sentence related to their circumstances as a victim.

One of our case studies concerned the issue of trafficking.

Retta was not initially believed and then was not effectively supported, even when a further vulnerability factor emerged. Trafficking cases are often very complex, and the full picture rarely emerges immediately, but despite this many trafficking victims are put on the Detained Fast Track, with little or no provision made for their full assessment or for appropriate care while in detention.

### Retta

Retta was brought up by her aunt in her home country, but was badly treated and forced into prostitution. She was then trafficked to the UK and forced to work in a brothel, which she was not allowed to leave. She eventually stole some money and managed to escape, only to be put into detention on the Detained Fast Track. The UKBA initially refused to believe that she was a victim of trafficking, but this was challenged when an NGO intervened and referred her into the National Trafficking Referral Mechanism. She was diagnosed HIV-positive while in detention, but again only after the intervention of an NGO who recommended she request a test, as she had not been offered this either by the UKBA or by the security company who ran the detention centre.

No Rule 35 report was made, and an application to the UKBA for temporary admission was refused, but she was eventually released on bail by the Immigration and Asylum Tribunal. Once it was discovered that Retta was HIV-positive she was given basic counselling, but it was left to a local NGO to make a referral to a local HIV support charity. She was detained for over five months before being released, and is now awaiting the outcome of a fresh claim based on the risk of being re-trafficked upon return.

### Secondary Evidence

In its Human Rights Review 2012,[67] the Equality and Human Rights Commission highlighted the State's positive obligation to identify and protect victims of trafficking and found that, '*victims of trafficking whose situation is not brought to the attention of the authorities may be criminalised or sent to immigration detention centres*'. In their 2013 inspection of Yarl's Wood IRC, HMIP found that *'detainees who had clear trafficking indicators – such as one woman who had been picked up in a brothel – had not been referred to the national trafficking referral mechanism as required.*'[68]

The Poppy Project, which works with women who have been trafficked into the UK, reported in October 2011 that they had come into contact with 180 victims of trafficking detained at Yarl's Wood IRC[69] since 1st April 2009, when the UK adopted the Council of Europe Convention on Action against Trafficking in Human Beings. The experience of many NGOs working with detainees is that not only are victims of trafficking rarely identified or believed on first contact with the

67 Equality and Human Rights Commission (2012) Human Rights Review 2012

68 Her Majesty's Inspector of Prisons (2013), Report on an unannounced inspection of Yarls' Wood IRC p6, available at http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/Yarls-Wood-2013.pdf

69 London Evening Standard, 21st Oct 2011, Scandal of Trafficked Women held in UK

Home Office, but that they are also frequently criminalised by being prosecuted for being in the country illegally or for possessing false documentation.

## 4.2.5 Age-disputed children

Many young asylum seekers who claim to be under 18 but whose age is disputed by the Home Office are detained. This is often due to the inadequacy of an initial age assessment conducted by social services prior to detention, which may not be compliant with the principles laid down in the Merton judgement of 2003, giving clear guidance as to how such assessments should be conducted in a clear, transparent and fair way.

### Our findings

Home Office policy is clear that those under 18 should not be detained. However, our case studies included a minor of 15 years of age, who was detained for six months before it was finally accepted that he was a child. He was then released to social services' care. Although this is an individual case, research suggests that there are persistent difficulties and problems with age assessments that are subject to error.[70]

Eric claimed to be 15 years of age from the beginning of his asylum claim. He was found to be over the age of 18 in an initial age assessment; however, the Refugee Council's Children's Panel and the solicitor involved disputed the assessment.

Despite the continued challenge to the initial age assessment, the Home Office kept Eric in detention for six months without pursuing an alternative assessment. During his time in detention Eric became increasingly upset and confused. In addition to his young age, Eric had very little understanding of English and thus required the support of another detainee who acted as a translator throughout the process.

### Case law

In a case in 2012, the Home Office was found to have falsely imprisoned a 15-year-old boy who entered the UK on the back of a lorry[71] and thereby to have breached the Human Rights Act and Article 5 of the European Convention of Human Rights. His initial age assessment, conducted by social services, found him to be 18 years of age. It was not conducted in accordance with the Merton principles, and the Immigration Officer involved failed to check. The Upper Tribunal eventually determined that his age had been 15, as stated, and he was awarded damages.

### Secondary evidence

In their Annual Report 2011-12, HMIP reported that *'age disputes continued to occur across the estate*', and described in particular a case at Haslar where *'UKBA caseworkers did not respond promptly to new documentary evidence showing that a detainee was under 18, which led to a child being unnecessarily detained. He was subsequently confirmed as a minor and moved to social services care.'*[72]

There are currently no accurate statistics on

70 See for example Coram Children's Legal Centre (2010) Age Disputes available at: [redacted] and also Coram Children's Legal Centre (2013) Happy Birthday? Disputing the Age of Children in the Immigration System, available at [redacted]

71 AAM (a child) v SSHD (2012) EWHC 2567 (QB)

72 HMIP, Annual Report 2011-2012 available at http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2011-12.pdf

the number of age-disputed minors detained, but Home Office statistics suggest nearly a quarter of all those that claim asylum as children have their age disputed.[73] A report by the Coram Children's Legal Centre states that this is not the full extent of the problem, in that many who claim to be children are not considered 'age-disputed' and are treated as adults throughout the process. Of cases seen by Refugee Council in 2011, 22 of 38 cases with age disputes were found to be under the age of 18.[74]

## 4.2.6 The elderly

None of our case studies were elderly detainees. The numbers of this group in detention are in fact relatively small. Nonetheless their needs are very specific and the recent death in detention – and in handcuffs – of an 84-year-old man attests the need to consider the impact of detention policy and practice on this particular group. Comparisons can be drawn with the prison system where evidence has shown the disproportionate impact of incarceration on older people.

Chapter 55.10 of the Enforcement Instructions and Guidance recognises that elderly people may need additional care and outlines that they should only be detained in exceptional circumstances. This is especially true *'where significant or constant supervision is required which cannot be satisfactorily managed within detention*'.

While none of our case studies involved an elderly detainee, the death of an 84-year-old in detention recently highlighted the complex needs of some older people, which may not be able to be met in immigration detention. Alois Dvorzac died in February 2013 after having become ill at Harmondsworth detention centre.[75] He was a Canadian national of Slovenian descent who was described as 'extremely distressed' and had been assessed as unfit for detention and requiring social care. Despite this he remained in detention for several days before being rushed to hospital, where he later died of a suspected heart attack whilst still being held in handcuffs. It is not clear how long he had been held.

The IMB at Harmondsworth IRC has highlighted that elderly people 'suffer a great deal of distress' in detention.[76] Unfortunately, statistics on elderly detainees are not produced in the quarterly Home Office bulletins, so there is no way of knowing whether the number of elderly people in detention has risen since the changes made to the EIG in 2010. It is unclear how the Home Office can ensure that the particular health and social care needs of elderly detainees are 'satisfactorily managed' if it does not collate these statistics.

However, parallels can be drawn between immigration detention and the prison system, where a series of reports have highlighted the special needs of older people. In 2004, an HMIP report criticised the lack of care available for older prisoners and a follow-up report in 2008 reiterated these findings. HMIP reported that the older a prisoner, *'the more barriers there were to active life, the greater their mental and physical health needs, and the less likely it was that they would be able to live and function in dignity.*'[77] The Prison Reform Trust

73 Coram Children's Legal Centre (2013) Happy Birthday? Disputing the Age of Children in the Immigration System, p 10, available at [redacted]

74 ibid at 21

75 [redacted]

76 Independent Monitoring Board for Harmondsworth (2013) Annual Report 2012, p5 http://www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/harmondsworth-2012.pdf

77 HMIP, cited in House of Commons Justice Committee (2013) Older Prisoners: Fifth report of session 2013-2014 at [redacted]

has researched the many and varied needs of older prisoners, pointing out that many of these particular needs are unmet. Their briefing paper states that '*over half of all elderly prisoners suffer from a mental illness, the most common being depression which can emerge as a result of imprisonment*'.[78]

In September 2013, the Justice Select Committee recognized that older prisoners should no longer be held in institutions which cannot meet their basic needs. Sir Alan Beith MP, Chair of the Committee, said that '*Many older prisoners are currently being held in establishments that cannot meet their needs. The lack of provision for essential social care for older prisoners, the confusion about who should be providing it, and the failure of so many authorities to accept responsibility for it, have been disgraceful.*'[79] The Committee's final report notes that various health and social care needs, mobility restrictions, rates of disability and the contribution of incarceration to accelerated ageing make prison an unsuitable environment for many older prisoners. It also notes with concern that the rate of depression in older people in prison is about three times higher than in those in the community. [80]

In the light of these prison comparisons, it is a particular concern that there is no policy in place to manage and audit the detention of elderly people, and that there is no statistical data on how many are detained. In these circumstances, it is not clear how the policy to only detain the elderly in exceptional circumstances is being followed.

78 Prison Reform Trust (2008), Doing Time: the experiences and needs of older people in prison available at [redacted]

79 Sir Alan Beith MP, Chair of the Justice Select Committee, House of Commons Justice Committee (2013) Older Prisoners: Fifth report of session 2013-2014 at [redacted]

80 ibid

## 4.2.7 Pregnant women

The rationale for detaining pregnant women is extremely questionable due to the extremely low rates of removals that are achieved by the Home Office. The detention of pregnant women remains common despite mounting criticism from a range of organisations.

Medical Justice and Asylum Aid note that detention of pregnant women, contrary to the Home Office's own policies, is 'commonplace'.[81] Medical Justice has also reported deficiencies of provision of treatment for pregnant women in detention, pointing out that '*Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy.*'[82] They found that 93 pregnant women were detained in Yarl's Wood IRC in 2011, despite the fact that on average only 5% of pregnant detainees are removed from the country. They also found that many of the pregnant women they encountered had complex cases, and were victims of rape, torture and trafficking.

An HMIP inspection report into Yarl's Wood in 2013 found that '*pregnant women had been detained without evidence of the exceptional circumstances required to justify this.*'[83] One of these women had been hospitalised twice because of pregnancy-related complications. They also reported in 2012 that they had encountered seven pregnant women in Yarl's Wood: '*Only one of the Home Office monthly review letters mentioned pregnancy. In one case, a pregnant woman had been transferred*

81 Medical Justice (2013) Expecting Change: the case for ending the detention of pregnant women, p 46; and Asylum Aid (2012), I Feel Like a Woman I am not Welcome: a gender analysis of UK asylum law, policy and practice

82 ibid: Medical Justice (2013), p 1

83 HMIP (2013) Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre 17-28 June 2013 and 30 Sept-1 Oct 2013 available at http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/Yarls-Wood-2013.pdf

*over the course of four days from Northern Ireland to Scotland to Manchester, where she had collapsed and been treated, and finally on to Yarl's Wood.*'[84]

Until February 2013, the use of force against pregnant women during their removal was common. Then, following a judicial review on behalf of a pregnant woman and four children (R on the application of Chen and Others v SSHD), the Home Office reinstated the previous policy which prohibited the use of force on pregnant women and children except when absolutely necessary to prevent harm. This policy strengthens the argument that pregnant women should no longer be detained as it makes the prospect of removal even smaller.

In 2011 the then Minister for Immigration stated in Parliament that the number of pregnant women in detention is not recorded centrally.[85] This makes the scale of the problem hard to quantify, and gives little confidence in the Home Office's ability to identify 'exceptional' circumstances.

84 Her Majesty's Inspector of Prisons (2013), Report on an unannounced inspection of Yarls' Wood IRC available at http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/Yarls-Wood-2013.pdf

85 HC Deb, 25th October 2011, c76621

## 4.2.8 Serious medical conditions

There have been a number of deaths in detention in recent times caused by medical conditions, and neglect by the Home Office has been found to be a contributing factor in some of these. Serious questions have been raised by clinicians and NGOs over the ability of the medical staff in IRCs to adequately manage those living with illnesses such as cancer, tuberculosis and HIV.

There is widespread criticism of the provision of healthcare services to those detained, as a result of a number of recent cases. For example, in 2011, two men died of heart attacks in Colnbrook IRC, and, as mentioned previously, a third man aged 84 died of a suspected heart attack in Harmondsworth in 2013.

A report by the Prisons and Probation Ombudsman (PPO) into the death of one of the Colnbrook cases includes a comment from the clinical reviewer who notes: '*I believe that opportunities were missed in this case to potentially prevent his death.*'[86] The report notes various issues about the response to his illness, including 'staff not recognizing the seriousness of the situation'.[87] A further report into the death of a man in Oakington in 2010 reports that he had been receiving paracetamol throughout the day but had been refused this before he died 'because it was night time'.[88] These reports highlight various failings on the part of detention centre staff to respond appropriately in emergency situations.

86 Prison and Probation Ombudsman for England and Wales (November 2012) Investigation into the death of a man at Colnbrook Immigration Removal Centre in July 2011 available at http://www.ppo.gov.uk/wp-content/uploads/2014/11/G088-11-Death-of-a-male-detainee-Colnbrook-31-07-2011-Nat-31-40.pdf

87 ibid

88 Prison and Probation Ombudsman for England and Wales (July 2011) Investigation into the circumstances surrounding the death of a man at Oakington Immigration Removal Centre at http://www.ppo.gov.uk/wp-content/ReddotImportContent/010-10-oakington-death-of-a-male-detainee-15-4-10.pdf#view=FitH

They make recommendations for improvement, including training. In two more recent cases of deaths in detention, inquest juries have found that neglect on the part of the Home Office was a contributing factor. [89]

Provision of healthcare has been most vociferously condemned in relation to mental health, but the extent to which serious diseases such as cancer or HIV are 'satisfactorily managed' has also been questioned by numerous sources including clinicians. For example, an expert paper on tuberculosis presented to the National Institute for Health and Care Excellence (NICE) in 2011 notes: '*Each detention centre appears to have developed its own written policies for TB management, which agree neither with each other nor with national guidance from NICE (where there is overlap), so far without visible success. The total absence of any policy in at least one centre was noted by the Prisons Inspectorate in early 2010.*'[90]

Medical Justice, the expert NGO which focuses on detainee healthcare, have documented numerous cases of failures in healthcare provision. Their in-depth research into the provision of care for people with HIV found:

- Failures by detention staff to carry out adequate investigations and procedures when a detainee arrives in detention (e.g. failure to contact previous treating clinicians; obtain medical records; arrange appointments with HIV specialists; and ensure continuity of care)

- Interruptions in antiretroviral therapy (e.g. failure to provide drugs; facilitate external appointments; and ensure that people were given medication en route to detention centres)

- Clinical practices which were demeaning, degrading and which in some cases worsened the detainees' condition (e.g. practices putting the detainee at risk of contracting infections; failure to investigate symptoms indicative of HIV infection; failure to respect confidentiality; and failure to carry out or pass on the results of tests determining resistance to particular medication).[91]

89 See [redacted] and [redacted]

90 Dr Frank Arnold, Medical Justice (2008) Expert paper 6: Hard to reach patients with, or at risk of, tuberculosis in immigration detention available at [redacted]

91 Medical Justice (2011), Detained and Denied: The clinical care of immigration detainees living with HIV, p 6, as cited in Cooke, Alexis (2013) Immigration Detention and the Rule of Law: National Report: United Kingdom (Bingham Centre for the Rule of Law) p 48 available at [redacted]

## 4.3 Other contributing factors to vulnerability

Our findings above relate specifically to cases where, contrary to their own guidelines, the Home Office has continued to detain individuals who fall into the categories of persons who, because of their vulnerability, are unsuitable for detention. Some of our case studies fall neatly into these categories, but others demonstrate that vulnerability in the detention system is complex and goes beyond pre-determined categories. Many of the cases suggest that vulnerability is a result of a combination of factors and that these may change throughout time in detention.

Although most of our cases involved vulnerabilities which meet the Home Office policy categories, these vulnerabilities were multifaceted and layered. For example, most of those who were survivors of torture were also dealing with significant mental health issues. The long-term experience of detention impacted on almost all the detainees in this report and reduced their capacity to cope within the detention centre, often making them more vulnerable over time. Language, physical health, literacy and access to information came up throughout the case studies as elements that affect mental health. Those we interviewed told us – often without direct questioning – about the many ways the detention centre impacted their daily wellbeing. It became clear that many factors contribute to vulnerability which are not covered by existing policy. We highlight just a few of these below.

### 4.3.1 General Physical Health

A number of detainees in our sample discussed the impact of their treatment in detention on their physical health. Mental health is significantly tied up with physical health.[92] Studies have shown that untreated pain has strong implications for mental wellbeing.[93] Because there were no targeted questions on physical health within this research, it is likely that these results represent only a fraction of detainees' overall experience with physical health within the detention centre.

A number of detainees described being refused medication for physical injuries, until the injuries were serious enough to require that they be transferred to an outside hospital. In one case, a detainee received surgery at a local hospital for a hernia and upon return to the IRC was forced to sleep in a wheelchair the next night due to lack of available bed space. After the surgery he was not given pain relief until he was transferred to an outside hospital. Another detainee complained of a broken leg for a month and was only given paracetamol periodically. When he was finally transferred to hospital the doctors found that his leg had indeed been broken and that he had therefore been denied care.

Two cases described extremely rough handling during the transfer process, resulting in untreated injuries. One reported harassment and physical bullying from detention centre staff. Studies have documented the use of excessive force during removals from the country: one, Outsourcing Abuse, cited 300 cases of alleged assault of detainees between 2004-2008,

92 Physicians for Human Rights with the Bellvue/NYU Program for Survivors of Torture (2003), From Persecution to Prison: the health consequences of detention for asylum seekers, p 85 available at [redacted]

93 Gatchel R (2004), Comorbidity of Chronic Pain and Mental Health Disorders: The biopsychosocial perspective, American Psychologist, 2004, at 796, 59: 8, 795-805

especially in removals.[94] Abuse by detention staff has significant psychological impacts on detainees, especially for asylum seekers with a history of abuse; physical handling can result in re-traumatisation and an overall sense of insecurity.[95]

Weight loss and lack of appetite came up consistently throughout our sample. Detainees described having to force themselves to eat when they had never before had problems with appetite. Loss of appetite was attributed to stress and to the quality of the food provided. Some detainees became weak and fragile over time as a result of not eating. Insufficient nutrition has been linked to decreased cognitive abilities, concentration and ability to articulate.[96] Such effects can seriously impair a detainee's ability to function, as well as to represent their case and to manage other stress factors.

Hunger strike and suicide attempts represent some of the most serious impacts detention may have on physical health. Thirteen (43%) of the detainees in this research had attempted suicide, undergone hunger strike, and/or self-harmed while in detention. Studies suggest that a person's liver, intestines, heart and kidneys begin to atrophy after about a week of hunger strike.[97] One detainee suffered persistent pain after a three-week hunger strike, but was not given medication once discharged from the hospital back to detention. Long-term impacts of self-harm and suicide attempts can include scarring, nerve damage and neurological damage.

In many of these cases, release was only obtained after legal challenges in the High Court, a worrying prospect for detainees who do not have access to diligent legal representatives. For those who remain in detention, the health impacts of hunger strike, suicide attempts or self-harm may go unmet, diminishing their ability to recover.

Case studies consistently demonstrate that physical health has an impact on detainees' wellbeing, and their mental health, throughout their time in detention. Symptoms such as loss of appetite, hunger strike, or suicidal ideation, are impacted by, and have an impact on, mental wellbeing. Poor treatment by staff and lack of adequate medical provision contribute to general insecurity and perceptions of detention as punitive in nature. Physical pain and overall diminished physical wellbeing often increased detainees' disillusionment with the system, and their capacity to manage other aspects of detention.

94 Birnberg Peirce & Partners, Medical Justice and the National Coalition of Anti-Deportation Campaigns (2008), Outsourcing Abuse: the use and misuse of state-sanctioned force during the detention and removal of asylum seekers, available at [redacted]

95 ibid

96 Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project'), p75, available at [redacted]

97 Kenny M, Silove D, Steel Z (2004), Legal and Ethical Implications of Medically Enforced Feeding of Detained Asylum Seekers on Hunger Strike (2004), Medical Journal of Australia, 180: 5, 237-240

## 4.3.2 Detention Conditions

It is understood that the physical space and conditions of detention will impact on a detainee's wellbeing. The Detention Centre Rules 2011 state that '*the purpose of detention centres shall be to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression*'.[98] The UNHCR's recent Detention Guidelines state that the conditions of detention must be 'humane and dignified';[99] outlining certain basic provisions that should be met. However, in many of our case studies, it is clear that the physical environment did more to heighten vulnerabilities rather to respect dignity.

Detainees in our sample said that conditions within the detention centre impacted negatively on their mental and physical health. In many cases they spoke of feeling as if they were 'treated as animals'. They mentioned the lack of privacy in the showers, and the placement of toilets without doors in the sleeping rooms, as particularly degrading or dehumanising. In one case a participant described the cumulative effect of poor conditions on his ability to maintain his wellbeing throughout his time in detention.

As well as these direct effects, detainees said their wellbeing was affected by the suffering or distress of other detainees. In many of our case studies, detainees reported feeling stressed by seeing their friends' or other detainees' difficulties in detention. In one case, a detainee found it hard to sleep because another detainee kept screaming during the night. Research has found that witnessing or hearing about detainees hurting themselves is particularly traumatic.[100]

Secondary evidence and the reports of national monitoring bodies bear out these conclusions. Various sources have criticised the prison-esque environment of immigration detention in the UK, including the judiciary, NGOs, IMB and HMIP.

HMIP and IMB play an important role in ensuring the humane treatment of immigration detainees by inspecting detention centres on a regular basis. Their reports often comment on the unsuitable environment. For example:

'*There was little evidence of effective and sustained work to soften the institutional environment. The noisy prison units seemed to raise tension and stress.*'[101]

'*The physical environment in centres was a particular concern. The closed air-conditioned units in the newer centres were the subject of much complaint. It was not just the uneven ventilation and stuffiness that concerned detainees, but the lack of control involved in not being able to simply open a cell window to get fresh air.*'[102]

HMIP and IMB reports in recent years identify patterns of failure to ensure 'humane'

98 Detention Centre Rules, 2011, Statutory Instruments, Purpose of Detention Centres, art. 3(1), available at http://www.legislation.gov.uk/uksi/2001/238/article/3/made

99 UNHCR (2012) Detention Guidelines: guidelines on the applicable criteria and standards relating to the detention of asylum-seekers and alternatives to detention, available at [redacted]

100 See for example: Coffey G, Kaplan I, Sampson R, Tucci M (2010), The Meaning and Mental Health Consequences of Long-term Immigration Detention for People Seeking Asylum, Social Science and Medicine, 70, 2070-2079

101 HMIP (2011) Report on a full announced inspection of Brook House Immigration Removal Centre 15 – 19 March 2010 p 12

102 HMIP(2011) Annual Report 2010-11

standards of accommodation, facilities and services. They repeatedly note the 'prison-like' environment of detention centres,[103] incompetence of the staff[104] and poor quality of accommodation facilities.[105]

A study by JRS Europe, Becoming vulnerable in detention, makes the same point: '*The architectural plan of the detention centre, the conditions of the cells and of the facilities within the detention centre has important links to vulnerability.*'[106] It found that detainees who are held for prolonged periods of time may suffer physically and mentally if the conditions of the space are inhospitable.

*'Detention is inevitably a stressful environment. It is not surprising that asylum-seekers ... struggle to come to terms with being detained in a prison-like setting, to cope with isolation from friends, family and local support organisations, and to process a wealth of information about how the detention centre itself operates.'* [107]
**Fast Track to Despair, Detention Action 2011**

## 4.3.3 Barriers to accessing information

Detainees who are unable to successfully communicate their claims to the Home Office are at particular risk of prolonged periods of detention and negative decisions about their cases. Without adequate safeguards, most detainees must advocate for their own needs and cases. Language and learning disabilities have an impact on an individual's chances for self-representation within the system, but are not always included as categories of vulnerability. Inadequate access to information leaves detainees extremely vulnerable to lengthy detention or unfair decisions.

### Language barriers

Many of the detainees in our study had at least a working knowledge of English. Those who spoke very little or no English found this a significant barrier to furthering their cases or making their needs known. Limited knowledge of English makes it difficult to obtain information about the process; it often results in isolation and creates a dependence on other detainees who share the same language, which at times can lead to positions of vulnerability.

The impact of language is especially heightened in complex cases. In two cases, detainees had limited understanding of English as well as complications arising from third country agreements, which made them more vulnerable. For 15-year-old Eric, the negative impacts of detention were exacerbated by the fact that there was only one other detainee who spoke his language within the detention centre.

Where documents are provided in multiple languages in detention centres, detainees with low-level literacy may still face significant hurdles in finding out about legal processes and the rules of the detention centre. Currently, most asylum claims are handled

103 HMIP (2011), Report on an unannounced short follow-up inspection of Lindholme Immigration Removal Centre, available at http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/lindholme/lindholme-2011.pdf; and Report on an unannounced full follow-up inspection of Brook House Immigration Removal Centre, at http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/brook-house/brook-house-2011.pdf

104 ibid (Brook House)

105 HMIP (2011) Annual Report 2010-11 p 66

106 Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project'), p 39

107 Detention Action (2011), Fast Track to Despair: the unnecessary detention of asylum seekers, p 15, available at [redacted]

through written documents, creating huge difficulties for those without legal support and those who are not literate – especially in Detained Fast Track cases, where appeals must be made within five working days. [108]

The issue of provision of information in languages other than English has been raised time and again by NGOs and in HMIP reports. The Detention Centre Rules 2001 contain no guidance on interpretation or translation, and while the Home Office operating standards do contain minimum auditable requirements on these, it is left up to individual detention centres to negotiate provision with telephone providers such as Language Line. NGOs who participated in this research have also highlighted that in many instances custody staff and detainees are used as interpreters, often in cases involving complex legal information or in medical appointments. There are obvious issues here with confidentiality, and the use of peer interpreters, rather than professional interpreters, falls far below NHS good practice standards.

108 Detention Action (2011), Fast Track to Despair: the unnecessary detention of asylum seekers, p15, available at [redacted]

## 4.3.4 Groups most at risk of long-term detention

All immigration detainees are held without time limit. While the average detention period is around two months, many are held for longer. Unnecessary, prolonged detention periods are not unusual. In R (Sino) v SSHD[109] and R(Mhlanga) v SSHD(2012),[110] the Court found that detention was unlawful on grounds of length – four years and 11 months and three and a half years respectively. While these are extreme cases, the impact of living in this uncertainty is well documented. Our case studies reveal high levels of mental ill health, worsening over time in detention. NGOs and statutory monitoring bodies have drawn attention to prolonged periods of detention that do not lead to removal. Some groups are more likely to be vulnerable to long term detention than others, such as those who have served time in prison or those who are stateless or 'unreturnable'.

### Third country cases

Currently there are no protections or provision of aid for individuals who fall under return policies in line with Dublin II regulations,[111] which stipulate that an asylum seeker may be removed back to the first EU member state through which they travelled. Many 'third country case' detainees end up detained for significant periods while the UK awaits a response from the other European country. This is particularly problematic for asylum seekers who arrive from countries such as Greece and Italy where protections and provisions are minimal, and where frequently

109 2011 EWHC 2249 (Admin)

110 2012 EWHC 1587 (Admin)

111 PROTECT –ABLE (2013),Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment, available at [redacted]

individuals have been subject to very poor treatment and even abuse. In one case, a detainee with evidence of violence by third parties in his home country, as well as in both France and Italy, was detained for months without access to legal representatives. In addition to limited protections based on his immigration status, he was limited by his knowledge of English. His inability to make his claims known, and his fear of return to the violence of his home country or 'safe' third countries, had a significant impact on his mental wellbeing.

## Unreturnable and stateless migrants

Migrants who cannot return to their countries of origin spend disproportionately long periods of time in detention.[112] Unreturnability can be caused by administrative factors, such as the inability or refusal of the country of origin to issue travel documents.[113] Some people are unreturnable because of litigation or because of suspensions of removals to countries in turmoil.[114] Some are stateless, in they are not considered to be a citizen by any state under the operation of its law. Unreturnable and stateless people are frequently detained after serving prison sentences, and repeatedly refused release based on their alleged risk of absconding or reoffending. Since the UK has no time limit on detention, these people are frequently detained for periods of years, without return ever becoming possible, before finally being released.

## Post-sentence Detainees

Although not traditionally thought of as vulnerable within the system, detainees who have served a criminal sentence (post-sentence detainees) face a number of additional barriers in access to representation and justice, and thus have their own particular vulnerabilities within the system. The Home Office does not have standardised statistics, but people awaiting deportation after serving a prison sentence often experience the longest periods of detention.[115] This was certainly true of our sample: those who had spent longest in detention had served prison sentences and were unable to be documented due to restraints from the home country. Foreign nationals are recognised as vulnerable within the prison system,[116] but there is no mention within detention operating standards of the particular needs of former prisoners.

*'There are people with 10-year sentences for serious crimes who are out after five year. I've been in here longer than people with 10-year terms when I've only had a three-year sentence. I've served longer, I've been inside longer just because I am not a British citizen.'*
**C from Iran**

Those who claim asylum during a prison sentence are often held in prison throughout the duration of their claim, making access to information and legal representation limited. For many detainees in our sample, indefinite detention following a criminal conviction led to feelings of extreme stress and a sense that they were likely to never be released. The

112 Flemish Refugee Action et al (2014) Point of No Return – the futile detention of unreturnable migrants

113 Sino was detained for four years and 11 months because the Algerian Embassy refused to recognise him as a national.

114 Mhlanga was detained for five years and two months due to the situation in Zimbabwe, which had led to a lengthy suspension of returns from the UK.

115 ICIUKBA (2011) A Thematic Inspection Report of how the Agency manages foreign national prisoners, available at http://icinspector.independent.gov.uk/wp-content/uploads/2011/02/Thematic-inspection-report-of-how-the-Agency-manages-Foreign-National-Prisoners.pdf

116 Association of Chief Police Officers (2012), Guidance on the Safer Detention and Handling of Persons in Police Custody, Second Edition, p 94, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117554/safer-detention-guidance.pdf

majority of foreign national prisoners in our sample had claimed asylum either prior to or after time spent in prison.

In determining whether to release or detain a former prisoner, the Home Office must weigh the risk of re-offending against the needs and rights of the detainee. It seems clear that there is a presumption in favour of detention, and an unwillingness to grant bail to any ex-prisoner, regardless of personal circumstances. This was substantiated in 2011 in a report by the Independent Chief Inspector of the UKBA which found that 97% of foreign national prisoners remain in detention post-sentence, while deportation is pursued. [117]

Another problem which emerges from our analysis of case law is the lack of transparency and consistency in interpretation and application of the Home Office's own policies as regards the treatment of post-sentence detainees. This issue came before the court in Lumba (Congo) and Mighty (Jamaica) v Secretary of State for the Home Department[118] which challenged a 'blanket policy' which presumed the continued detention of a foreign national prisoner upon the expiry of his sentence. The court found that application of an unpublished policy – where there is an existing published policy which otherwise would be applicable – was contradictory and constituted a breach of public law duties. Not only this, but the blanket policy of detention was itself was itself found to be unlawful.

It seems clear, therefore, that decisions to detain foreign nationals following the completion of their custodial sentence are often made arbitrarily and without any real justification. The fact of their criminal sentence and a perceived risk to the public is repeatedly given priority over the risk to the individual through their continued detention. This de facto presumption of detention is set out in Chapter 55 of the EIG. It seems that the 'vulnerability' criteria are effectively bypassed for those with a criminal conviction. [119]

## 4.3.5 Conclusion

The above case studies reveal the inherent difficulties in relying on a 'categories' based approach to vulnerability, as it is clear that there are many other contributing factors which may make someone vulnerable in detention and as a consequence less 'suitable' for detention than others. Because the Home Office currently relies on identification of individuals within a set of pre-existing categories, those who don't fit this definition are left at risk. Vulnerabilities are also not fixed and they will fluctuate over time, and the uncertain length of detention has a major impact on mental health and wellbeing. It must be acknowledged that there are significant other issues which, if left untreated or unsupported, could manifest themselves in more serious mental ill health. Our sample revealed that the Home Office guidance (which the Home Office does not always follow) does not recognise the full spectrum of vulnerability and does not factor in changes over time. We discuss this further below.

117 ICIUKBA (2011) A Thematic Inspection Report of how the Agency manages foreign national prisoners, available at http://icinspector.independent.gov.uk/wp-content/uploads/2011/02/Thematic-inspection-report-of-how-the-Agency-manages-Foreign-National-Prisoners.pdf

118 2011 UKSC 12, 2 WLR 671

119 See the discussion in BA (2011) EWHC 2748 (Admin) at 165-176

## 4.4 Increasing vulnerability in detention over time

Our case studies demonstrate that longer someone is detained, the greater the impact of detention on them will be. A process which relies solely on screening for pre-existing vulnerabilities risks ignoring the very important manifestations of vulnerability which only become apparent over time. The most serious of these, in our case studies, were hunger strikes and self-harm/suicide attempts or ideation.

*'Detention weakens persons with pre-existing special needs, but it also weakens otherwise healthy people.'*[120]
**JRS DEVAS project – Becoming Vulnerable in Detention**

### 4.4.1 Hunger Strike

Five (16%) of detainees in this research were on hunger strike at some point during their detention. In each case, the cause was extreme desperation related to lengthy detention with little or no support.

All five detainees mentioned the length of time in detention as a significant factor in their decision to refuse food. The shortest period was three and a half months. The other four were detained for between five and 12 months. Two of the detainees could not be documented, and three had ongoing asylum claims. Two of the detainees refused food as an attempt to end their own lives in response to what seemed an intractable and irresolvable situation, caught between fear of returning home and fear of remaining in detention.

Several of these detainees had expressed suicidal feelings and extreme depression, but were not given any medical care until after they went on hunger strike. Two detainees who ended their hunger strikes in response to serious health conditions, found, to their distress, that both the visits of medical staff and psychiatric support ended almost immediately. This suggests a lack of continuous care for vulnerable detainees and a strategy of management rather than prevention.

120 Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project')

## Joseph

Joseph spent eight months in Harmondsworth Immigration Removal Centre (IRC) after serving a prison sentence of 12 months for drug possession. He claimed asylum on the basis of his sexuality while in prison, having left Gambia after his family and friends had disowned him. With no way to be free at home and no community here in the UK he turned to heavy drink and drug use because he felt 'like he was nothing, like his life was over'.

Joseph waited close to four months for an asylum interview, and was refused while still in prison. His mental health worsened, and when he started hearing voices and having trouble sleeping he saw a psychiatrist for the first time. He remembers waking up and feeling like he had someone sitting on top of him. Unable to move or breathe, he would sweat and panic, until he was finally able to push himself up. He was diagnosed with a mental health problem, given medication and saw a psychiatrist regularly. When he completed his sentence he was kept in prison for ten days before being transferred to Harmondsworth IRC.

Joseph remembers being asked a few questions about his mental health upon arrival, and seeing the nurse for his medication. His medication was changed without a visit to the psychiatrist. Joseph's health slowly deteriorated: the medication did not seem to be working. He kept asking to see a psychiatrist, but was never taken to see one. When his asylum appeal was turned down and his further appeal rights were denied, Joseph spiralled downwards. The thought of returning home made him decide to go on hunger strike.

*'I know if I return home I would face a slow death, so I'd rather kill myself here, I can't hang myself so I will starve myself. If I could go back I would have gone back a long, long time ago, would have jumped on the plane but in my country you can't be bisexual or gay, people find out and they will hurt you, you know they will kill you. That is why I want to starve myself. I don't want no one else to take my life… they will stone me to death, my family, they will put me in a hole and stone me to death, can you imagine how painful that would be for me?'*

Joseph was on hunger strike for 43 days. He had a Rule 35 report submitted on his claims of torture but never received a response. His medical reports repeatedly stated that he was unfit for detention. His caseworker responded by stating that he did not have a residence to return to, despite the fact that he had submitted a request for section 4 housing with the address of a friend who had agreed to host him. A solicitor brought his case to the High Court and after 43 days he was released to the care of a local hospital and thereafter to the home of his friend.

Joseph's story illustrates both the desperation felt by many in detention, and also the dangers when mental illness is left untreated. Recent reports suggest that the Home Office is becoming increasingly reluctant to release detainees in response to food refusal. Most recently, this has been demonstrated by the case of Isa Muazu who was deported to Nigeria after being on hunger strike for over 100 days, despite compelling medical evidence that he was unfit to travel. Such a prolonged period of hunger strike can have substantial and enduring physical impacts.

## 4.4.2 Suicide and self harm

*'Individuals in detention remain vulnerable to self-harm and suicide.'*[121]
**Equality and Human Rights Commission, 2012**

*'People simply deteriorate – suicide attempts and sectioning are common. The stress of being in a chaotic environment with the constant threat of deportation for many months is devastating for people with pre-existing vulnerabilities.'*[122]
**Detention Action (London Detainee Support Group), 2010**

As outlined above, mental health issues were prevalent in the majority of our case studies. Thirteen (43%) of the detainees in our research had attempted suicide, undergone hunger strike, and/or self-harmed while in detention. Eight (26%) cases involved detainees with suicidal ideation. Of those who reported feeling suicidal, four had been placed on an Assessment Care in Detention Teamwork (ACDT) self-harm reduction strategy. The majority of detainees were only placed on ACDT after attempting suicide.

ACDT is a preventative strategy, which was adapted from prison service policies. It aims to identify detainees at risk of self-harm and to ensure they receive adequate support. However, many of our cases told us that it had been clear that their mental health was poor long before any monitoring was carried out. Although placed under supervision, one detainee on an ACDT plan was able to attempt suicide three times (see below). In another case, medical findings that deemed the detainee unfit for detention were ignored. In three of the cases, suicidal ideation contributed to the decision to refuse food and life-saving HIV medication.

### Abas

Abas has been in the UK from the age of seven, is married to a British citizen and has two young children. He was detained for nine months following a conviction for a non-violent offence. Three months into his detention he was seen by a psychiatrist who found him to be unfit for detention. In spite of this, he remained in detention for a further six months.

After six months in detention Abas was seen by a number of outside psychiatrists who reiterated the finding that he was unfit for detention. He was diagnosed with paranoid schizophrenia and severe depression. During this time he was put on an ACDT plan and periodically placed in segregation in order to provide constant supervision, keeping him isolated from other detainees and staff.

Despite the ACDT plan, Abas attempted suicide on three separate occasions. After eight months, he went on hunger strike, which eventually led to his release from detention. Abas was refused bail more than ten times. On one occasion, the judge maintained that if he was not ill enough to be sectioned, his mental health could be properly managed in detention. On another, the judge reasoned that there was not enough mental health support outside of detention, despite the fact that he had a clear pathway to mental health support and letters from psychiatrists advising acute inpatient treatment.

Following bail for rehydration after his hunger strike, Abas is currently out of detention with an unlawful detention and Article 8 claim pending.

121 Equality and Human Rights Commission (2012) Human Rights Review 2012, p 25

122 Jerome Phelps, cited in Mind (2010) A Civilised Society: Mental health provision for refugees and asylum seekers in England and Wales, p 9. Available at [redacted]

It is widely recognised that custody contributes towards mental distress and can exacerbate existing mental health problems, heighten vulnerability and increase the risk of self-harm and suicide.[123] Our case studies appear to bear this out, and show that current screening for mental health is inadequate.

Despite the existence of a procedure to 'manage' those at risk of self-harm, quarterly statistics show that numbers are rising. In Brook House, for example, there were 52 instances of self-harm 'requiring medical treatment' between January and June 2013 and 251 detainees on ACDT documents in the same period. These figures were amongst the worst ever recorded. HMIP recommended that a 'care suite' for detainees at risk of self-harm should be established in Brook House. The Home Office rejected this on the basis that '*the building design does not enable this to be facilitated*'.[124]

HMIP have highlighted both good and bad practice in suicide prevention and self-harm management in detention. Their Annual Report for 2010-11, for example, found that staff had an adequate understanding of suicide and self-harm intervention but that safeguarding policies were ineffective.[125] The detention estate has no equivalent to the Samaritans' 'listeners' scheme which exists in the prison system. HMIP also noted that *'counselling services were limited across the inspected establishments*'.[126]

The Equality and Human Rights Commission, in their 2012 review of Human Rights in the UK, found that the approach to preventing self-harm in detention was 'inadequate': '*Measures in IRCs are based on those in prisons but IRCs do not have access to similar mental health services, and health care staff lack expertise in trauma associated with torture. This inadequate approach means that IRCs may not meet their Article 2 obligation in preventing suicide and self-harm.*'[127]

Levels of self-harm or suicidal ideation are high in detention, and the situation is not improving in spite of policies set in place in response to concerns about the conditions of detention. Our case studies, and evidence from HMIP and human rights bodies, show that there is a huge gap between policy and practice in dealing with self-harm and suicide attempts.

Those with poor mental health are the most likely to be ignored in a system that requires detainees to stand up for their own day-to-day needs. Poor mental health often makes detainees less able to advocate on their own behalf. Lack of screening and support additionally makes detainees vulnerable to putting their own health at risk through self-harm or suicide attempts.

123 See for example McGinley A and Trude A (2012), Positive Duty of Care? The mental health crisis in immigration detention (AVID and BID), p 4

124 UK Border Agency (2010) Brook House Service Improvement Plan, p 11

125 HMIP (2011) Annual Report 2010-2011

126 ibid

127 Equality and Human Rights Commission (2012) Human Rights Review 2012

### 4.4.3 Conclusion

The most striking – and in many ways the most obvious – conclusion from the examples above is that the negative effects experienced by vulnerable people in detention are closely linked to the length of detention, and that in most cases, the longer someone is detained, the more vulnerable they become. Therefore, it is likely that many people, who do not fit into one of the category definitions of vulnerability when they are detained, become vulnerable and at risk of serious harm while in detention.

At present, there are no effective safeguards in place to assess how vulnerability develops over time in detention, so there is no real way of identifying those who are being seriously harmed. We would argue that it is possible to develop a system to assess vulnerability in a more dynamic way, and that there are already tools in use in other contexts which could be developed for use in detention.

# 5. Assessing vulnerability

## 5.1 Definitions

The language of 'vulnerability', 'special needs' or 'disadvantaged groups' has been given attention in recent years by policy makers and NGOs alike, but there is little agreement on definitions. As a result definitions are as varied as they are limiting. For example, the UNHCR and the UK Home Office use a category-based approach to defining vulnerable or special needs groups. The UK Office of the Public Guardian recently moved away from the term 'vulnerable adult' to 'adult at risk'. In health and social care policy in the UK, vulnerability is married to the concept of 'safeguarding', based on the need to protect particular groups from further harm. These are just examples of the many different approaches.

Our research shows that detention harms great numbers of people. We would argue that previous attempts to define vulnerability, by focusing largely on pre-determined categories of special need, have been so narrow, that they have left many at risk – however well-intentioned those attempts at definition may have been.

*'Within the context of detention…. "vulnerability" can be conceptualised as a concentric circle of personal (internal), social and environmental (external) factors that may strengthen or weaken an individual's personal integrity.'*[128]
**JRS DEVAS project – Becoming Vulnerable in Detention**

## 5.2 Reconceptualising vulnerability

Traditionally, vulnerability is conceptualised through the use of categories which define some groups as vulnerable in comparison to and at the exclusion of others. As we have seen, in the UK this includes pregnant women, children, the mentally ill and physically disabled, and victims of torture and trafficking.

These group-based approaches are useful in recognising those who are likely to have special needs within the detention centre environment. A pregnant woman, for example, is considered unfit to be detained both because of increased medical needs and because the stress of detention may create complications with pregnancy.[129] Children are considered less able than adults to advocate for their own needs and may suffer psychological and developmental damage as a result of detention.[130] Individuals who have been tortured and/or trafficked are likely to have experienced psychological distress that requires more care than that available within the detention centre and which could be exacerbated by the experience of detention. While these categories are useful in creating visibility for some, they simultaneously create the misconception that those who fall outside them are not vulnerable. [131]

Many detainees in our sample did not fit within these categories, but were vulnerable. Our case studies demonstrate that vulnerability is cumulative, and likely to change over time. To some extent, everyone who is detained can be considered vulnerable.

128 Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project') p90

129 Ashdown J and James M (2010), Women in Detention, International Review of the Red Cross (2010), 92:877, 123-141

130 Medical Justice (2010), State Sponsored Cruelty: children in immigration detention, available at [redacted]

131 Hogan D and Marandola E (2005), Towards an Interdisciplinary Conceptualization of Vulnerability, Population, Space and Place, 2005, 11, 455-471

In fact, prisoners and immigration detainees are recognised as vulnerable groups under the Government's Safeguarding Vulnerable People's Act 2006.[132] Being detained, especially for long periods, is proven to be stressful and highly detrimental for all detainees. [133] Isolation from society, poor conditions, lack of meaningful activity, inadequate services, especially health services, all contribute to the way detention undermines the well-being of those detained.[134]

Because a detainee's liberty is limited, their wellbeing is under the control of the state responsible for the detention.[135] Detainees therefore have less ability to make their own decisions and respond to their own needs. They can be considered vulnerable to harm by staff or other detainees, whether through physical harm, neglect or exploitation. They can be considered vulnerable because detention may create new or exacerbate pre-existing mental or physical illnesses. Diminished capacity to advocate for their own cases may make them vulnerable to negative and unjust decisions. However, every individual's response to the experience of detention is unique.

There is a need for a reconceptualization of vulnerability that takes account of individual experience over time. In general terms, vulnerability is defined as a susceptibility to harm or attack.[136] In risk analysis terms, vulnerability is the interaction between exposure of a system to external stressors, and internal capacity to cope with, and recover from, an impact.[137] Each system's internal coping capacity may be bolstered or diminished by a range of factors. For an individual, internal capacity to cope with external stressors is impacted by both social and personal factors,[138] which will vary for each person.

Detainees have little control over the way a detention centre is organised. How a detainee deals with this situation will be influenced such personal and social factors as language capacity, age, literacy, level of information, psychological characteristics, education, family or relational support, relationships within detention. In this sense, vulnerability can be understood as contextual (i.e. related to conditions), relational (i.e. impacted by interaction with social factors) and dynamic (i.e. not static, but subject to change over time and space).[139]

A concept of vulnerability that recognises its dynamic nature is especially important in the context of detention, which has consistently been shown to diminish individual wellbeing over time. Some may have an extremely low capacity to cope with the stresses of detention from the beginning. A variety of factors may help others to cope for longer. The factors of vulnerability are often cumulative; one dimension of vulnerability can increase the likelihood of other vulnerabilities.[140] In order

132 Safeguarding Vulnerable Groups Act 2006 at http://www.legislation.gov.uk/ukpga/2006/47/contents

133 Coffey G, Kaplan I, Sampson R, Tucci M (2010), The Meaning and Mental Health Consequences of Long-term Immigration Detention for People Seeking Asylum, Social Science and Medicine, 70, 2070-2079

134 United Nations Office on Drugs and Crime (2009), Handbook on Prisoners with Special Needs, Criminal Justice Handbook Series, p10, available a [redacted]

135 ibid, p4

136 [redacted]

137 Costa L and Kropp J (2013), Linking Components of Vulnerability in Theoretic Framework and Case Studies (2013), Sustainable Science, 8, 1-9 at 5

138 Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project') p36

139 EVASP Project (2010) Enhancing Vulnerable Asylum Seekers' Protection: trainer's handbook (EVASP Trans-national Report) p 27, available [redacted]

140 ibid p20

to minimise vulnerability and susceptibility to harm, it is necessary to take account of all the contributing factors and to take action to minimise those that are detrimental and to strengthen those which are beneficial.[141]

Poor conditions, which may be manageable by a detainee with social support and access to information about their own case, may become overwhelming for a detainee with less support and information. This example is by no means a rule but rather suggests that each individual interacts differently with the lived realities of the detention system. The provision of care, access to outside support, mental and physical wellbeing, conditions of detention, treatment by staff and daily realities of the detention centres will contribute to a detainee's reaction to being detained.

Overall, detention centres are ill-equipped to handle complicated cases and respond to vulnerabilities within the detained population. Few detainees have access to the physical and mental health care needed in order to endure prolonged detention. Detention is likely to exacerbate pre-existing conditions, or create new complications. Those not traditionally seen as vulnerable are often overlooked in provision of care.

## 5.3 The need for vulnerability screening and assessment over time

The continuous detention of vulnerable people in the UK must be seen in the context of current policy. Although detention guidance suggests that certain groups of vulnerable individuals should not be detained, there is currently no effective mechanism or requirement in place to systematically identify this vulnerability. As we have shown, the current safeguards are often not implemented or not implemented properly. Additionally, it is useless to rely on the detention centre healthcare team for vulnerability assessments if detainees do not have access to good quality healthcare.

Without such a requirement or mechanism, every individual is responsible for representing their own needs to the Home Office or detention centre staff. In many cases, as we have shown, extremely unwell individuals were kept in detention while their health and wellbeing plummeted, and were only released in response to proactive advocacy by legal aid solicitors. This suggests inherent difficulties in relying on a self-advocacy framework in a detention context.

Our research shows that without an adequate assessment or screening system, detainees can remain for substantial periods of time without adequate provision for their needs, often in breach of international human rights protections. The rate and extent of psychological distress and self-harming detailed here and in other research corroborates these findings. If the Home Office decides that detention is unavoidable, a proper mechanism must be put in place that identifies vulnerability both before the decision to detain is made and throughout the duration of detention.  Needless to say, the government should be working towards an immigration control system that does not rely on detention. A range of studies by international NGOs provide a useful starting point. These identify screening mechanisms for vulnerability used overseas in the immigration detention or prison context, both of which can be viewed as transferable to the UK detention context.

### DEVAS Project

A large scale study, Becoming Vulnerable in Detention, was carried out by Jesuit Refugee Service Europe (the DEVAS project) in 2010.

141 ibid

Their objective was to 'investigate and analyse vulnerability in detained asylum seekers and irregular migrants'. The project, which covered 23 EU member states and involved 685 interviews with detainees, examines how those with pre-existing vulnerability cope with detention and how detention can lead to vulnerability.

The DEVAS project is one of very few in-depth research studies in this area. It shows that detention can harm those with pre-existing vulnerabilities as well as those otherwise deemed to be 'healthy'. It finds that the '*human cost of detention is too high*'.[142] While the DEVAS project acknowledges that pre-determined criteria or categories of vulnerability can be useful, it acknowledges that vulnerability is more complex than this and it offers a more holistic perspective.

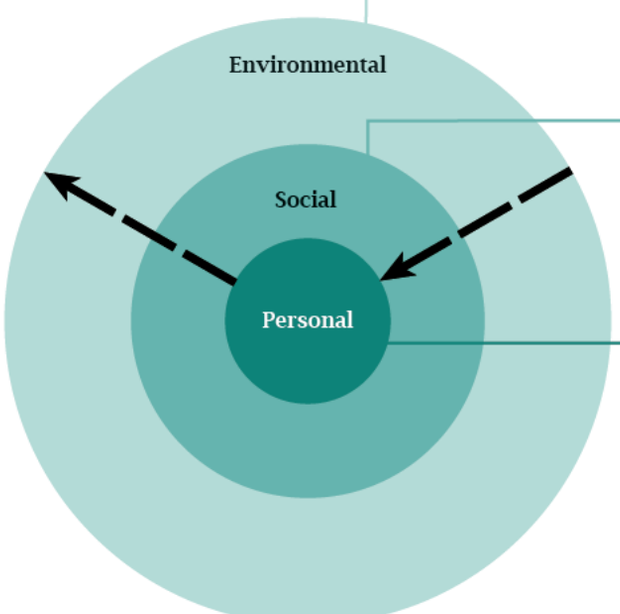
DEVAS conceptualises vulnerability as a concentric circle of personal (internal), social and environmental (external) factors that may strengthen or weaken an individual's personal integrity and ability to cope. The presence or absence of these factors may either empower someone to cope with detention or expose them to further harm. Personal factors include factors which enable a detainee to act on their own behalf – such as language capacity, awareness of the immigration process and mental health. Social factors include means of contact with the outside world, access to NGOs, family visits etc. Environmental factors include terms and length of detention, living conditions and the rules of the centre.

142 Jesuit Refugee Service Europe (2010) Becoming Vulnerable in Detention: civil society report on the detention of vulnerable asylum seekers and irregular migrants in the European Union (the 'DEVAS Project') p 13

## The Concentric Circle of Vulnerability

At each level, any one factor can strengthen one's ability to cope with detention, or it can weaken and thus make one vulnerable to the harmful effects of detention.

Devised by the DEVAS Project.




**Environmental**

- Rules of the centre, 'written' and 'unwritten'
- Staff preconceptions and prejudices
- Existing EU and national legislation and policies
- The architecture of the detention centre and its geographic location
- The terms and length of detention
- Living conditions of the detention centre

**Social**

- Family/friends network in the 'outside world'
- Family/friends network detained separately in the same facility
- Information carriers, such as lawyers and immigration authorities
- The 'outside world' (means of contact to)
- Co-detainees
- Detention centre staff
- Medical personnel
- Visiting NGOs and spiritual/faith counsellors

**Personal**

- Sex and gender
- Age
- Marital/family status
- Personal financial resources
- Personal faith/spirituality
- Personal experiences, past and present
- Level of education
- Level of awareness of asylum/immigration/detention policies
- Sense of self-respect and self-esteem
- Language capacity
- Personal sense of control
- Nationality/ethnicity
- State of physical and mental health

## Project PROTECT

In response to the Common European Asylum System (CEAS) protocols, NGOs from a number of European member states created a simple screening mechanism for early identification of asylum seekers with traumatic experiences.[143] The *Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment* (PROTECT) consists of ten questions which establish a risk rating for the individual who has been screened. The questionnaire is designed to recognise asylum seekers who may be psychologically vulnerable and ensure that they are provided with medical screening and adequate provisions. It was created for use by non-medically trained staff, to ensure that, with training, those in first contact with asylum seekers will be able to assess the risk of each individual.

The implementation of this questionnaire in a number of European member states suggests that a system of screening is possible. The questionnaire focuses strictly on psychological vulnerability within the asylum-seeking population, and thus is not adequate for the purposes of screening for detention. However, the process of creating the questionnaire and implementing the training provides a useful starting point for future screening procedures within UK IRCs.

## EVASP

The *Enhancing Vulnerable Asylum Seekers Protection* (EVASP) research project was conducted across four European countries to investigate '*how vulnerability in asylum seekers is understood and acted upon*'. This was developed in response to the 2007 Green Paper on the Common European Asylum System that recognised that '*serious inadequacies exist with regard to the definitions and procedures applied by member States for the identification of more vulnerable asylum seekers*'. The project was led by the Centre for Trauma, Asylum and Refugees at the University of Essex. The outcome was the establishment of a framework for ascertaining vulnerability and a training package for all those who work with vulnerable asylum seekers.

According to the research, any screening for vulnerability should be focused on ascertaining vulnerability, rather than defining or measuring it. They propose '*a new understanding of vulnerability in asylum seekers that is not locating it exclusively within the coping mechanisms of one person or entirely within the adverse conditions that asylum seekers face, but it is a combination of both external factors and the way asylum seekers experience and respond to them; also it is proposed that we understand vulnerability as an interaction between the asylum seekers and the services available to them.*'[144]

They suggest a broad assessment of asylum seekers' vulnerable positions, which can be used by service providers to ensure they are meeting the needs of all asylum seekers using their services.

Unique to EVASP's conceptualisation of vulnerability is the idea that a person is not necessarily traumatised because they have undergone a traumatising experience. In the case of asylum seekers, this means recognising that every individual will respond to traumatic experiences differently, and that there may be positive and negative outcomes. As a result, EVASP focuses on the specific circumstances of the individual and takes a holistic and fluid approach similar to the DEVAS concentric model, rather than a static or category-based approach.

143 PROTECT –ABLE (2013),Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment, available at [redacted] note 44 at 14

144 EVASP Project (2010) Enhancing Vulnerable Asylum Seekers' Protection: trainer's handbook (EVASP Transnational Report) p6

The EVASP training package includes a range of tools to 'ascertain' vulnerability, which could be adapted to the detention context. For example, their screening process is based on recognising potential vulnerabilities, as well as positive protectors for each individual. Their research found that asylum seekers often describe reception conditions as contributing more to vulnerability than past experiences, so these evaluations take account of individuals' present circumstances – such as their social networks. EVASP presents a trauma and vulnerability grid of 'Adversity Activated Development' which can help service providers ascertain the possibility of vulnerability related to a variety of interpersonal, personal, social and environmental factors.

The researchers present three separate mechanisms for ascertaining vulnerability that focus on the many 'vulnerable positions' of every asylum seeker. To do this, each analysis considers an individual's situation in relation to current provision of services, future provision of services, personal history and dynamics, social connections, family or community support. This evaluation incorporates a dynamic understanding of vulnerability that recognises more than just traditional categories of vulnerable people.

The EVASP toolkit was developed specifically for evaluating asylum seekers, and thus is not automatically transferrable to the UK detention system, but nonetheless provides a holistic, credible model which could be considered and adapted. It has already been adapted for use by the Scottish Refugee Council in their one-stop shop for assessing vulnerable asylum seekers.

## Prison Manuals

In addition to these screening strategies directed towards asylum seekers, prison-based strategies may also provide insights. As prison is punitive, prison policies are not directly transferrable, but they may provide useful angles on the way individuals may become vulnerable within detention. For example, in New Zealand youth prisons a vulnerability scale is used to highlight previous history of victimisation, lack of experience of detention institutions, or lack of social connections within prison as significant risk factors.[145]

Prison manuals produced by the UK and the UN express the *dynamic* nature of vulnerability within detention. They suggest the need for *consistent screening and periodic review of the vulnerable*, especially after any significant changes in their cases.[146]

All these examples show that there are mechanisms which can be drawn upon to assist the Home Office in preventing vulnerability in detention. If prevention of the detention of vulnerable people improves, it is feasible that this would significantly reduce the risk of harm to those concerned and also reduce the number of legal challenges which arise. This could lower the cost of detention overall. We would suggest that analysis of these and other mechanisms is essential to ensuring a positive duty of care towards immigration detainees.

145 Tie, D and Waugh, E Prison Youth Vulnerability Scale Administration and Technical Manual [redacted]

146 Association of Chief Police Officers (2012), Guidance on the Safer Detention and Handling of Persons in Police Custody, Second Edition, p 94, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117554/safer-detention-guidance.pdf

## 5.4 Community alternatives to detention for vulnerable people

The Detention Forum believes that vulnerable people should never be detained and that community alternatives should be sought wherever possible. The detrimental impact of detention on vulnerable detainees, as outlined above, poses serious questions as to the purpose of what is an administrative measure. Research suggests that increased use of detention is ineffective as a means of deterrence,[147] and that compliance rates are often high in areas of positive community alternatives.[148] By using detention for administrative purposes, the state has a responsibility for the daily needs of each of the detainees under their ambit. Use of community alternatives to detention gives those under immigration control better control over their own day-to-day life and decision-making. This increases wellbeing and compliance with international human rights standards.

Models such as the International Detention Coalition's CAP[149] (Community Assessment and Placement) draw on international best practice. They suggest that community-based case management processes can reduce the need for detention and still achieve high rates of compliance – for all irregular migrants, not just those who are vulnerable to the worst effects of detention. The CAP model stresses the importance of forming partnerships with health, child protection and family services, and with NGOs and civil society groups, including legal advice providers and religious organisations, so that individuals are supported to remain engaged in immigration proceedings. This is of course particularly important for vulnerable people.

As our sample shows, detention, especially when prolonged, often creates new hurdles to case resolution, such as claims based on human rights and challenges for unlawful detention. Studies of community alternatives have found that migrants and asylum seekers are more likely to comply with negative decisions when they feel that their cases have been treated fairly and that all options have been pursued, than they are when they feel that their case was ignored or treated unfairly.[150]

The use of detention in the UK is costly and in many cases inefficient and unfortunately we are yet to explore and develop community-based alternatives to detention which follows the case management model described above. The use of community alternatives in other countries suggests that it is possible to have a system that both ensures better treatment for the people affected and also fulfils the State's objectives of immigration control. Although official policy suggests detention should only be used as a last resort, there is no requirement to prove that community alternatives are impossible. This loophole allows for detention even when community alternatives may be well suited. And where detention *is* pursued, increased screening is necessary in order to ensure oversight and protection of those who are vulnerable or become so while in detention.

147 International Detention Coalition (2011), There are Alternatives: a handbook for preventing unnecessary immigration detention, at 011, available at [redacted]

148 ibid at 017

149 ibid

150 ibid at 028

# 6. Conclusion and recommendations

Our study has found that the UK government is continuing to detain large numbers of people who are clearly vulnerable and at serious risk of harm in detention. This in itself is no news; a range of other organisations have criticised policy and practice in this area for many years.

Our case studies include people who fall within categories that the Home Office accepts should only be detained in exceptional circumstances. However, we have also found others whose complex circumstances made them, in our view, vulnerable in detention.

The government appears to accept that current policies and practices are not sufficient to safeguard the wellbeing and health of those in detention, particularly those who may be vulnerable; in February 2015, the Home Secretary announced an independent review of policies and procedures which affect the welfare of those held in immigration removal centres.[151]

Unfortunately, the review's Terms of Reference focuses on the treatment of those who are *already* detained and explicitly excludes examining the role of Home Office decisions to detain. The review, therefore, falls short of considering how the detention of vulnerable people can be prevented.

Our research suggests that the Home Office needs to think about vulnerability in a different way, in order effectively to prevent detention of vulnerable people.

The issue is not just that current policy is failing but that it is inadequate in its own terms.

The current policy focuses the decision-maker's mind solely on whether a person fits straightforwardly into a specific category of vulnerability at the point at which a decision to detain is made. This creates an impression that those who do not fit neatly into the existing categories are not and will not be vulnerable in detention.

This narrow, static and category-based approach to vulnerability contrasts starkly with a holistic approach recommended and used by researchers and other specialists. Our literature survey shows that this more holistic approach to vulnerability acknowledges a range of personal, social and environmental factors which may affect or indeed cause a person's vulnerability. Such an approach also highlights the need to monitor how individuals' vulnerability may change over time.

While we were completing this report, the parliamentary inquiry into immigration detention published its report in March 2015. The inquiry panel concluded that 'detention is currently used disproportionately frequently, resulting in too many instances of detention' and urges the government to radically reform its detention system, starting with the introduction of a time limit of 28 days and the development of community-based alternatives to detention.

Our case studies of vulnerable people in detention demonstrate what the inquiry panel called 'the enforcement-focused culture of the Home Office' – its narrow, static and category-based vulnerability assessment is used primarily to reduce as far as possible the number of people who cannot be detained, rather than to prevent vulnerability from happening in detention.

We propose that reform of detention should include the introduction of a more holistic approach to vulnerability so that the detention of vulnerable people for immigration purposes can be truly eliminated. This is likely to be a complex task, and we hope

151 https://www.gov.uk/government/news/home-secretary-announces-independent-review-of-welfare-in-detention

that the government initiates dialogue with practitioners and experts to overcome various shortcomings identified by this report and others.

With this in mind, we recommend the following:

- **Vulnerable people should never be detained. As recommended by the parliamentary inquiry, community-based alternatives to detention utilising a case management model should be developed.**

  This would enable a move away from an enforcement culture and significantly reduce the use of detention. It would ensure that vulnerable and potentially vulnerable people can go through the immigration system without experiencing detention. The development of such a model is likely to take time and effort, as well as the participation of civil society organisations and other institutions, but the reduced use of detention will generate cost savings which can be reinvested into case working and support in the community.

- **The government should implement all of the recommendations made by the parliamentary inquiry into the use of detention.**

- **The Home Office should develop a vulnerability assessment tool and practice which enables a more thorough approach to screening of individuals before detention, but is also adaptable to changes over time in detention.**

  As we have shown, the current policy on detention of vulnerable people is not working because of its narrow, static and category based approach. It cannot be resolved by an expansion of the types or numbers of categories used to identify and describe vulnerability. A new approach to vulnerability should be based on the use of a holistic assessment tool, building on good practice developed by researchers and other expert practitioners in vulnerability. The primary purpose should be to prevent detention of vulnerable people and the occurrence of vulnerability in detention.

- **The development of such a tool should be carried out in consultation with independent experts, including clinicians and mental health professionals, researchers, and practitioners, through the establishment of an independent expert working group.**

  This working group should oversee both the development of a vulnerability tool and its implementation, which should be regularly reviewed and externally audited.

- **Such a vulnerability tool should be engaged at regular intervals, to enable changes over time to be reviewed. People identified as becoming increasingly vulnerable over time should be released immediately.**

# Appendix: Case Studies Questionnaire

The attached questionnaire is part of a larger research project undertaken on behalf of the Detention Forum (DF). The DF is a loose network of organisations working collaboratively on issues of immigration detention in the UK. The DF's Vulnerable People Working Group is looking specifically at the situation of vulnerable people in the UK's Immigration Removal Centres, with the aim of lobbying for positive change. Currently the Working Group consists of representatives from the Association of Visitors to Immigration Detainees (AVID), Gatwick Detainees Welfare Group (GDWG), Yarls Wood Befrienders, UK Lesbian and Gay Immigration Group, and the Poppy Project. Ali McGinley from AVID and Nic Eadie from GDWG co-convene the group.

The aim of the questionnaire is to gather information on detainees who could or should be considered vulnerable and thus should not be held in detention, but who are in or have been placed in detention regardless. While each of the questions is important for the research in order to be able to gain a full picture of the situation, the most important aspect of the case studies is to determine a) whether there are people who are vulnerable in detention, b) how the UKBA is screening for this, c) whether the screening is being used and what provisions are being made to ensure that the vulnerabilities highlighted are 'managed' in the IRCs.

We have no set definition of what vulnerability means, but rather understand it in a broad sense. In this regard, we welcome a wide range of responses, for those who would consider themselves, or who your organization would consider vulnerable, or otherwise have a situation that makes them unfit for detention.

Each of the questions can be answered with as much detail as available/possible, but considering the essence of time involved, even brief answers will be very much welcomed. They can be answered directly with a detainee or could be filled out with previously obtained information (where detainees have given consent). All information included will be anonymised and held according to data protection standards. Any identifying information will be excluded in the final write-up. Individuals have the right to withdraw their information at any time. If you have pre-written case studies that you are willing to share which deal with similar issues; these could replace the questionnaire for convenience.

I (the researcher) am available to attend a meeting or telephone call to fill-out the questionnaire if it proves more convenient. I am also looking for individual detainees who are willing to participate in a short interview consisting of a similar set of questions for the purpose of gathering more detail. This interview will have no impact on the immigration process and will be anonymised by the same standards as the questionnaire. If you have anyone who would be interested in participating, please be in touch.

Please feel free to be in contact with any questions.

Thank you!

# Case Studies Questionnaire

## Brief history of the case

1. Initials/Pseudonym (optional):

2. Home country:

3. Claim for asylum?
   Yes
   No
   Unknown

   i. If yes, please provide a brief background to better understand the case, and the claim:

   ii. If no, please provide a brief background of the situation prior to detention:

4. Current situation, i.e. outcome of case, case still pending, in or out of detention:

## Specific Issues Prior to or While Being Detained / Vulnerability and Wellbeing

1. What, in your opinion, or in the opinion of the detainee themselves, made the detainee vulnerable in detention?

2. Were UKBA or detention staff made aware of this vulnerability?
   Yes
   No
   Unknown

   i. If yes, how were they highlighted and by whom? i.e. UKBA staff, solicitor, detainee, etc?

   ii. If yes, at what stage did this happen?
   Before detention
   At Initial screening
   Whilst in detention/over time

   iii. If no, was there anything that stood in the way of making any possible complications or vulnerabilities known?

iv. Were the issues recognized and acted upon, recognized and ignored; not recognized at all; or disbelieved altogether? Please elaborate.

v. What was done as a result? i.e. were any ‘special provisions’ made to accommodate the detainee?

3. Was Rule 35 pursued? (If not already answered above):

i. Was there a response issued?

4. How did language impact the process?

## Detention

1. Length of time in detention:

2. Detained Fast Track?
   Yes
   No
   Unknown

3. Was any screening related to vulnerability (in addition to general physical health) undertaken upon entrance into detention?
   Yes
   No
   Unknown

4. Was any screening related to vulnerability undertaken during the duration of detention?
   Yes
   No
   Unknown

   i. If so, can you outline what the screening/questions consisted of?

   ii. Was any response offered? Or was there any change made to the provisions offered in the centre?

   i. Were these adequate?

5. Were issues of vulnerability raised to detention centre staff in any other way? i.e. documents from another centre, another detainee, visitors, chaplain, health centre, etc.

6. How long did the detainee remain in detention after these issues were raised?

7. Any requests for bail or temporary admission?
   Yes
   No
   Unknown

   i. If yes, how many?

   ii. Was there a reason given for refusal?

8. Effects of time spent in detention, i.e., anything important to know about how this impacted health or vulnerability in the long or short term?

9. Did vulnerabilities have any specific impact upon the immigration/asylum case?

10. Were there any specific problems with the staff or other detainees that were not dealt with while in detention?

## Legal

1. Was a solicitor involved?
   Yes
   No
   Unknown

2. What representations did they make? i.e., Temporary Admission application, Bail, First-Tier Tribunal, Upper Tribunal, Judicial Review, Other Representation:

3. What impact did this have?

4. Anything else you would like to add, please do so here:

Thank you!

The Detention Forum