Review into the Welfare in Detention of Vulnerable Persons

A report to the Home Office by Stephen Shaw

January 2016

Cm 9186



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Presented to Parliament
by the Secretary of State for Home Department
by Command of Her Majesty

January 2016

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ACKNOWLEDGEMENTS

In conducting this review, I have been assisted immeasurably by the three colleagues assigned by the Home Office to support me: Ms Debbie Browett MBE, Mr Ian Cheeseman, and Ms Pamela Lloyd. We have worked together as a team in a manner that has been both supportive and collegiate.

I am also grateful to Ms Clare Checksfield, Director, Returns, Immigration Enforcement, who commissioned the review on behalf of the Home Secretary, and to all those in the Home Office, the National Offender Management Service (NOMS), NHS England, and the private sector contractors, who responded to my requests for information, or who agreed to meet with me, or who facilitated my visits across the immigration detention estate.

I have benefited too from the written submissions of evidence that I received from a wide variety of individuals and interest groups. These were, without exception, of an extremely high standard and the fruit of many hours work. My thinking has also been informed by the meetings I held both with past and present detainees – indeed, these meetings were a crucial component of the methodology I have followed – and with other stakeholders.

In addition, Mr Cheeseman, Professor Mary Bosworth and Mr Jeremy Johnson QC provided specialist sub-reviews that are annexed to my report. These sub-reviews are documents of great significance in themselves.

Notwithstanding the collective approach detailed above, all responsibility for this report – both its content and judgements, and any errors or omissions – remains mine alone.

Stephen Shaw
September 2015

FOREWORD

About half-way through my work on this review I came across an essay published nearly thirty years ago concerning the rights of refugees. I may usefully quote these lines: "Over recent years the detention of asylum seekers in Britain has increased alarmingly. In early 1987 as many as 200 asylum seekers were detained … This number has decreased in 1988 to under 50 …"[1]

In contrast, the total number in detention today (whether asylum seekers, ex-offenders, or those otherwise deemed without a legal right to stay in the United Kingdom) is now over 3,000, and the number of people detained at one time or another during the year exceeds 30,000.

The reasons for this increase (including the degree to which it reflects changes in the pattern and scale of international population movements, and/or a change in UK policy) are far beyond the scope of this review. But it is striking that, despite this growth in the use of detention, the places in which immigration detainees are held are so little known to the public at large, and the policies by which they are run are subject to little informed debate outside a small number of dedicated interest groups and an equally small number of Parliamentarians. I refer in this report to the recent court cases in which the Home Office has been found *by the domestic courts* to have breached Article 3 of the European Convention on Human Rights (which outlaws torture and inhuman or degrading treatment) in respect of the treatment of individual detainees. It is simply inconceivable that these cases would be so little known if they involved children in care, hospital patients, prisoners, or anyone else equally dependent upon the state.

It is regrettable that the Home Office does not do more to encourage academic and media interest in immigration detention. Indeed, I think its reluctance to do so is counter-productive – encouraging speculative or ill-informed journalism, while inhibiting the healthy oversight that is one of the most effective means of ensuring the needs of those in detention are recognised and of preventing poor practice or abuse from taking hold. It has been argued internationally that immigration detention is "one of the most opaque areas of public administration."[2] It would be in everyone's interests if in this country it were less so.

More could be done too to develop a clearer identity for the immigration removal centres (IRCs) and an agreed statement of purpose. When I spoke to senior officials of the private sector contractors, a theme of our conversation was the need for Home Office policy and process to reflect what was actually required for the immigration detention estate to do its job rather than trying to transpose prison practices into a very different environment. Current policies and processes do not always distinguish the role of an IRC from that of a prison. One emblematic example: rule 42 of the Detention Centre Rules permits temporary

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[1] Martin Barber and Simon Ripley, 'Refugees' Rights' in *Human Rights in the United Kingdom* (ed. Paul Sieghart), Pinter Publishers, London and New York, 1988.

[2] *Monitoring Immigration Detention: Practical Manual*, Association for the Prevention of Torture/UN High Commission for Refugees (UNHCR), 2014, p.21.

confinement (i.e. segregation) of detainees deemed 'refractory', a word that has been copied directly from the Prison Rules, but one that is not in common use nor likely to be familiar to those whose first language is not English.

The terms of reference for this review were broad, and I must acknowledge that in the time available to me I have not covered every issue in as much detail as I would have liked.[3] I have, however, thought long and hard about two words in those terms of reference: 'welfare' and 'vulnerability'.

So far as 'welfare' is concerned, I have taken the common sense view that all aspects of a detainee's treatment affect his or her welfare to some degree. Thus I have comments on matters as apparently unconnected as access to social media, complaints systems, the location and size of IRCs, and provision for those with physical and mental illnesses. It was also clear from all my discussions with detainees that their immigration status, and the fact, length and uncertain duration of their detention, was the key determinant of their own sense of welfare.

I believe the notion of 'vulnerability' is best understood as a dynamic term. The Home Office recognises through its own guidance that particular individuals – pregnant women, elderly people, victims of torture, among them – have special needs (however inapt that term in the context of torture and other abuse), and should only be detained in exceptional circumstances, and there are international protocols to this effect. I have proposed that victims of rape and other sexual violence, those with Learning Difficulties, and some others, should be added to the list. However, vulnerability is intrinsic to the very fact of detention, and an individual's degree of vulnerability is not constant but changes as circumstances change.

Two clauses in my terms of reference were repeatedly criticised in the written submissions I received and in correspondence sent to the Home Office. Those clauses were "Detention is necessary in the interests of immigration control and the principle is not in question"; and "… the review shall focus on policies applying to those in detention, not the decision to detain". However, I take the first sentence as being a simple statement of fact: I know of no country that does not use detention to some degree at some stage of the removal process. And in the absence of the second sentence I would have been taken into the province of individual caseworking decisions. I have seen nothing in my terms of reference to prevent me discussing the length of detention, the effectiveness of detention reviews, and the use of alternatives to detention, as aspects of welfare and vulnerability, and I have done so.

---

[3] For example, this review focused exclusively on the UK and has not considered experience in other countries. Nor have I much to say on staffing matters, and their impact on detainee welfare. And the review does not extend to looking at children visiting IRCs or what happens to them when their parents are detained (subjects covered in *Fractured childhoods: the separation of families by immigration detention*, Bail for Immigration Detainees, 2013).

Given the pressure on public spending and the need to use scarce resources to their best effect, I have also considered the financial costs of immigration detention and (insofar as I can) the outcomes in terms of immigration control. The use of detention is determined on a direct one-to-one basis by the number of available spaces. A strategic decision therefore needs to be made about the size and location of the IRC estate over the next decade and longer. But my analysis calls into question whether there is a similar correlation (or indeed any correlation at all) between the size of the detainee population and the number of successful removals of those with no right to remain in the UK. In other words, is the Home Office making the most efficient use of resources to achieve its objective of maximising voluntary and enforced removals?[4] In this light, it is particularly surprising that the Home Office makes so little use of alternatives to detention including electronic monitoring.

As my report makes clear, healthcare and particularly the impact of detention upon detainees' mental health, has been at the heart of this review. For that reason alone, it is not possible to distinguish the fact of detention from the consequences for welfare and vulnerability. As a result, while the many proposals I make in this report should improve care and wellbeing, and ensure that the most vulnerable do not suffer unnecessarily, in themselves they do not go far enough.

Speaking for the then Coalition Government, Lord Bates told the House of Lords on 26 March 2015: "I can also say as a statement of intent that we do not, as a direction of travel, want to see growth in the numbers of people in the immigration detention centres." I am not aware that the current Government takes a different view, but based on what I have seen and heard for the past six months my own conclusion is that the direction of travel should be clearly downwards – both for reasons of welfare and to deliver better use of public money. If Ministers and their officials decide to follow the direction pointed by my report, I trust they will do so boldly and without delay.

Stephen Shaw
September 2015

[4] "There is no empirical evidence that detention deters irregular migration, or discourages persons from seeking asylum." (Global Roundtable on Alternatives to Detention of Asylum-Seekers, Migrants and Stateless Persons. *Summary Conclusions*, UNHCR/OHCHR, July 2011, quoted in *Monitoring Immigration Detention: Practical Manual*, op.cit., p.19.)

EXECUTIVE SUMMARY

1. This is the report of a review commissioned on behalf of the Home Secretary. Its focus has been upon Home Office policies and operating procedures that have an impact on the welfare of immigration detainees.

2. The key paragraph in my terms of reference asked me to consider the appropriateness of current policies and systems designed to:
   - identify vulnerability and appropriate action
   - provide welfare support
   - prevent self-harm and self-inflicted death
   - manage food and fluid refusal safely without rewarding non-compliance
   - assess risk effectively
   - transmit accurate information about detainees from arrest to removal
   - safeguard adults and children
   - manage the mental and physical health of detainees
   - other matters the review considers appropriate.

3. I have conducted the review with the assistance of three colleagues seconded from the Home Office. I have visited each of the immigration removal centres, along with other facilities, considered a range of written evidence and other material, and met with a wide range of officials and stakeholders.

4. I commissioned three sub-reviews to help inform my thinking:
   - A review of Home Office policies governing the use of detention and the treatment of detainees
   - A review of those recent cases in which the domestic courts had found the Home Office to be in breach of Article 3 of the European Convention on Human Rights in respect of individual detainees, conducted by Mr Jeremy Johnson QC
   - A literature review of the evidence linking detention with adverse mental health outcomes, conducted by Professor Mary Bosworth.

5. In Part 1 of the report, as well as detailing my terms of reference and the methodology I followed, I summarise themes emerging from the written evidence I received and from my meetings with Home Office officials and stakeholders.

6. Part 2 of the report begins by setting out the history and current structure of immigration detention. I point out that the ten IRCs are very different from one another, and that size, physical security, and location all have an impact upon detainee welfare. I argue that the system has developed in piecemeal fashion and that a more strategic and cohesive approach is required. I recommend that the Home Office prepare a strategic plan for immigration detention.

7. I detail the routes into detention, summarise the legal framework, and introduce the audit of all Home Office policies governing immigration detention that was carried out on my behalf. The audit found no gaps or overlaps in the policy framework, and the individual policies are regularly reviewed. I conclude that there is no case for root-and-branch reform of the Detention Centre Rules, but a process of updating is now overdue. (The full audit is attached as one of the appendices to this report.)

8. In Part 3, I present my impressions of the immigration estate, based on the visits I made during the course of the review.

9. Amongst other matters, I recommend that the pre-departure accommodation at Cedars should be closed or its use changed. I say that a discussion draft of the short term holding facility rules should be published as a matter of urgency.

10. In Part 4, I discuss the concept of vulnerability. I draw upon a model developed by the Jesuit Refugee Society and based upon a study of detention across the European Union. I consider the list of those considered unsuited to detention that the Home Office has issued as instructions and guidance for its caseworkers, arguing that the presumption against detention should be extended to victims of rape and sexual violence, to those with a diagnosis of Post Traumatic Stress Disorder, to transsexual people, and to those with Learning Difficulties. I argue that the presumptive exclusion of pregnant women should be replaced by an absolute exclusion, and that the clause "which cannot be satisfactorily managed in detention" should be removed from the section of the guidance covering those suffering from serious mental illness.

11. I propose that the Home Office should consider introducing a single gatekeeper for detention.

12. I give detailed consideration to rule 35 of the Detention Centre Rules, a rule meant as a key safeguard for those who have been subject to torture or whose health is likely to be injuriously affected by continued detention. I conclude that rule 35 does not do what it is intended to do – to protect vulnerable people who find themselves in detention – and that the fundamental problem is a lack of trust placed in GPs to provide independent advice. I recommend that the Home Office immediately consider an alternative to the current rule.

13. In Part 5, I say that I was acutely concerned to discover that there had been six recent cases (one of which was overturned on appeal) in which the domestic courts had found the Home Office in breach of Article 3 of the European Convention on Human Rights in respect of its treatment of individual detainees. I point out that that such findings are extremely rare as the threshold for finding a breach is understandably a very high one.

14. I go on to summarise the report that I commissioned from Mr Jeremy Johnson QC into the implications of those cases. (His report forms another of the appendices.) I record Mr Johnson's finding that the cases suggest a particular need to focus upon healthcare assessment and treatment, upon failings in detention reviews, and failures in communication between different agencies. Mr Johnson also suggests that the cases may indicate problems with attitude and cynicism on the part of some staff.

15. In Part 6, I give detailed attention to the regimes and practices of the immigration estate. Under personal wellbeing and safety, I consider the prevention of self-harm and suicide, food and fluid refusal, deaths in detention, how information about risk is shared, room sharing risk assessment, allocation criteria, and safeguarding. Under support and advice, I look at the provision of welfare support, legal advice, and access to the internet and social media. In a section entitled day-to-day life, I consider the range of activities available to detainees, the issue of paid work, recreational and educational opportunities, and the central role played by religious observance in the life of each IRC. I also argue that the contractual requirement for an Incentives and Earned Privileges scheme should be ended.

16. After a short section on security and searching, I focus on the issue of segregation, arguing that there is a case for combining rules 40 and 42 of the Detention Centre Rules and recommending that all contractors should be asked to develop improvement plans for their Care and Separation Units.

17. The next section of Part 6 looks at transfers and logistics. Amongst other things, I recommend that the Home Office negotiate night-time closures at each IRC, the times of which should reflect local circumstances. I report observations of charter operations and other transfers.

18. The final section concerns redress and oversight. I offer views on complaints systems, inspection and staff conduct.

19. Part 7 of my report focuses upon healthcare. I welcome the introduction of NHS commissioning, but say that that I found significant variations in access to services across the estate. I look at the process of induction screening and the use of interpreters, and reproduce what I find to be incomplete data on the level of demand for healthcare. Nonetheless, it is apparent that the level of need is extraordinarily high when compared with the general population.

20. I report that much of the written evidence I received concerned healthcare, confirming my view that it is a fundamental aspect of the experience of detention. Deep frustration with healthcare was also a feature of most of my discussions with detainees. I discuss what is sometimes called a culture of disbelief amongst some staff, healthcare

complaints, continuity of care, inpatient arrangements, self-medication, patient confidentiality, staffing levels, and specialist services.

21. In part 8, I introduce the third specialist sub-review: a literature survey on the relationship between detention and adverse mental health outcomes, conducted at my request by Professor Mary Bosworth.

22. The terms for Professor Bosworth's review were as follows:

> "To provide a literature review, within the UK and internationally, of reputable academic work, in any field including clinical studies, that may provide insight into the impact on mental health of immigration detention, identifying gender and vulnerability where possible. Could attention be drawn to any evidence of whether detainees' compliance or non-compliance is a variable in any studies. It would also be helpful to distinguish between the fact of detention, the length of detention, and the indeterminacy of detention as potentially independent factors, and whether there are individual detainee characteristics (for example, age, gender, immigration history and status) associated with higher risk."

23. I have included Professor Bosworth's review amongst the appendices to this report. I regard it as a study of the greatest significance.

24. Two of Professor Bosworth's key findings are as follows:
    - There is a consistent finding from all the studies carried out across the globe and from different academic viewpoints that immigration detention has a negative impact upon detainees' mental health.
    - The impact on mental health increases the longer detention continues.

25. These findings have evident ethical, policy, and practical implications.

26. I recommend that the Home Office should draw up a research strategy for immigration detention.

27. Part 9 presents my other findings in respect of mental health services. I recommend that the Home Office, NHS England, and the Department for Health develop a joint action plan to improve the provision of mental health services for those in immigration detention,

28. Part 10 considers caseworking. I conclude that the Home Office should review its processes for conducting detention reviews, including if and in what ways an independent element could be introduced. I also argue that further consideration should be given to ways of strengthening the legal safeguards against excessive length of detention.

29. I also consider the current use of alternatives to detention, including electronic monitoring, arguing that the Home Office should show much greater energy in its approach.

30. In Part 11, I present my conclusions. I say that a smaller, more focused, strategically planned immigration detention estate, subject to the many reforms outlined in my report, would both be more protective of the welfare of vulnerable people and deliver better value for the taxpayer.

31. I then list 64 specific recommendations.

32. There are nine appendices.

PART 1: INTRODUCTION

Terms of reference

1.1 This review was commissioned on behalf of the Home Secretary, the Rt Hon Theresa May MP, and announced via a Written Ministerial Statement on 9 February 2015. In her statement, Mrs May said:

> "I have today commissioned an independent review into the Home Office policies and operating procedures that have an impact on immigration detainee welfare. Immigration detention plays a key role in helping to secure our borders and in maintaining effective immigration control.
>
> "The Government believe that those with no right to be in the UK should return to their home country and we will help those who wish to leave voluntarily. However, when people refuse to do so, we will seek to enforce their removal, which may involve detaining people for a period of time. But the wellbeing of those in our care is always a high priority and we are committed to treating all detainees with dignity and respect.
>
> "I want to ensure that the health and wellbeing of all those detained is safeguarded. Following the work I commissioned into the welfare of people with mental health difficulties in police custody, I believe it is necessary to undertake a comprehensive review of our policies and operating procedures to better understand the impact of detention on the welfare of those in immigration detention. The purpose of this wider-ranging review is to consider the appropriateness, and application, of current policies and practices concerning the health and wellbeing of vulnerable people in immigration detention, and those being escorted in the UK. I am committed to considering any emerging findings made by the review and to taking action where appropriate."

1.2 Mrs May's reference to the welfare of people with mental health difficulties in police custody has proved especially pertinent.[5] Mental health has been a core element to this review.

1.3 I have appended the terms of reference as Appendix 1.

1.4 The crucial paragraph invites me to consider the appropriateness of current policies and systems designed to:

- identify vulnerability and appropriate action
- provide welfare support
- prevent self-harm and self-inflicted death

[5] The Government is to end the use of police cells under ss.135 and 136 of the Mental Health Act 1983 as 'places of safety' for under 18s, and strictly limit their use for adults.

- manage food and fluid refusal safely without rewarding non-compliance
- assess risk effectively
- transmit accurate information about detainees from arrest to removal
- safeguard adults and children
- manage the mental and physical health of detainees
- other matters the review considers appropriate.

1.5 These terms were not formally amended. However, further to a debate in the House of Lords on 26 March 2015, the Home Office Lords Minister, Lord Bates, wrote to me on 2 April to say that "there was general agreement that it would be helpful if as well as looking at vulnerable persons in general, you were able to look in particular at the issues of pregnancy, disability and victims of rape or sexual violence." (I have reproduced the text of Lord Bates's letter at Appendix 2.)

1.6 In line with what I believe to be the intention of the terms of reference, I have taken a broad approach to the words 'health and wellbeing'. In effect, I have followed the definition of wellbeing that is found in the s.1(2) of the Care Act 2014 which reads:

> "'Well-being', in relation to an individual, means that individual's well-being so far as relating to any of the following—
> (a) personal dignity (including treatment of the individual with respect);
> (b) physical and mental health and emotional well-being;
> (c) protection from abuse and neglect;
> (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
> (e) participation in work, education, training or recreation;
> (f) social and economic well-being;
> (g) domestic, family and personal relationships;
> (h) suitability of living accommodation;
> (i) the individual's contribution to society."

1.7 As a consequence of that definition, this report covers most aspects of a detainee's life while in detention.

How I went about the review

1.8 I was assisted throughout this review by three colleagues seconded from the Home Office: Ms Debbie Browett MBE, Mr Ian Cheeseman, and Ms Pamela Lloyd.

1.9 I have followed an orthodox methodology, summarised as follows:

- I have visited each of the immigration removal centres, Larne House short term holding facility (STHF),[6] Cedars pre-departure accommodation, and the port holding facilities at Heathrow and Dover.[7]
- During each visit I spoke both with staff and with individual detainees, and met with a representative of the Independent Monitoring Board (IMB).[8]
- I also held forums with groups of detainees at the majority of IRCs.[9]
- I visited Holloway and Wormwood Scrubs prisons, meeting staff and detainees.[10]
- Observations were made at Lunar House and Eaton House holding rooms.
- In depth observations of reception were conducted at Yarl's Wood.
- In depth observations of healthcare were made at Harmondsworth.
- Two overnight observations were made of in-country movements of detainees conducted by the escort contractor, Tascor, and one in-country escort for a charter flight.
- I asked for submissions of written evidence and have carefully considered all of those I was sent.
- I met with many stakeholders both one-to-one and in groups.
- I met with a small group of former detainees at the offices of the organisation, Women for Refugee Women.
- I commissioned three sub-reviews to help inform my thinking –
    a) A review of Home Office policies governing the use of detention and the treatment of detainees, conducted by Mr Cheeseman
    b) A review of those recent cases where the domestic courts had found the Home Office to be in breach of Article 3 of the European Convention on Human Rights in respect of individual detainees, conducted by Mr Jeremy Johnson QC
    c) A literature review of the evidence linking detention with adverse mental health outcomes, conducted by Professor Mary Bosworth.

  Each of these reviews is summarised in the text of this report and is annexed in full.
- The President of the National Council of Independent Monitoring Boards kindly arranged for a questionnaire to be sent to every Board focusing on each of the limbs of my terms of reference.
- I have reviewed the existing literature on immigration detention.

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[6] Members of my team also visited Pennine House short term holding facility at Manchester Airport, and the escort contractor's 'cross hatch' area at Heston near Heathrow. I had myself visited Pennine House and Heston in 2013.

[7] There are holding rooms at many airports in the UK, but most are little more than waiting rooms rather than places of detention.

[8] The model for each visit was in line with that advocated in the Association for the Prevention of Torture/UN High Commission for Refugees document, *Monitoring Immigration Detention: Practical Manual*, 2014, p.55.

[9] Attendance at the forums was voluntary and self-selective. I am conscious that there was some over-representation of those who had been in detention a long time and of those with a working command of English.

[10] One of my team also visited HMP Eastwood Park.

- I made a series of information requests to the Home Office. Many of the statistics in this report have not previously appeared in public.

1.10 Although the review was not formally run on project management lines, an action log was kept of all outstanding issues and this was subject to regular review.

Written evidence

1.11 A list of those who submitted written evidence is at Appendix 7. Twenty-nine separate submissions were received. A majority were from Non-Governmental Organisations with an interest in detainee welfare and/or the rights of immigrants.

1.12 The overall quality was extremely high, and I thank everyone who contributed. Extracts are quoted throughout the report, and in the interests of concision I have decided not to provide a synopsis of each submission. Below is a summary of issues of particular interest.

(i) Definitions of vulnerability

1.13 A significant minority of contributors said that all detainees should be viewed as being vulnerable and/or that detention made people vulnerable. There were references to chapter 55 of Home Office Enforcement Instructions and Guidance (EIG), guidelines 5 and 9 of UNHCR Detention Guidelines, and rules 33, 34, 35 of the Detention Centre Rules. Chapter 55 was widely reported as being ignored at the point of detention.

1.14 It was suggested that acute vulnerability was a fluid combination of personal, social and environmental factors, or a matrix of issues that changed over time.

1.15 Screening to avoid the detention of anyone with a particular vulnerability was reported as inadequate, and that it varied depending on the route into detention. There was a call for the implementation of a vulnerability tool to provide a more thorough approach to screening.

(ii) Food and fluid refusal management

1.16 There were various recommendations for improvements to the published policy, including that prison was not a suitable environment for someone refusing food or fluids at the point at which they required inpatient medical care.

1.17 There was a view that clinical advice should be taken more seriously when someone had refused to eat or drink, and that the rules were unnecessarily prescriptive.

(iii) Transmission of accurate information about detainees from arrest to removal

1.18 Information chains were thought to be too long. Caseworker workload was thought to be too great.

(iv) Safeguarding

1.19 There were suggestions that the Home Office did not properly assess the risk of absconding and thus detained those with family responsibilities as single parents. This raised safeguarding issues so far as the children were concerned.

1.20 Rule 35 was strongly criticised, and it was said that reports under the rule were unlikely to result in release or were not given sufficient weight.

1.21 It was suggested that the use of segregation and restraint on those with mental health problems had damaging effects, and should be subject to multi-disciplinary review.

1.22 Referrals to the NRM (National Referral Mechanism) in respect of victims of trafficking were said to have been made without consent, and could be incomplete. Such referrals did not result in suspension of substantive asylum claims, despite the guidance saying that "when deciding to interview the competent authority must consider the benefits of doing an interview against the traumatising effect of conducting it". Furthermore, release of victims was not automatic, but was reliant on independent evidence that could be difficult to obtain.

1.23 It was widely held that releases from detention were not managed well, leaving victims open to re-trafficking or being released to situations that did not meet their care needs.

(v) Management of the mental and physical health of detainees

1.24 It was repeatedly argued that detention harmed mental wellbeing. It was reported that most victims of torture experienced re-traumatisation, including powerful intrusive recall of torture experiences and a deterioration of pre-existing trauma symptoms.

1.25 It was proposed that the range of treatments should be the same as in the community: including the provision of talking therapies such as counselling, cognitive behavioural therapy, access to therapeutic groups and activities, drop-in sessions, specialist services and alternative therapies, all delivered by competent practitioners and consistent with National Institute for Health and Care Excellence (NICE) guidance.

1.26 Linked to this it was suggested that the provision of mental health care in immigration detention should be governed by a set of guiding principles similar to those in the Mental Health Act Code of Practice. People with mental health problems should have access to a trained mental health advocate to assist them

in understanding their rights and advocating for appropriate, effective and timely treatment.

1.27 At present, continuity of treatment for both physical and mental illnesses was disrupted by detention, sometimes with serious consequences.

1.28 It was suggested that mental health care in detention should also comply with:

- the Clinical Guidance on Service User Experience in Adult Mental Health
- the national standards set by the Department of Health's National Service Framework for Mental Health, and
- the Care Quality Commission's Essential Standards of Quality and Safety, which are designed to help providers of healthcare to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people receiving healthcare services (including immigration detainees) have a right to expect.

(vi) Healthcare

1.29 It was said that detainees often struggled to access healthcare, for reasons including language and cultural issues, lack of knowledge about their rights, and negative perceptions of healthcare (sometimes related to their experiences of unethical medical practices in their home countries).

1.30 NHS commissioning was welcomed, although it was argued that there was an organisational distance between commissioners and providers, with healthcare staff often not being consulted properly.

1.31 It was reported that a culture of disbelief persisted in healthcare units, with a risk that doctors may become inured to abusive or negligent practices, or consistently believe that a patient is lying/exaggerating their condition.

(vii) Detention timescales

1.32 The indefinite nature of detention was almost universally raised as making people more vulnerable and for its impact on mental health. There was strong support for a time limit for detention, starting at 28 days.

(viii) Alternatives to detention

1.33 It was suggested that alternatives to detention were not routinely considered by the Home Office. A cultural shift was required to ensure the use of detention as a last resort (as law and policy require), with powers currently being used excessively, harmfully and ineffectively.

(ix) Sexual abuse by staff

1.34 Several case studies were reported. There were accusations that investigations had been inadequate and biased, and that abuse was/is more widespread than reported.

(x) Detention in prisons

1.35 The absence of policies protecting those immigration detainees held in prisons was identified.

1.36 It was reported that detainees held in the prison estate found access to legal advice more difficult, reducing their ability to progress their immigration case, and to seek independent scrutiny and release from detention, as well as affecting their physical and mental wellbeing.

(xi) Terms of reference

1.37 No fewer than eleven submissions referred to the exclusion of the decision to detain from my terms of reference, stating that it was critical to the issues of welfare and vulnerability. One contribution was concerned that the terms of reference did not explicitly cover those detained in prisons.

(xii) Detained Fast Track (DFT)

1.38 DFT was reported as becoming the default option for asylum seekers. It was said that screening did not exclude vulnerable people. There were suggestions that the DFT should be abandoned or subject to fundamental reform.

(xiii) Short term holding facilities

1.39 It was noted that formal rules and regulations had not been published despite a series of consultations and promises/commitments from the Home Office.

(xiv) Staff training

1.40 The submissions identified a wide range of training needs for staff involved in detention – from welfare officers to caseworkers. Such training should incorporate:

- the findings of the courts in the cases where breaches of Article 3 had been found

- compulsory mental health awareness and mental health first aid training to help ensure that staff are able to identify those detainees who are developing a mental health problem or whose existing mental health problem is deteriorating

- training on the provision of culturally appropriate mental health care, including awareness of possible variations in the presentation of mental health problems in detainees from different backgrounds

- training on the Mental Health Act 1983 and the Mental Capacity Act 2005, including the differences between them, so that staff understand how the two statutory regimes relate to each other and can recognise when a detainee's capacity needs to be assessed

- training on the use of de-escalation techniques.

Meetings with Home Office officials and stakeholders

1.41 As part of the evidence gathering, I also met with Home Office officials and with external stakeholders with an interest in the subject matter of the review (a full list of those with whom I met formally is annexed as Appendix 8). At this stage, I simply list without comment the principal points raised:

(i) The principles of detention

1.42 The fact that a large number of people were detained for a significant period of time and subsequently released suggested that some were being detained inappropriately. There should be a stronger focus on getting the right people detained and then dealing with their cases quickly so that they were not detained for too long.

1.43 Alternatives to detention should be more rigorously pursued, including the use of electronic monitoring.

(ii) Movement across the estate

1.44 Transfers between centres were of concern to detainees as they were movements towards the unknown, towards removal, or possibly away from support from detention staff or friends and family.

1.45 Completion of the Person Escort Record (PER) was of variable quality.

1.46 Late night transfers were not always necessary; it was more convenient for the service provider and the Department but very disruptive for the detainee. The transfer process was cumbersome, with detainees having to spend too long sitting on vans.

1.47 Allowing IRCs to be closed to new receptions during night-time hours (say 10.00pm-4.00am) would produce cost savings in terms of nurses and reception staff.

1.48 Transfers were detrimental to detainees' health, especially those taking place in the middle of the night.

(iii) Risk assessment

1.49 Movement orders were being served on ex-offenders without the receiving IRCs being provided with easily accessible details of any offences committed. This made it difficult for the service providers to plan properly and to make risk assessments. The contractors were not set up to manage and assess huge paper files, but were often presented with such files and expected to identify the relevant information. It should be incumbent on the Detainee Escorting and Population Management Unit (DEPMU) to provide a helpful summary of the detainee's history so that the receiving IRC would be in a position to make informed decisions in quick time.

1.50 Detainees should be able to use Skype or similar technology in order to facilitate contact with families, legal representatives etc.

1.51 The whole approach to risk assessment should be reviewed and risk should be properly taken into account in determining population mixes.

1.52 DEPMU lacked the means to carry out a sophisticated assessment of risk. Risk levels were not, as they should be, reviewed every time someone was moved.

(iv) Treatment of detainees/regime issues

1.53 Good leadership in IRCs was an important factor in ensuring that detention staff engaged with detainees effectively, and that staff were representative of the diverse communities they served.

1.54 At Yarl's Wood there was day-to-day intrusive behaviour on the part of staff – entering rooms unannounced, room searches by male teams, etc.

1.55 The complaints process in detention settings was not adequate and often failed to address complaints of bullying.

1.56 Detainees would benefit from the opportunity to undertake more purposeful, constructive and therapeutic activities in detention, such as painting and decorating, or working on a vegetable patch, with a higher wage than was currently possible.

1.57 In IRCs run by the National Offender Management Service (NOMS), the presence and availability of extendable batons – without them necessarily being used – could be useful in crowd control situations. Sometimes, for example, a physical barrier needed to be created between groups of people in dispute. This was not possible in the privately-managed centres.

1.58 Soft personal skills on the part of a member of detention staff often went hand-in-hand with confidence in their own personal safety. Public sector staff were more likely to possess this confidence – private sector staff were perhaps more likely to back away in conflict situations because they lacked it.

1.59 The approach taken to discharge in the immigration estate was too regimented, and did not recognise detainees' vulnerability or serve their best interests. Regardless of the time of day, people were discharged at the appointed time – even if this was late at night when, for example, transport was not available and there was nowhere to go until the morning. This occurred because detention staff were worried about legal challenge if they detained someone a minute longer than they were allowed to (or if that person then suffered an injury). The Prison Service was willing to accept the low risk of being subject to litigation for having acted in the interests of the detainee.

(v) Vulnerability in detention

1.60 There was a natural distress in being detained and any vulnerabilities would enhance this distress.

1.61 All people in immigration detention were vulnerable or potentially vulnerable.

1.62 The unknown length of detention and obliqueness of the process contributed to the potential vulnerability of an individual detainee. This was in contrast to a prison regime where the length of detention was known.

1.63 There must be exceptional reasons to justify the detention of a pregnant woman. There was little evidence that this was the case.

1.64 While the physical care of pregnant women was of an acceptable standard, there was concern whether wider welfare issues were being addressed.

1.65 The vast majority of pregnant detainees in Yarl's Wood were subsequently released. This raised questions about whether they had been correctly detained in the first place.

1.66 There needed to be an ongoing assessment of an individual's level of vulnerability as it varied from person to person and from situation to situation. Some groups of people might be inherently vulnerable (e.g. those with mental illnesses) whereas others might be particularly vulnerable to certain situations (e.g. at the point at which they received their removal notice).

1.67 A working definition of vulnerability would be helpful but there were risks (from the detainee perspective) involved in a prescriptive definition.

1.68 An individual could be vulnerable, but not identified as such, for reasons including their own lack of trust in authority, lack of understanding of processes, or the failure on the part of a caseworker to identify an issue.

1.69 Individuals became vulnerable by virtue of being detained and by virtue of the threat of being sent 'back' to a country they might never have been to before.

1.70 Particularly vulnerable people should not remain in detention. Vulnerability should be identified through an 'indicator' approach and not require 'independent evidence'. Detention should only be continued if there was evidence that such indicators were *not* present.

(vi) Suicide and self-harm protection

1.71 ACDT (Assessment, Care in Detention and Teamwork) care maps and triggers were not widely understood and the quality of observations varied widely across the estate.

1.72 There was a proportionately much higher reliance on ACDTs in IRCs compared with their use in prisons.

1.73 ACDT was more about process than outcome and it drove a staff culture that was, as a consequence, over-interested in the process at the expense of good outcomes. However, the scope for contractors to take a different approach was limited as there were contractual implications should they fail to comply with the required processes.

1.74 The ACDT process was, effectively, 'defensive medicine'. ACDTs were overused and were devalued as a result. Because they were triggered by comparatively minor events, there was a risk that individuals in real situations of crisis might be overlooked.

1.75 Much of the ACDT process applying to IRCs was derived from prison process and was, in many ways, 'Prison Service-lite'. This was a legacy issue. Policy and process should be reviewed in the light of what was actually required for the immigration detention estate to do its job rather than trying to transpose prison practices onto a different regime.

1.76 The trigger for an ACDT was often an individual's fear about their immigration status – and there was no medical or operational action that could be taken in respect of that.

(vii) Rule 35

1.77 The rule 35 process was not fit for purpose and there were cases in which there was physical evidence or accepted mental health reports linked with torture, but decisions were made to continue to detain.

1.78 Medical staff either did not make a judgement as to the consistency of the account by the detainees or, where this judgement was made, it was often rejected by the caseworker.

1.79 Most readers of rule 35 reports were lay. Letters to detainees discredited rule 35 reports on the grounds that the doctor was not independent.

1.80 Rule 35 should be re-written in line with the principles of the Istanbul Protocol.[11]

1.81 Doctors were not given the time and training they needed in order to produce quality rule 35 reports.

1.82 A full review of all aspects of rule 35 was urgently required.

(viii) Healthcare

1.83 There was a relatively high incidence of mental health issues.

1.84 The position had changed from one where mentally ill people were not normally detained at all to one in which mentally ill people would only *not* be detained if they could not be managed in detention.

1.85 People with mental illness could not be satisfactorily managed in detention. There was a clear link between people's experiences of suffering in their country of origin, Post Traumatic Stress Disorder, and exacerbation of symptoms of mental illness in detention.

1.86 Healthcare treatment could be compromised by movements around the estate; sharing information about treatment was often difficult when moves occurred.

1.87 There was a culture of disbelief in terms of both considering asylum claims and dealing with healthcare issues.

1.88 There was a difference in healthcare provision between centres. For example, there was a counselling service in Dungavel but not in most other centres, and there was a variation in the quality of sexual health services across the estate.

1.89 The availability of inpatient beds meant that sick people could stay in detention when they should not be there. Beds were seen as an outward sign of good care provision. Removal centres should not have beds – people who needed healthcare beds should be in hospital.[12]

1.90 Access to external healthcare was restricted by transport availability.

1.91 NHS England had not mobilised as well as might have been hoped. NHS England had commissioned the Central and North West London NHS Foundation

[11] *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

[redacted]

[12] A contrary view was also expressed: that there would always be a need for some healthcare beds – for cases of infectious diseases, for example.

Trust to provide the healthcare services in the Heathrow detained estate (Colnbrook and Harmondsworth) but the Trust may have underestimated the scale of the task. On the positive side, useful lessons were being learned quickly.

1.92 Because the Home Office was a step removed from the commissioning of healthcare services it was not in control of the situation. Looked at from one perspective, this allowed the Home Office to distance itself from the arrangements and take no direct responsibility for any failures. The detention service provider had to deal with difficult healthcare issues but did not yet have a well-founded relationship with the NHS. The Home Office should be performing this function – though it was not clear that the Home Office had as close a relationship with NHS England as might have been expected.

1.93 In some cases in Yarl's Wood, the health service provider had refused to deal directly with Serco, instead referring them to NHS England.

1.94 There was some friction with detention service providers who were frustrated at not having more direct management of healthcare provision. This was evident when volumes of complaints were discussed with them.

1.95 There were huge variations in the IRCs in the levels of healthcare staffing, access to healthcare, training of doctors and nurses, access to interpreters and the time clinicians had available to do the job.

1.96 Doctors in IRCs needed training in human rights and an awareness of their dual responsibilities.

1.97 The issue of equivalence of care was particularly relevant to mental health. For example, there was an absence in IRCs of cognitive-behavioural therapies.

1.98 There was a mistrust of healthcare professionals amongst some detainees that was based on their previous experience of doctors' participation in their mistreatment abroad.

1.99 Detention worsened mental health because it diminished the sense of safety and freedom from harm, it was a painful reminder of past traumatic experiences, it aggravated fear of imminent return, it separated people from their support networks and it disrupted their treatment and care.

(ix) Immigration decisions/advice

1.100 The system needed to be redesigned to facilitate proper resolution of cases. This could include better use of technology (e.g. video links).

1.101 Caseworking should be market-tested.

1.102 There were concerns about detainee access to advice surgeries, in terms of time available to discuss issues, length of wait for an appointment, and quality of advice received.

1.103 Good quality, robust legal advice was necessary, in part to avoid detainees spending money on appeals that were unnecessary and unlikely to succeed.

1.104 There was reported difficulty in persuading legal representatives to attend The Verne, both because of the physical distance from London and because most cases involving Foreign National Offenders (FNOs) no longer qualified for legal aid.

1.105 Bail applications had been rejected on the basis of unsubstantiated comments about the likelihood of an individual absconding.

1.106 Research into the nature of incidents in the immigration estate was required. Detainees were angry about the immigration process rather than the detention regime or the institution, and this often caused flare-ups.

1.107 Video technology should be used to maximise access to detainees in relatively out-of-the-way places like The Verne. Criminal courts were moving towards three-quarters of cases being dealt with by video link, and it was not clear why the same could not apply to immigration cases.

1.108 There was a detachment between immigration case-owners and detainees, not helped by the remote locations of the detention sites.

(x) Other issues

1.109 Significant finds of new psychoactive substances (NPSs or 'legal highs') were being made in prisons and use of these substances was beginning to be observed in IRCs.

1.110 The security arrangements maintained by the detention providers were, to a large degree, governed by the contract arrangements. Because the contracts were based on Prison Service arrangements, it was conceivable that the security requirements were not always appropriate for immigration detainees.

1.111 There were some anomalies in the contracts – for example, the escorting contract required 'softer' escorting arrangements whilst also imposing bigger fines on the contractors when detainees escaped/absconded.

1.112 The Home Office did not have sufficient people at senior level with relevant operational experience.

PART 2: THE CURRENT SYSTEM

Context

The brief history of immigration detention

2.1 Although a power to detain or expel foreign nationals is of long standing, the immigration removal estate is of much more recent origin. A small unit on the site of what is now Harmondsworth IRC opened in 1970, and others were established at Dover and Gatwick. Campsfield House was converted from a young offender institution to an IRC in 1993, but many of those whom I recall were then termed Immigration Act prisoners continued to be held in prisons until the end of the 1990s.

2.2 The total number of such prisoners was relatively small. I am not aware of any time series dating back to the 1970s (although one could probably be constructed from the *Prison Statistics*): a figure of 102 for February 1982 is not unrepresentative.[13]

2.3 The current structure of ten designated immigration removal centres (Dover, Morton Hall, and The Verne, run by NOMS, and Brook House, Campsfield House, Colnbrook, Dungavel, Harmondsworth, Tinsley House, and Yarl's Wood, run by private contractors), plus two short term holding facilities, port detention facilities, and a residual reliance upon prison places, is a creation of the 21st Century, and the drive to increase the number of removals of people with no right to remain in this country.[14] The policy arrangements are also relatively new: the Detention Centre Rules (the statutory instrument that governs how the IRCs are run) themselves only date from 2001.

2.4 It is relevant to the physical conditions in which detainees are now held that the early years of the century witnessed a number of serious disturbances, the most significant of which (Yarl's Wood in 2002, Harmondsworth in 2004 and 2006) resulted in the near total destruction of the buildings.[15]

2.5 There have been other controversies: notably allegations of racism and other malpractice, and protests both inside and outside the centre perimeters.[16]

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[13] Cited in Mary Bosworth, *Inside Immigration Detention*, Oxford University Press 2014, p.44. I have drawn upon Professor Bosworth's book for some other details in this section of the report.
[14] Haslar was decommissioned as an immigration removal centre shortly after I commenced this review.
[15] I conducted the Government's inquiry into the events at Yarl's Wood: *Report of the inquiry into the disturbance and fire at Yarl's Wood Removal Centre*, HC 1257, November 2004. Other inquiry reports were not formally published.
[16] As Prisons and Probation Ombudsman at the time, I carried out two inquiries for the Home Office into the allegations of racist mistreatment. One concerned Yarl's Wood: *Investigation into allegations of racism, abuse and violence at Yarl's Wood Removal Centre*, Prisons and Probation Ombudsman, March 2004. However, despite focusing on an institution that has since closed, the report that may retain the most resonance today is *Report into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort*, Prisons and Probation Ombudsman for England and Wales, July 2005. Shortly after I commenced the current review, Channel 4 News broadcast footage showing some staff at Yarl's Wood

2.6 Reports on each of the IRCs have been published regularly by HM Chief Inspector of Prisons (HMIP), and the local IMBs and the Prisons and Probation Ombudsman (PPO) provide other oversight. However, there has been little academic or Parliamentary interest in the removal estate.[17] Although the Immigration Minister has visited a number of IRCs, officials have been unable to tell me of any visit to an IRC by a Home Secretary.

Ten very different institutions

2.7 The ten IRCs differ in their size and physical security, and these factors have an influence upon the welfare issues that are the focus of this review. Dungavel, Campsfield House, and Tinsley House are relatively small and the perimeter security and internal zoning is relatively unobtrusive. The three NOMS-run centres: Dover, Morton Hall and The Verne, all have significant open air space. In contrast, Brook House, Colnbrook, and Harmondsworth were constructed to category B prison standards, and are somewhat claustrophobic and have the 'feel' and look of contemporary gaols. Yarl's Wood was rebuilt after the 2002 arson and disturbance, and is characterised amongst other things by long corridors and an absence of natural light.

2.8 That the centres have so little in common in terms of their size and architecture betrays the fact that each has developed or been converted in piecemeal fashion rather than as a result of any strategic plan. The strengthened perimeter and internal security that is a feature of Brook House, Colnbrook, and Harmondsworth is intended to prevent a repetition of the serious disturbances to which I have referred, but it is difficult to discern any other systemic characteristics.

2.9 Nor is there much logic to the location of the centres. It is true that Brook House and Tinsley House are on the edge of Gatwick, just as Colnbrook and Harmondsworth are adjacent to Heathrow. But there is no centre east of the Pennines, and none between Lanarkshire and Lincolnshire. The nearest large town to Morton Hall is Newark, and that closest to The Verne is Weymouth. But there is no IRC close to Manchester, and none between Birmingham and Bristol.

2.10 The geographical spread has a real impact upon the welfare of detainees. I found men in Dungavel who received no visits as their families were in Liverpool and Greater Manchester. I found detainees arriving late in the night at Morton Hall, having been transferred from police stations on Teesside. I found women from across the country concentrated in Yarl's Wood in rural Bedfordshire.

2.11 It is my view that the Home Office should begin to think and plan strategically for the type and scale of detention estate it thinks necessary and the

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describing detainees as "animals", "beasties" and "bitches". A separate review, commissioned by the contractor Serco, is currently under way.

[17] An important exception was the *Report of the inquiry into the use of immigration detention in the United Kingdom*, published by the All-Party Parliamentary Group on Refugees and the All-Party Parliamentary Group on Migration shortly before the 2015 General Election.

purposes it will serve. A necessary first step is to decide how much immigration detention it wants and is willing to fund. Over the longer run, those insights should drive decisions about the size, security and location of individual IRCs. Former NOMS sites should only be incorporated if they meet the aims of such a strategic approach.

Recommendation 1: I recommend that the Home Office prepare and publish a strategic plan for immigration detention.

A range of providers

2.12 The table below sets out the current contractual arrangements for each major detention facility and for escorts.

Contract	**Service Supplier**	**Contract start date**	**Maximum Contract Term (years)**	**Bed Space Capacity**	**Healthcare Provider**
Brook House IRC	G4S Custodial & Detention Services	14 March 2009	8	448	G4S Medical Services
Campsfield House IRC	MITIE Care & Custody	30 May 2011	8	282	The Practice
Dover IRC	HM Prison Service	n/a	n/a	401	Integrated Care 24
Dungavel IRC	GEO	25 September 2011	8	249	Med-Co Secure Healthcare Services
Heathrow IRCs (Harmondsworth and Colnbrook are run as one site)	MITIE Care & Custody	01 September 2014	11	1,061	Central North West London NHS Foundation Trust (CNWL)
Morton Hall IRC	HM Prison Service	n/a	n/a	392	Nottingham Healthcare Trust
Tinsley House IRC	G4S Custodial & Detention Services	20 May 2009	8	153	G4S Medical Services
The Verne IRC	HM Prison Service	n/a	n/a	580	Dorset Healthcare University Foundation Trust
Yarl's Wood IRC	Serco	26 April 2015	11	410	G4S Medical Services
NOMS Service Level Agreement	HM Prison Service	n/a	n/a	400	n/a
Larne House STHF	Tascor Services Limited	01 May 2011	7	19	Tascor Medical Services Limited
Pennine House STHF	Tascor Services Limited	01 May 2011	7	32	Spectrum
Cedars pre-departure accommodation (PDA) (part of Tinsley House contract)	G4S Custodial & Detention Services	01 April 2011	6	44	G4S Medical Services

Escorting Services	Tascor Services Limited	01 May 2011	7	n/a	IPRS (sub-contractor to Tascor)
Total No of Bed Spaces				4,471	

2.13 It will be seen that there are five providers of IRC spaces, plus 400 allocated bed-spaces in prisons (purchased by the Home Office under a Service Level Agreement), plus one provider of the two short term holding facilities and the escort contract.[18] A range of providers should encourage innovation and drive down costs, and it is no part of my brief to consider whether a different contracting framework would be advantageous. However, it is open to question how far a set-up of multiple suppliers in competition with one another allows for the development of a more systemic approach or for sharing – and learning from – best practice. Information technology is a further problem with different software programmes not talking to each other.

2.14 I would like to see a clearer corporate identity, and more shared training, communications and staff recognition.

Recommendation 2: The Home Office should consider how far it can encourage a more cohesive system through more joint training and planning, shared communications, and a recognition scheme.

Population

2.15 At my request, the Home Office provided me with a snapshot of those held in immigration detention at March 2015. At that date, there were just over 300 women in detention, and over 3,200 men. (The figures are averages for the month as a whole.)

No. of Females Detained	March 2015
NRC (National Removals Command)	162
TCU (Third Country Unit)	4
Operation Nexus[19]	1
CCD (Criminal Casework Directorate)	48
DFT (Detained Fast Track)	75
Other	3
Border Force	20
Grand Total	313

[18] Figures provided by the Home Office. Maximum numbers as per contracts. Bed capacity can be affected by room usage, accommodation issues etc.
[19] A joint initiative by the Home Office and Metropolitan Police focusing on the identification of foreign nationals who break the law.

No. of Males Detained	March 2015
NRC	1,111
TCU	165
Operation Nexus	62
CCD	939
DFT	798
Other	61
Border Force	83
Grand Total	3,219

2.16 I was also provided with an age breakdown (at 31 March 2015) set out in the table below. Over one third (38 per cent) of those in detention were aged between 21 and 29, and over 90 per cent were under 50. However, there were 174 people aged 20 or under, and 52 people aged 60 or above.

Age	**No. detained**
Under 18	0
18-20	174
21-24	462
25-29	893
30-34	694
35-39	475
40-49	573
50-59	209
60-64	31
65+	21
Total	3,532

2.17 Although the overall age structure is relatively youthful, I am struck by the numbers in their thirties and forties.

2.18 The next tables show the average length of time spent in detention for those either released or successfully removed from the country.

Average Bed Nights per Release	March 2015
NRC total	38
TCU	53
Nexus	152
Criminal Casework	125
DFT (Total detention)	63
Other	3
Border Force	13
Total estate	44

Average Bed Nights per Removal	March 2015
NRC total	43
TCU	49
Nexus	75
CCD	38
DFT (Total detention)	115
Other	12
Border Force	5
Total estate	44

2.19 Those held as time-expired foreign national offenders spend the longest periods on average in detention as the next table shows.

Average Bed Nights per Currently Detained	March 2015
NRC total	39
TCU	44
Nexus	116
CCD	109
DFT (Total detention)	56
Other	48
Border Force	58
Total Estate	65

2.20 As the following tables demonstrate, the number of detainees who are released from detention more or less equals the numbers who are removed (albeit some of those released may be subsequently re-detained or may be removed at a later date). The figures for the NRC and DFT show that significantly more individuals were released than were removed. These figures may call into question the extent to which the current use of detention is cost-effective or necessary – or they may suggest that the NRC and DFT are properly releasing individuals when it becomes apparent that they are no longer suitable for

detention. It would be helpful if the Home Office could analyse some of these release cases in depth.

Number of People Released	March 2015
NRC	654
TCU	87
Operation Nexus	11
CCD	104
DFT	225
Other	213
Border Force	58
Grand Total	1,352

Number of People Removed	March 2015
NRC	452
TCU	61
Operation Nexus	26
CCD	385
DFT	155
Other	57
Border Force	211
Grand Total	1,347

2.21 Of the total of 1,347 people removed in March 2015, 159 were female and 1,188 were male.[20]

Cost

2.22 The Home Office has told me that it costs, on average, £92.67 to keep someone in detention for one night. That amounts to nearly £34,000 per detainee place per year.

Routes into detention

2.23 Those held within the immigration detention estate have entered through a variety of routes.

2.24 They will most likely be:

[20] All figures quoted from paragraph 2.15 onwards have been derived from Home Office management information and are therefore provisional and subject to change. This information has not been quality assured under National Statistics protocols.

- time served FNOs, in other words, those who have committed a crime or crimes and/or been sentenced to a term of imprisonment that reaches the statutory threshold,[21] or who have been issued with a deportation order
- individuals who have claimed asylum, where it is thought that their claims are straightforward to decide (this is called the Detained Fast Track, currently suspended in the light of legal challenge)
- those encountered on enforcement operations - illegal entrants, failed asylum seekers with no further rights of appeal, alleged sham marriage cases etc
- those encountered by the police and who are referred to Immigration Enforcement (IE) as being of potential interest
- people who have previously been encountered, who are reporting to IE regularly, and whose cases have progressed to the point at which they can now be removed from the UK
- people who are detained at the border as having no right to enter the United Kingdom, but whose immediate return cannot be arranged for some reason.

2.25 While the routes themselves are multiple, the means by which people are detained involve four core Home Office processes: asylum cases, criminal cases, cases managed by the National Removals Command, and port cases.

2.26 All individuals in asylum and NRC cases are interviewed and screened and their details are passed to a routing team that decides whether they are suitable for detention at the time at which their details are referred. Border Force makes similar decisions in port cases without referral to a routing team. In criminal cases, decisions on detention and removal are made on the basis of an assessment of a number of factors, including the nature of the crime committed and length of sentence.

The legal framework

2.27 The power to use administrative detention derives from the Immigration Act 1971, and is not an obligation upon the Secretary of State but a means that may be deployed to achieve other lawful purposes. This statutory power of detention has been subject to important case law, of which perhaps the most significant is the *Hardial Singh* judgment. In broad terms, this says that the power to detain is to be strictly and narrowly understood: that is, if detention is not for a statutory purpose it is unlawful, and the power is limited to such period that is reasonably necessary for that purpose to be achieved.[22]

2.28 Detention must also be justified by all the circumstances of the individual case.[23] And the jurisprudence includes the principle that: "Where there is no prospect of removing the deportee within a reasonable time, then detention

[21] Further to the UK Borders Act 2007, ss.32 and 33.
[22] *R v Governor of Durham Prison ex parte Hardial Singh* [1984] 1 WLR 704.
[23] *The Queen on the Application of I v Secretary of State for the Home Department* [2002] EWCA Civ 88, judgment of Lord Dyson.

becomes arbitrary and consequently unlawful under Article 5, and the deportee must be released immediately."[24]

2.29 These principles are reflected in the Home Office Enforcement Instructions and Guidance (EIG), paragraph 55.1.3 of which says:

> "Detention must be used sparingly, and for the shortest period necessary. It is not an effective use of detention space to detain people for lengthy periods if it would be practical to effect detention later in the process, for example once any rights of appeal have been exhausted if that is likely to be protracted and/or there are no other factors present arguing more strongly in favour of detention. All other things being equal, a person who has an appeal pending or representations outstanding might have relatively more incentive to comply with any restrictions imposed, if released, than one who does not and is imminently removable (see also 55.14)."

2.30 Paragraph 55.3 is entitled 'Decision to detain (excluding criminal casework cases)'. It reads as follows:

> "1. There is a presumption in favour of temporary admission or temporary release - there must be strong grounds for believing that a person will not comply with conditions of temporary admission or temporary release for detention to be justified.
>
> "2. All reasonable alternatives to detention must be considered before detention is authorised.
>
> "3. Each case must be considered on its individual merits, including consideration of the duty to have regard to the need to safeguard and promote the welfare of any children involved."

2.31 Paragraph 55.3.A is entitled 'Decision to detain – criminal casework cases'. It reads:

> "As has been set out above, public protection is a key consideration underpinning our detention policy. Where a foreign national offender meets the criteria for consideration of deportation, the presumption in favour of temporary admission or temporary release may well be outweighed by the risk to the public of harm from re-offending or the risk of absconding, evidenced by a past history of lack of respect for the law. However, detention will not be lawful where it would exceed the period reasonably necessary for the purpose of removal or where the interference with family life could be shown to be disproportionate. In assessing what is reasonably necessary and proportionate in any individual case, the caseworker must look at all relevant factors to that

[24] *R (Mahfoud) v Home Secretary* [2010] EWHC 2057 (Admin).

case … and weigh them against the particular risks of re-offending and of absconding which the individual poses."

2.32 Paragraph 55.3.1 of the EIG (entitled 'Factors influencing a decision to detain') states that all relevant factors must be taken into account when considering the need for initial or continuing detention including:

- the likelihood of the person being removed and likely timescales
- a history of compliance with immigration rules and control
- personal ties with the UK
- factors such as an outstanding appeal, an application for judicial review or representations which might afford more incentive to keep in touch than if such factors were not present
- risk of offending or harm to the public (requiring consideration of the likelihood of harm and the seriousness of the harm if the person does offend)
- whether the person is under 18
- a history of torture.

2.33 Individuals who claim to have been tortured should not be detained, or should be released from detention, if there is independent evidence of torture having occurred, and there are no very exceptional circumstances to justify detention. Separately, in the Detained Fast Track, it has been Home Office policy that individuals who have been accepted for a pre-assessment appointment by the Helen Bamber Foundation or Freedom from Torture should normally be dropped out of the DFT, and released from detention, on the basis that a quick decision is no longer in prospect. Both the Helen Bamber Foundation and Freedom from Torture currently have long waiting lists, and the process is creating very significant problems for the two organisations, for those who must wait long periods for assessment and treatment, and for the Home Office. With appointments being set months and years in advance, it is not clear to me that this system can be maintained in the longer run.

2.34 Paragraph 55.10 of the EIG (entitled 'Persons considered unsuitable for detention') establishes explicit categories of individuals whose detention would be appropriate "only in very exceptional circumstances". I list those categories and will review them later in the report.

2.35 At the time at which detention is confirmed, the person who is to be detained is issued with an IS91R form. This tells them that they are being detained, and why. Where detention is confirmed as being appropriate, DEPMU issues instructions (known as movement orders) to the Home Office's escort contractor, Tascor. Should there be any risk factors or medical conditions identified when an individual is interviewed and screened then the case-owner should also issue an IS91 RA. The IS91 RA should be explicit about any known issues or risks. (These documents are produced through the Home Office IT system and should therefore be immediately available to the caseworker responsible for case progression.)

2.36 Depending on where the person is being moved from, there may already be a Person Escort Record (PER form) in existence. If not, one should be created by Tascor. The PER also gives brief details of risks and medical issues. It moves with a detainee every time they are transferred.

The policy framework

2.37 At my request, my colleague Mr Ian Cheeseman conducted an audit of all Home Office policies governing immigration removal, deriving ultimately from the Immigration Act. I have annexed Mr Cheeseman's paper at Appendix 3.

2.38 The extent of implementation and the appropriateness of the policies were not part of Mr Cheeseman's brief as I considered that these were matters for my overarching review.

2.39 In broad terms, Mr Cheeseman finds no gaps or overlaps in the policy framework, and commendably the policies are regularly reviewed. Some are poorly drafted, but the majority are not.

Recommendation 3: Where weaknesses in particular policies have been identified in Mr Cheeseman's audit, I recommend these be remedied at their next iteration.

2.40 While I have not given detailed attention to revising the wording of the Detention Centre Rules as a whole, I have considered rule 3 - which sets out the overarching purpose of the immigration estate. It is the nearest that the immigration estate has to a mission statement and it reads as follows:

> **Purpose of detention centres**
>
> **3.**—(1) 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.
> (2) Due recognition will be given at detention centres to the need for awareness of the particular anxieties to which detained persons may be subject and the sensitivity that this will require, especially when handling issues of cultural diversity.

2.41 It seems to me that a modern rule would properly include a more positive assertion of the need to maintain and enhance detainees' welfare, and their rights, for example, to legal advice. In addition, the rule should emphasise the importance of community and family ties, and activities designed to prepare detainees for life in the countries to which they will return.

2.42 Likewise rule 45, which sets out the general duty of detainee custody officers, would benefit from some attention.

2.43 Rule 45(6) currently reads: "At all times the treatment of detained persons shall be such as to encourage their self-respect, a sense of personal responsibility and tolerance towards others." The maintenance of detainees' wellbeing and the protection of their rights are notable for their absence. I note that UNHCR Detention Guideline 8, paragraph 48 (xvii) reads: "With regard to private contractors, subjecting them to a statutory duty to take account of the welfare of detainees has been identified as good practice."

2.44 Having considered Mr Cheeseman's findings, I am not persuaded that there is a case for root-and-branch reform of the Detention Centre Rules. However, in addition to my ideas for strengthening rule 3, a more general process of updating is now overdue (for example, the references to contract monitors and visiting committees should be amended).

Recommendation 4: I recommend that work to amend the Detention Centre Rules commence following the Home Office's consideration of this review.

2.45 Elsewhere in this report, I have argued for other policy changes that I do not need to anticipate here.

PART 3: MY IMPRESSIONS OF THE IMMIGRATION ESTATE

3.1 During the course of this review, I visited every IRC and all the other principal places of detention. These visits were not inspections, and my approach can best be described as semi-structured. However, as part of the process, my colleagues and I drew up a list of areas/questions to be covered, based on my terms of reference, but informed by the work of HM Chief Inspector of Prisons.[25] Given the limited scope of my visits, I have made relatively few formal recommendations. However, the text includes many other observations and suggestions that I trust will be taken forward.

3.2 During these visits, and during other meetings, I also met with a large number of current and former immigration detainees.[26] I have included relevant comments from these discussions in the accounts below.

Immigration Removal Centres

(i) Brook House (visited on 22 May 2015)

3.3 Brook House is the sister IRC to Tinsley House, located on the perimeter of Gatwick Airport. It is prison-like in aspect and in terms of security, and has a small footprint meaning the facilities are rather cramped. I felt the mosque was now too small for the number of Muslim detainees. There was no sports hall, but there was a well-equipped gym and outdoor games were organised in the yards. The welfare room was also cramped, although other facilities could be used.

3.4 At the time of my visit Brook House held 448 detainees, 20 per cent of whom were FNOs. One man had been in detention for 30 months, and seven others had been detained for more than a year. However, the average length of stay was 52 days.

3.5 The accommodation comprised double rooms, resembling prison cells, albeit with fairly tall ceilings. The toilet/shower was separated from the room by a curtain. Consideration was being given to installing a third bunk (which would be positioned above one of the existing bunks) in each room in order to increase the IRC's capacity. Given the pressure on the other facilities, I do not believe this should go ahead.

3.6 The reception area was spacious and allowed for several arrivals to be processed at once - although I was told there were still bottlenecks and long waiting times if several Tascor vans arrived at once. Some 2,500 people (either arriving or leaving) passed through reception every month.

3.7 The main waiting room was beyond the reception area. It contained soft furnishings, a television, games and reading material, but would have benefited from being carpeted and for provision of magazines as well as books.

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[25] HMIP, *Expectations: Criteria for assessing the conditions for and treatment of immigration detainees*, v.3, 2012.

[26] I was pleased to learn that all IRCs hold regular Detainee Consultative Meetings.

3.8 The two teachers, who covered English, maths, IT, and arts and crafts, fulfilled a pastoral role as well as an educational one. The Centre housed a 'cultural kitchen', where detainees could cook their own preferred meals. (I found similar kitchens elsewhere in the estate; all were excellent and all were extremely popular.)

3.9 Welfare support was provided 365 days a year by two welfare officers, supplemented by external organisations. Detainees mainly accessed welfare services for information on their immigration claims.

3.10 I note this extract from the most recent report of the Brook House IMB:

> "Healthcare has to deal with a very needy population within the Centre. Many men arrive with apparent mental health issues or behavioural problems. These men may be in considerable distress at what is happening to them and they are, perhaps, facing their first time in detention. Self-harming and the threat of self-harm is frequent. A common sight when members visit Eden Wing is to see an officer sitting outside one of the two constant watch rooms watching and making 5-minute observations in the record."

3.11 The Board also reported: "When mental illness is diagnosed detainees will generally be held in the Care and Separation Unit …"

3.12 However, healthcare was said to be good and improving, and better relationships had been developed with local NHS trusts. Feedback from detainees was positive. NHS commissioning had meant quicker and more direct access to mental health services. I was pleased to learn that Occupational Therapists were now employed.

3.13 The 22-bed Eden Wing was a bright environment with a high staff to detainee ratio, serving a variety of purposes. It was used to provide a break from the regular wings, for reintegrating detainees back onto the wings, to separate individuals who were expected to be difficult at point of removal, and to house highly vulnerable individuals. I was not convinced that all these purposes were consistent with one another, and was pleased to learn that a review was under way.

3.14 As elsewhere, I found that ACDTs were used quite freely, even when there was only a small risk. I was pleased to note a drive to reduce the levels of constant supervision on the grounds that it had been used too freely in the past.

3.15 G4S had developed its own, very impressive, Supported Living Plan for those with vulnerabilities including reduced mobility, visual impairment, speech impairment, Learning Disabilities, palliative care and mental illness (an indication of the range of vulnerabilities for which IRCs must provide care). I think the Home Office should consider if aspects of the G4S Supported Living Plan could be introduced in other IRCs.

3.16 At the time of my visit, consideration was being given to introducing additional anti-suicide netting, which I feared would have the effect of making Brook House yet more claustrophobic and prison-like. I understand the netting was installed in June 2015 and that it has already prevented one death or serious injury, albeit netting can sometimes encourage the very behaviours it is designed to safeguard against.

3.17 Despite Brook House housing a number of openly gay detainees, I was told there was no evidence of homophobic bullying. Assault rates as a whole were low, although there had been some assaults against female members of staff. In general, I was pleased to find that the Care and Separation Unit (segregation) was used only exceptionally. However, levels of verbal abuse and threats were quite high, and the use of 'legal highs' (with the associated intimidation) was a developing problem. There had been some concerted indiscipline during the past year by Albanian nationals, "disgruntled by their non-removal".

3.18 Detainees told me that, with one unnamed exception, there was no problem with the behaviour of the staff running the centre. They argued that access to the internet was inappropriately limited, with detainees not able to access information relevant to their cases. They also said the food was poor, did not reflect the diets of African people, and that the portions were very small.

3.19 As elsewhere, most concern was focused on immigration caseworkers. Detainees said letters from the Home Office showed signs of having been cut and pasted. They were not confident that individual cases were properly considered. Monthly review reports said the same thing month after month.

(ii) Campsfield House (visited on 30 April 2015)

3.20 Campsfield House has a good reputation. I found the atmosphere in the centre to be relaxed, with a high level of respect shown by staff and by detainees. Moreover, there were obvious signs of investment in the site, with two wings having recently been refurbished. There were, however, ongoing problems with leakages in showers, although funding was being sought.

3.21 A cap of 100 FNOs had been imposed after a disturbance in 2004, subsequently reduced to 60. At some point the cap had been removed, and at the time of my visit 28 per cent of the population were FNOs. Most detainees seemed to be from the Indian sub-continent. There was no one on the DFT and, more generally, managers said they would like to see a more scientific approach to allocation decisions.

3.22 The rooms were mostly shared, with up to six people sleeping in bunk beds. However, surveys by the centre management and by HMIP showed encouraging results, with detainees reporting low levels of bullying despite the room sharing. However, detainees told me that former FNOs found it difficult transitioning from a single room in prison to sharing with four or five others.

3.23 Pleasing features about Campsfield House included:

- a variety of activities were available and outdoor spaces were accessible
- the mosque was excellently appointed (at Campsfield House as elsewhere, the ability to practise their religion plays a key role in detainees' welfare)
- there was open access for detainees between 6.00am and 11.00pm, with wing access throughout the night, including to showers
- intelligence-led searches were conducted, but routine room searches were not made (something from which other IRCs could learn)
- staff always knocked before entering rooms (something too that has implications for other parts of the estate)
- a Buddy (peer support) scheme was in place
- there had been recent and regular site visits from caseworkers that were thought to have proved useful.

3.24 However, I was not persuaded that there is a need for four roll calls each day. And the reception area was cramped and busy, conversations about welfare and other issues being conducted within earshot of other detainees. These matters needed attention.

3.25 One detainee was observed interpreting for a number of his friends, and staff told me they were aware they could make fuller use of telephone interpreting when new detainees arrived. They should be encouraged to do so.

3.26 Detainees said their dissatisfaction mainly related to their immigration case. Campsfield Houe staff reported that they had recently had a number of people who had wanted to go home, but who had been kept waiting because of problems with documentation or restricted flight numbers.

3.27 The IMB told me that detainees were subject to too many transfers. They also raised issues relating to complaints, legal advice, and access to counselling.

3.28 There were two areas that I felt did not remotely mirror the high standards shown elsewhere in the centre:

- The segregation/separation area (CASU – the Care and Separation Unit) gave the impression of having been abandoned and neglected. Although commendably little used, I found the CASU in need of urgent refurbishment.

- There was an outdoor metal cage for use by detainees who smoked. It was an awful environment and should be replaced by more appropriate arrangements.

3.29 As I understand the position, former plans to expand Campsfield House will not now proceed. For that reason, I have not considered the implications of such an expansion in this report.

(iii) Colnbrook (visited on 14 May 2015)

3.30 Colnbrook IRC sits next to Harmondsworth IRC to form the Heathrow estate. It is prison-like in design with razor-wire surrounding the building. The population is predominately male, although there is also a short term holding facility for women (the Sahara Unit) that holds up to 27 detainees at a time. At the time of my visit, the recently-appointed contractor (Mitie Care and Custody) was still in the process of settling in, and there had been a large turnover of staff.

3.31 The intake unit for men was especially redolent of prison. The ground floor contained the initial accommodation in which new arrivals would be detained for one night. The rooms were small, dingy, and highly unpleasant. They consisted of two bunks, a very narrow standing space, and a toilet and washbasin separated from the living area by a curtain. This was among the very worst accommodation I encountered during this review. The rooms in the other parts of the intake unit were standard new-build cell-like rooms, consistent with those in other centres. The rooms were identifiable with large numbers using typography redolent of Victorian prisons and therefore wholly inappropriate.

3.32 As at January 2015, seven Colnbrook detainees had been in detention for over two years, and a further 29 for between one and two years. Detainees were confined to their rooms from 9.00pm to 8.00am.

3.33 The segregation unit consisted of approximately fifteen rooms over three floors. There were few occupants at the time of the visit. There was little in the way of stimulation for detainees. I was told there had previously been an exercise cycle but this had been removed. The assessment and integration unit was a carpeted area with pictures on the wall, but its overall purpose was unclear.

3.34 The welfare service was well-frequented and dealt with a range of issues. However, I found the room that was used to be very noisy and to offer little confidentiality.

3.35 Approximately 70 per cent of the male detainees accessed healthcare every day. The healthcare unit ran a daily drug clinic at which heroin addicts received their methadone doses. Two GPs were on site every day during office hours and they were on call in the evening. A psychiatrist was also on site. Most of the nursing staff were agency or bank nurses. It was said that around 70 men on the Heathrow estate suffered from a psychotic illness. Because of the demands on healthcare and staff shortages, the healthcare provider had not yet been able to bring its healthcare model up to speed. Detainees complained about long waits for appointments and the attitude of nursing staff.

3.36 The inpatients unit provided heightened monitoring and observation of people in acute states. Some of the former FNOs needed to be in secure NHS mental services outside of Colnbrook, but I was told it was proving difficult to secure beds for them.

3.37 The IMB told me there were delays in transferring detainees out to hospital; there were four healthcare moves per day but this was not sufficient. (I understand there is no contractual limit on the number of transfers.)

3.38 Detainees complained that the food was poor, and there was only limited access to the shop. They said that there was generally little to do. Pay under the paid work scheme was too low, but the principal problem was boredom. Detainees said that the staff were sometimes disrespectful, and that they made noises during the night – for example, jangling keys and talking and laughing. A floor-buffing machine had allegedly been used at 2.00am. Officers were said often not to display their name badges.

3.39 It was reported that healthcare was not as good as was available in prison and it was delivered more slowly than in gaol. Detainees said there were long waits for appointments. The nurses were alleged to be rude and, in an echo of what is often said in prison, paracetamol was usually all they would prescribe.

3.40 One detainee would not talk about conditions in Colnbrook – the fact of his incarceration was the issue. He had spent all of his life in the UK and had no direct connection with the country to which he was due to be 'returned'.

3.41 Others focused on the indeterminate nature of detention. It was claimed that those who had been in prison had only been informed the day before their date of expected release that they would continue to be detained, when arrangements had already been made for their families to greet them on release. In prisons, people knew how long they would be detained. In immigration detention they did not.

3.42 Caseworkers were said to be driven by targets and forgot that they were dealing with human beings. For example, the Home Office had used the fact that a London man had not had many family visits whilst in prison in Scotland as grounds for arguing that he did not have close family ties and did not, therefore, have a valid Article 8 claim. (These criticisms of caseworking decisions were largely endorsed by what I was told by the IMB.)

3.43 Detainees were also worried about being moved out of Colnbrook at short notice and further away from their families. But most said they had arrived at the centre at reasonable times.

3.44 It is clear to me that a lot needs to be done at Colnbrook to ensure that detainees' needs are properly met. There is much pressure upon healthcare, and a need for a greater range of activities. Aspects of staff culture need addressing too. From a welfare perspective, my principal concern at Colnbrook is with the ground floor rooms of the male intake unit. They should be decommissioned.

3.45 As well as the male accommodation, I observed the Sahara Unit during my visit. It consisted of nine three-bedded rooms and a communal area. The bedrooms were rather cramped and looked out onto either a wall or razor wire. In contrast, the living area was quite spacious with soft furnishings, a cycling

machine, a multi-trainer, a pool table and a table tennis table, albeit there was no natural light. The atmosphere was relaxed, but access to the external areas was through locked doors and could only be attained on an escorted basis.

(iv) Dover (visited on 5 June 2015)

3.46 Dover IRC occupies buildings constructed to defend Britain against Napoleon. They were taken over by the Prison Service in the 1950s. Areas of the centre are listed, but the accommodation blocks are more recent additions.

3.47 There is a mixture of accommodation, ranging from single rooms to six-man dormitories. Rye Unit provides three storeys of prison-like accommodation, complete with suicide netting. Deal Unit holds the detainees (many of them ex-prisoners) whose behaviour is deemed the most challenging.

3.48 At the time of my visit the centre held a high percentage (40 per cent or more) of time served Foreign National Offenders (TSFNOs).

3.49 The segregation unit (Care and Separation Unit) was used for a variety of purposes, including where individuals were segregated for their own protection and for those with communicable diseases. Two of the fifteen rooms were basically stripped cells. One of the rooms had a Perspex screen for use when a detainee was under constant supervision.

3.50 There was a lot of outdoor space that seemed to be well used and a range of physical and educational activities were available. More generally, considerable effort had been taken to improve the environment through re-decoration and the removal of grilles. The ethos reflected the Prison Service's longstanding 'decency' agenda, applied to the different circumstances of an IRC, with a particular emphasis upon the reduction of violence. There was much to commend in this approach.

3.50 The primary purpose of my visit was to consider healthcare commissioning through NHS England in a centre where the arrangements were mature. I found evidence to make me confident of the benefits that NHS commissioning will in time deliver across the IRC estate.

3.51 I was told that mental health treatment and management were key issues, with the healthcare team (the contractor is IC24, a not for profit social enterprise) reporting up to 20 per cent of the population on a treatment regime that involved taking medication for their illness. Psychologists provided three sessions a week for detainees, with a focus on coping mechanisms such as mindfulness. Where a detainee required longer-term psychiatric assessment than Dover was able to provide they were usually moved to Colnbrook.

3.52 The transfer to psychiatric hospital of sectioned patients was said to work well; the transfer of those with serious physical illness was not so smooth but was effective in emergencies.

3.53 Despite the high number of detainees receiving some form of treatment for mental illnesses, there was no care suite. Soft seating and a cool down area were available in the segregation unit, but it was reported that the facilities were not often used.

3.54 The healthcare team demonstrated a more progressive medications management regime than I had seen at other IRCs, with a range of more routine drugs held in the possession of the detainee.

3.55 The team reported that all the doctors who worked at the centre had been trained in the completion of rule 35 reports, and that they submitted an average of twelve such reports each month. It was their impression that very few detainees were released as a result.

3.56 Nine people were on detoxification programmes at the time of the visit, with methadone being the predominant maintenance therapy. The organisation RAPt (Rehabilitation for Addicted Prisoners Trust) provided a substance misuse programme.

3.57 There were counselling sessions made up of short intervention programmes (as talking therapies should last 12 weeks, and many detainees would not otherwise be able to complete them).

3.58 The healthcare suite had benefited from recent investment. However, it included a detoxification cell not used for detoxification, but which I was alarmed to learn had been used as short-term accommodation for a transsexual detainee. The room was not fit to be used for any residential purpose, and its use for a transsexual person was wholly inappropriate.[27] I believe that the detoxification cell at Dover IRC should be decommissioned immediately. Never again should it be used to house transsexual detainees.

(v) Dungavel House (visited 4 March 2015)

3.59 Dungavel House is the only IRC in Scotland. This Scottish context explains why healthcare is not commissioned by the NHS, and why mutual aid is provided by the police and not the prisons.[28]

3.60 The centre has a good reputation within the Home Office, with its IMB and with HM Inspectorate of Prisons. In its 2014 Annual Report, the IMB described the accommodation as "of excellent standard".

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[27] UNHCR Guideline 9.7 (paragraph 65) says of LGBTI asylum-seekers: "Where their security cannot be assured in detention, release or referral to alternatives to detention would need to be considered. In this regard, solitary confinement is not an appropriate way to manage or ensure the protection of such individuals."

[28] I did not enquire into the matter further, but I was surprised to learn that there is no Memorandum of Understanding between Dungavel and the Scottish Prison Service meaning, amongst other things, that prison records are not transferred. I gather there is no agreement with the Northern Ireland Prison Service either. I assume this is something that the Home Office will continue to pursue with the Scottish Government and Northern Ireland Executive.

3.61 At the time of my visit I was not so impressed with the accommodation. In particular, the female area was cramped, with two dormitories sleeping six and eight women respectively. Observation suggested that it would be possible to touch the beds on either side of the one in which a detainee was sleeping. There was no outdoor space designated for the use of women only. If Dungavel is to have a long-term future within the immigration estate, the living accommodation should be refurbished to more acceptable standards, with particular attention paid to the sleeping arrangements in the women's dormitories.

3.62 More positively, there was no restriction on movement, except that female detainees were not allowed on the male unit and vice versa. Freedom of movement at night was within individual blocks.

3.63 The outside space was well used and a variety of sports facilities were available. There were several educational and recreational activities, and the art facilities appeared to be popular.

3.64 Staff in reception said that they saw one person at a time, and that detainees waited in the van until they were seen. Detainees reported that waiting times for reception were up to three hours, with long waits on vans being commonplace and long transfers to Dungavel the norm.

3.65 Healthcare was available seven days a week 8.30am - 5.00pm. However, I was subsequently advised that out-of-hours GP cover was provided on a grace and favour basis: it was not covered in the contract. The complement included three registered mental nurses (RMNs) plus a counsellor. A range of group therapies are described in the IMB's annual report.

3.66 Detainees told me there was a long wait for healthcare appointments. The dentist and optician visited only once a month. Uncertainty about length of detention was reported as being a significant worry, causing deterioration of welfare and mental health.

3.67 They also criticised the fact that only 16 single rooms were available, challenged the frequency of rice and chips in the meals, and said that library resources were inadequate.

3.68 There had been movements with only thirty minutes notice and transfers in the middle of the night. It was alleged that some detainees had arrived in January and been turned back because of snow on the approach to the centre. Consequently the six detainees had been returned to their starting point, a round trip of eleven hours. (I have not endeavoured to confirm this account.)

3.69 Detainees also said that written and verbal information from the Home Office was poor and there was inconsistency in the handling of similar cases. Caseworker names and contact details changed regularly and they were often unavailable.

3.70 Two detainees claimed they had been detained despite being carers for wives with mental health conditions. Three detainees had been in detention for more than a year.

3.71 A surprisingly large number of those who attended the detainee forum I organised had been detained because of allegedly sham marriages. Most had been detained after Home Office interviews in Liverpool or Manchester. The questions they said they had been asked by caseworkers to ascertain whether their marriage was a sham included their knowledge of their wife's National Insurance number, the colour of her underwear, and her bra size. If this was indeed the case, it is questionable whether such questions were either appropriate or useful.

3.72 I was concerned to find that the IMB had only three members and was not functioning as it should. The Home Office should liaise with colleagues in the Ministry of Justice to ensure that the Dungavel IMB has a full complement of active members.

(vi) Harmondsworth (visited 24-25 March 2015)

3.73 Harmondsworth is a large IRC (648 detainees) with very limited outdoor space. It has the look and feel of a closed prison.

3.74 The majority of the beds at Harmondsworth were used for those detainees whose asylum cases were being dealt with through the DFT process, but there were also a large number who had been moved to Harmondsworth for other reasons, including to be closer to departure flights.[29]

3.75 Harmondsworth had recently become the responsibility of Mitie Care and Custody. It was reported that this had brought renewed determination to improve facilities, with a better reception environment, new interviewing rooms, softer lighting and an enhanced welfare facility.

3.76 Recent regime changes included ending day-time lock-ups and a lengthening of the hours within which detainees could access services from three hours to eight hours. Night-time lock-in was between 9.00pm and 8.00am. Between these hours detainees in the new-build were locked in their rooms and those in the older part of the complex were restricted to their rooms and connecting corridor. Healthcare service improvements were also reported as being in train, and I was able to observe some improvements to counselling services at first hand.

3.77 There is certainly a long way to go. Harmondsworth IMB's 2014 annual report includes this line: "Harmondsworth IRC is in large parts a depressing, dirty place and in some cases has a destructive effect on the welfare of detainees."

[29] A Home Office official interviewed for this review questioned the use of Harmondsworth for those on the DFT. It is certainly odd that some of the most secure accommodation in the estate is used for those who have committed no criminal offences.

3.78 The IMB report raises many issues:

- physical facilities
- "chaotic" healthcare
- staffing levels and low staff morale
- length of detention ("there is an urgent need to set up an independent review of those detained for more than one year")
- inter-IRC moves
- contact with caseworkers
- use of segregation as a 'therapeutic' environment while waiting for a mental health bed
- legal advice
- body cameras
- problems for disabled detainees.

3.79 In addition, "the IMB consistently questions whether certain detainees are fit to be detained."

3.80 The Board's report is especially impressive – and would be a model for others. I do not know whether it is routine for all IMBs to exchange their annual reports; if not, they should be encouraged to do so.

3.81 During my visit, I discovered there was a high number of open Assessment, Care in Detention and Teamwork documents, and there were long waits to access welfare services when I observed the new drop-in system.

3.82 I was also concerned that the care suite had been closed despite Harmondsworth being the centre that received mentally ill patients and long term food and fluid refusal cases from elsewhere in the detention estate.

3.83 Privacy in the toilets in some rooms consisted of a shower curtain, and I found toilets that were without basic hygiene equipment (soap and paper towels).

3.84 Detainees I met were concerned about the treatment they received from some staff, about the quality of healthcare treatment, and more generally about the management and progression of their cases by the Home Office. They said that waiting times for healthcare were too long (there were reports of two to three days to see a nurse and three to four weeks to see a doctor). As elsewhere, I was told that the general response in the majority of cases was to provide paracetamol. As elsewhere, I was told that healthcare staff were rude.

3.85 I arranged for a team member to observe healthcare in Harmondsworth for a day:

> "The healthcare team on site reported improvements in record keeping and appointment management through the introduction of SystmOne. They also reported that they were improving appointment booking

further by introducing direct booking by detainees rather than through DCOs [detainee custody officers]. Waiting times for routine appointments were three days maximum, but appointments for specialist services were up to 16 weeks.

"There was some backlog for receipt of medications in the evening, but that was because a drugs delivery was late from the supplier. It was reported that there was a meeting with the pharmacy concerned planned to resolve any issues. More than one detainee was allowed at the dispatching hatch at any one time, however, and there was some confusion about delivery dates for multiple prescriptions for detainees. No interpreting services were used, but it was evident in at least one case that this would have been useful.

"A member of the mental health team reported that two psychiatrists were on site, supported by a large team of mental health specialists. The team delivered a range of services consistent with those available in the community, including talking therapies. There were plans to introduce group sessions, but this was hampered by the lack of therapeutic environment. During our discussions a DCO knocked and entered the consultation room we were using without permission. This was reported as a frequent occurrence.

"It was clear that the physical facilities were being improved with ongoing work in the dentistry suite and the kitchen on the inpatient corridor. There was evidence of dilapidation, however, with frayed particle board covering plumbing, holes in linoleum that appeared to have been there for some time, and chairs with worn covers."

3.86 There were also allegations from detainees that some staff had used inappropriate language or made threats. There was said to be no connection with officers – no personal officer scheme and no pictures of officers on walls. Detainees did not know the names of staff.

3.87 Detainees also said that the food was of poor quality and there was not enough variety. The number of fax machines was inadequate for detainees' needs. The shop was not open for long enough and the barbers was available at random times.

3.88 I also encountered much criticism of the DFT process.

3.89 It is apparent that a process of improvement and reform needs to take place at Harmondsworth. There is no merit in my repeating recommendations made by the IMB and the Inspectorate.

(vii) Morton Hall (visited on 29 May 2015)

3.90 Morton Hall has the largest footprint of any IRC (92 acres), much of it outdoor space that is not used. The centre gave every impression of being very well-run, although I saw some litter and some graffiti.

3.91 At the time of my visit the centre reported that 55 per cent of the population were time served FNOs. A third of the detainees were under 25 years of age.

3.92 Morton Hall had a relaxed regime and the accommodation was in single rooms. The rooms were adequately furnished, but I observed that the showers were in need of a deep clean, having mould around the seals at the bottom of the units. Some of the toilets were in similar need of a deep clean. The shop was small and tired.

3.93 I was told that criminality and drug use were issues, with little in the way of sanctions for inappropriate behaviour other than moves within the estate. The use of 'legal highs' had risen and there were reports of detainees testing substances on their peers.

3.94 The centre reported an average of five detainees on ACDT at any one time, with the majority managed in dedicated rooms on each unit.

3.95 The rooms used on first reception were in a wing that was remote from the rest of the site, and which required a new detainee to walk long distances with luggage in all weather and at all times of the day and night. I trust that a means to remedy this can be found. The log showed that there had been eleven arrivals the night before my visit, with an average of three and a half hours wait until the detainees were moved to the first night rooms. One detainee had left the centre at 03.45 for a move to Campsfield House.

3.96 There was a wide range of activities and paid work available. Education offered courses in less traditional skills such as confidence building. Detainees are not paid to take part in educational activities, but there was also some paid work, although I was told there was much less activity than in the days when Morton Hall had operated as a prison.

3.97 It was argued by one manager that Morton Hall's catering contract with 3663 (as part of a Prison Service-wide contract) did not meet the different dietary needs in an IRC.

3.98 Healthcare had more space than in most IRCs, and so there was greater respect for privacy, and separate areas for arranging appointments and for receipt of medications. Healthcare staff reported that up to half of the people they saw had mental health problems, and that Post Traumatic Stress Disorder symptoms were relatively high having been previously undiagnosed. I shared with staff what I believed to be a ligature point in the CSU.

3.99 There was no care suite; I was told that ACDT procedures were generally triggered by immigration issues.

3.100 There was a seven-to-ten day wait for NHS and private dental healthcare; an optician was on site once a month.

3.101 I was concerned that some aspects of risk were not being properly assessed in allocation decisions (ten per cent of the detainees at Morton Hall had markers for risk to women). There was some criticism of DEPMU staff as being junior, inexperienced, and non-operational.

3.102 The visits room was nicely appointed, but on inspection it was clear that the box containing visitor survey forms had not been emptied since at least September 2014. All bail hearings were conducted by video link.

3.103 Detainees told me that the mobile phone signal was poor (this did indeed seem to be the case).

3.104 There appeared to be no specific programmes to help drug users. I was told there were three different approaches to detoxification in IRCs: sustain; detoxify; do nothing.

(viii) Tinsley House (visited 8 May 2015)

3.105 Tinsley House is adjacent to Gatwick Airport and is managed in combination with Brook House further down the same perimeter road. It was reported that this meant that detainees who were felt to need a more structured regime were moved to Brook House, while those who may be more vulnerable were moved from Brook to Tinsley.

3.106 The centre was bright and airy, with a relaxed regime and well maintained outdoor space.

3.107 At the time of my visit, no detainee had been held for longer than six months.

3.108 There was accommodation intended for families on the site. This had recently been used to house vulnerable people when there were no children in residence. (While this indicates some 'mission creep', the accommodation was appropriately furnished.) It was bright, well decorated and well equipped, although with limited facilities for older children. There was a separate reception area that was staffed at all times. [30]

[30] Family groups arrested at Heathrow go to Tinsley. At Manchester or Glasgow Airports such families would be temporarily admitted and housed locally.

3.109 The rule 40/42 (segregation) accommodation was very poor, and little thought had been given to the holding area. This area was also used for those in need of constant supervision.[31]

3.110 Paid employment mainly consisted of cleaning and kitchen work. There were no workshops and Tinsley was acknowledged as being a service economy, not a production economy. There were limited education facilities, consisting of English/maths/IT/food hygiene/first aid/health and safety training/arts and crafts. Healthcare facilities were accessed via a stable door, affording little privacy when talking to healthcare staff. I would hope this could be remedied.

3.111 IMB membership was well below complement. As at Dungavel, this should be corrected.

(ix) The Verne (visited 17 March 2015)

3.112 The Verne is the most recent addition to the IRC estate, having previously been a prison. There was a long transfer period from the National Offender Management Service, during which the site had been used exclusively for housing Foreign National Offenders.

3.113 There was still a high proportion of FNOs at The Verne at the time of my visit (over 50 per cent), although I understand this has now fallen. This included MAPPA 1 cases,[32] individuals who would certainly not have been held at The Verne when it was a prison. There were 21 so-called Prominent Nominals.[33] Although at first sight counter-intuitive, the level of physical security had been increased on conversion to an IRC with the addition of grilles, fences and razor wire. Given the nature of the population, I felt this was justified.

3.114 The site on the Isle of Portland was some way from the nearest station in Weymouth. (It was also some considerable way from the homes and communities from which most detainees hailed. I met many from London.) There was no routine public transport, although NOMS had been asked to provide a bus from the station. There was no visitor centre either. I am told that the visits hall itself is large and has recently been refurbished.

3.115 Video conferencing was used between the centre and the immigration court in Wales.

3.116 I was concerned during my visit on observing behaviours that I have frequently encountered in prisons. Violent incidents between detainees were said to have increased, and to be higher in number than at other IRCs. As I also found at Morton Hall, this raised questions about the sophistication of allocation procedures (the Prison Service has developed an algorithm to prevent the

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[31] "… those who needed constant supervision were held in the bleak care and separation unit", HMIP, *Report on an unannounced inspection of Tinsley House Immigration Removal Centre*, 1-12 December 2014.

[32] MAPPA – Multi Agency Public Protection Arrangements.

[33] Individuals believed to pose a particular risk.

accumulation of too many young and potentially disruptive prisoners in its less physically secure establishments).[34]

3.117 Just before my visit, there had been an incident during which a detainee had climbed onto a low flat roof, put a noose around his neck, and threatened to hang himself. He had been brought down but, when the staff present had tried to assess his condition, they had been charged at by other detainees. Windows had been broken and there had been some disorder, but other staff had quickly come to the area, spoken to detainees, and ended the disruption.

3.118 The staff concerned acted quickly and commendably, and from what I could see they had prevented a much more serious outcome. I trust this has been appropriately recognised.

3.119 The general accommodation mainly consisted of single rooms, although there were double rooms dubbed 'limo rooms' that were narrow and had beds toe to tail. These rooms did not seem to be fit for purpose or appropriate for shared use. I believe they should be re-designated for single accommodation.

3.120 The first night accommodation was made up of cubicles within dormitories. While staff reported that the dormitories were very popular with detainees, I was asked to look at the accommodation by one detainee who was dissatisfied with it.

3.121 There was free association within the secure area for detainees, with night access restricted to zones of 20 detainees.

3.122 There was also a relatively large number of practical skills being taught, in addition to the usual IRC activities. These seemed to be broadly welcomed by staff and detainees and there was evidence that they were in demand. The industrial workshops (a hangover from The Verne's time as a prison) were both popular and impressive.

3.123 The block where the management team was based was outside the inner perimeter fence, creating an artificial barrier between managers, staff in the centre and detainees.

3.124 There was strong demand for the shop, and this created queues outside the building. This was openly criticised by detainees, and there were plans to change the layout to give access to more customers at any one time.

3.125 I had a most useful meeting with the healthcare team. They told me there had been more elderly detainees than predicted, more mental health problems than predicted, and longer periods of detention than anticipated. They argued very strongly against IRCs having inpatient beds, on the grounds they would be used for detainees on open ACDTs or to prevent transfers to secure mental hospital. (I am conscious that the term 'inpatient bed' is not strictly comparing

[34] See also paragraphs 6.69-6.75 below.

like with like.) It was said that The Verne had successfully transferred more detainees with severe mental illness into psychiatric hospital than other IRCs. It was also suggested that some of this mental illness had gone undiagnosed in prisons.

3.126 The vulnerability of Type 1 insulin dependent detainees was emphasised, as was the impact of stress on both diabetes and asthma.

3.127 Other issues raised at The Verne included:

- it was said that 24 out of 25 detainees upon whom rule 35 reports had been submitted had not been released
- detainees could not be bailed for the purposes of drug rehabilitation and were not entitled to rehabilitation services. However, maintenance doses of methadone were not allowed
- not all IRCs were yet on SystmOne (to enable the electronic transfer of medical records)
- one transfer in three took place after 10.00pm.
- The Verne had no care suite
- there were no care packages for vulnerable people who were released from detention
- one man had been kept in segregation in the CSU for 40 days
- adult safeguarding boards did not engage
- an audit had found three detainees without an immigration caseworker.

3.128 I was pleased to learn of the proposal to allow IMB members to have a phone to ring detainees. This has implications for IMB practice throughout the estate.

3.129 Several staff emphasised the physical health dangers of new psychoactive substances like 'spice', use of which was said to have become more frequent. These included side effects such as epileptic fits, and 'near misses' including choking on vomit.[35]

[35] In one month in 2014-15 for which I obtained figures, there were 23 drug finds across the estate, 14 incidents involving the use or brewing of alcohol, and 37 assaults (either detainee on detainee or detainee on staff). The smuggling and abuse of drugs and 'legal highs' is almost always associated with intimidation and violence.

(x) Yarl's Wood (visited on 24 February 2015 and 31 March 2015)

3.130 Yarl's Wood is the main accommodation for female detainees. It houses one of the largest concentrations of women deprived of their liberty anywhere in Western Europe[36] and, as HM Chief Inspector of Prisons has argued, it is "rightly a place of national concern".[37] For that reason, I have devoted more time to this IRC than to any other.

3.131 The accommodation itself was observed as being clean and well cared for with a variety of on site services available. There was a wide range of activities, educational opportunities and paid work. There was less activity at weekends, to some extent because this was when friends and family could visit. There was little opportunity to spend time in the open air.

3.132 In a most thoughtful contribution, the Yarl's Wood IMB told me:

> "A high proportion of detainees arrive at night and are disoriented, frightened and confused and are therefore unable to take on or impart the information given or required during the lengthy 'Reception' process. Many will have had a long journey. Healthcare screening as part of this process is all too often conducted by male nurses, so the female detainees may be reluctant to disclose sensitive information which might be highly relevant to their vulnerability and/or suitability for detention. Some detainees have little or no English so the induction briefing must be confusing, carried out as it is when the detainee is already feeling disoriented. The use of a telephone translation service can hardly encourage detainees to reveal sensitive information."

3.133 I met with a large number of women detainees who raised concerns about case management by the Home Office and (vehemently) about treatment by healthcare. Indeed, the most striking aspect of Yarl's Wood was the number of women accessing healthcare every day. I was told this was in the region of 90 per cent of detainees. There could be no more striking example of their vulnerability. Very many of the women were taking anti-depressants. A feature of the 'regime' was the queue to see healthcare every morning.

3.134 I was told that GP hours had been reduced and, as a consequence, the time before a detainee could see a GP had risen. There was a reliance on agency and bank staff.

3.135 ACDT was reported as being widely used. It was almost universally unpopular amongst detainees, who thought of it as an invasion of privacy.

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[36] HMP Holloway and HMP Styal both have a somewhat larger population.

[37] HMIP, *Report of an unannounced inspection of Yarl's Wood Immigration Removal Centre 13 April – 1 May 2015*. Yarl's Wood also houses men and women in its family unit, and single men, referred to as 'lorry drop' cases. I will not repeat the findings of the Chief Inspector in this report. His overall conclusion was that: "Yarl's Wood has deteriorated since our last inspection [in 2013] and the needs of the women held have grown."

3.136 A key issue for Yarl's Wood is the number of women staff. I was told that Serco aims to have 60 per cent female staff by the end of 2015.[38] It should plan for a higher proportion still. (The organisation Women for Refugee Women has argued the case for gender specific standards, in particular that no male staff should be employed in roles where they come into contact with women detainees. They draw attention to the number of women asylum seekers who have disclosed experiences of rape or other sexual violence.)

3.137 Serco should also address the under-representation of women and visible minorities amongst its management positions.

3.138 More positively, I was pleased to learn of the review at Yarl's Wood into what support groups are available to visit the centre on a regular basis to assist detainees with grief counselling, trauma, and rape. There are lessons here for all IRCs about the importance of maximising external involvement and support groups.

3.139 Detainees also complained to me about late night moves to the centre, and the time they spent waiting after transfer to be brought into reception. On the basis of those complaints a member of my team, Ms Debbie Browett, spent a night in reception to observe what happened, and I reproduce her comments below. A fuller version of her report is at Appendix 6.

Reception observations

The reception area itself is light and reasonably furnished. By the end of our observations there was some food debris in the waiting areas that made the environment less attractive.

We arrived at reception at 22.30, and found seven detainees in the reception area, a group of five women in one of the waiting rooms and an elderly couple in a second waiting room.

At first inspection it seemed that there was not a Serco officer on duty, and personal property was left unsupervised in the main arrival area. We were able to move freely around the reception area, and into back offices. However, one of the on duty staff was in the second waiting room, talking to the detained couple, and a second officer appeared soon after our arrival.

Those who arrived at 20.50 were shown to their rooms by 22.45. The arrivals at 22.15 were moved to bedrooms by 23.00. The last arrivals we observed (though not the last planned) arrived at 01.45 and left reception at 04.15.

[38] UNHCR Guideline 9.3 (paragraph 59) says that where detention is unavoidable for women asylum-seekers, "The use of female guards and warders should be promoted."

The two officers were also expected to manage night moves out of the centre, and during our period of observation someone who was moving to catch a flight was kept waiting in order to settle new arrivals. Other vignettes include:

A 58 year old woman who was going through the induction process when we arrived had been transferred from Birmingham Airport, having arrived there at 08.25 that morning. She had arrived at Yarl's Wood at around 19.00, and had been taken to bed in shared accommodation at 22.45. She had been asleep for approximately one hour when she had been woken for a pick up at 01.45 to return to the airport for a 06.00 flight home. This was unfair to the woman herself, but also to the other person in the shared room who was woken twice in the space of one night.

One of the women who transferred from Colnbrook was placed on ACDT at the request of the nurse, after reporting violent tendencies. She spent some time waiting for an officer trained in ACDT to arrive. When he did arrive he was flustered, and reported that the delay was due to waiting for cover to leave his post on a wing. The ACDT interview was conducted at a desk in the main reception area, within hearing of new arrivals and with work such as baggage searches happening around the officer and the detainee.

The couple who were detained were dealt with by a member of staff who spoke their first language, and so was able to see them relatively quickly. He dealt with their possessions search quickly and sympathetically. They appeared to be seen together by healthcare, raising questions of privacy.

We took time to discuss arrival and transfer conditions with two groups of detainees, those who were already in reception when we arrived and a subsequent group of arrivals:

Of those who were already waiting to be seen one woman reported that she had taken four days to get to Yarl's Wood, having been detained in Belfast for three days. She reported being put on a flight from Belfast that arrived at Gatwick at 16.00, being left at Gatwick until 02.00, and being driven round in a van undertaking multiple pick ups before arriving at Colnbrook at 06.00 on 29 March. She had then been given one hour notice of a move from Colnbrook to Yarl's Wood on 31 March. A fellow detainee had travelled with her from Colnbrook and corroborated the one hour notice of movement.

A detainee who arrived at 01.45 had left at 14.30 the previous day for a flight from Heathrow, but had not travelled, allegedly because of disruptive behaviour. She reported that she had been subject to abusive language in the holding area at Heathrow and that the holding area was cold, with plastic moulded chairs.

Another detainee had returned with her, having undertaken a similar round trip. Her return had been halted by a Judicial Review granted while she was at the airport.

We were able to talk to staff during the quieter periods. Reception staff confirmed that their priority during busy periods was to have detainees seen by healthcare and moved to wings. They would try and complete all paperwork and search bags in between this, but bag searches could be done at a later stage. (There was a five day backlog of detainee requests to access baggage that was being held securely at the time that we were there.)

We took the opportunity to walk round the centre during the course of the evening. The general atmosphere was calm, but there was some room juggling in evidence as the early days accommodation (Crane) was full, and so one arrival was taken from Crane before being found a room.

Staff were aware of those individuals who were on constant supervision in their own rooms and were on observation rosters. There was sympathy expressed for those detainees who were thought to require more specialist care, but who were finding a transfer difficult.

Healthcare had two members of staff present, a male and a female. Both seemed to be familiar with the night-time regime. However, there was a drugs cabinet left open and a bag of medical waste left in a corridor.

Movements around the centre were emphasised by the sound of security doors being banged shut as people moved through them.

3.140 Separate from this observation of reception, I learned of detainees' experiences of Yarl's Wood from a well-attended forum held at the Centre and from a meeting at Women for Refugee Women. I outline below, as in Part 1 without comment, what I was told:

(i) Feelings about detention

- Immigration detention was worse than prison because the detainees had not done anything wrong and (unlike those held in prison) they did not know how long they would be detained.

- Those in detention were frightened to complain in case the Home Office took it out on them.

- The most vulnerable detainees were those who did not speak English.

- Detainees still suffered once they were released. The psychological impact of detention did not stop once they were back in the community. "That's when reality begins … "

(ii) Healthcare

- Doctors and nurses did not take medical conditions seriously, diagnosing conditions as viruses. There was a lack of consideration for patients, the healthcare staff were rude, and they showed a lack of belief in the detainees. There was poor treatment of individuals with diabetes, including failure to administer drugs.

- Insufficient appointments with a doctor and optician were available. It was not always possible to see a woman doctor.

- Detainees were often not told what medication they were being given.

- Pregnant women miscarried in Yarl's Wood.

- Mental health counselling was not fit for purpose. One woman felt worse after counselling than she had before it.

- Officers often interrupted counselling sessions. The number of available counselling sessions had been reduced.

(iii) Movements

- There were long delays in reception, especially at night. Detainees were kept in vans outside the centre, and there were multiple moves of individuals and multiple pick-ups by one van. There was a report of ten escorts being used for a single removal.

(iv) Regime

- The food contained too many carbohydrates, sugar was put on fish, and there was too much bread and rice.

- Former detainees reported that male officers came into women's rooms without knocking and whilst detainees were showering, and that the officers never apologised for these intrusions.

- When one of the detainees in a bedroom was on constant observations,[39] the other woman in the room would, by default, also be observed by the officer observing the suicide risk. The officer would be able to hear whatever either woman was doing in the toilet/bathroom, and the officer's presence made it difficult for the women to sleep without covers on hot nights.

- It was embarrassing for detainees to have to ask for sanitary protection from officers. For some detainees, it was irrelevant whether they were

[39] The term 'suicide watch' seems to be common parlance both amongst detainees, support groups, and Yarl's Wood staff. It is an ugly and inexact term, and would be better avoided.

dealing with male or female officers – they did not want to have to discuss personal issues with a stranger.

- Officers at Yarl's Wood had been heard laughing at having seen detainees naked or on the toilet.

- During one incident when a detainee had tried to call an ambulance for a woman who was in poor health (after the healthcare staff had, in the view of the detainee, not acted with the appropriate urgency), she had been told that she had committed a criminal act and that she would be "sent to Kingfisher" (the segregation unit).

- One young woman had been told by an officer that he would help her with her immigration claim if she slept with him (she did not).

- It felt as if searching was used as a way of intimidating detainees.

- Random searches were carried out by male and female officers. For personal searches male officers used electronic wands whilst female officers 'patted down' the detainees. However, male officers were often present when the women were being patted down.

- A woman had been forced to remove her hijab in front of men in the reception area when she was being taken for a hospital appointment.

- During a random room search, the officers had handled clothing, including underwear, without respect and had left it lying on the bed for the detainee to tidy away.

- Medication was examined in detail during searches so the staff effectively had access to personal medical information.

(v) Home Office behaviours

- Many women had been reporting to the Home Office regularly and could not understand why they had been detained when they were. One woman had wanted to buy her own ticket home but was being removed anyway. In another case, the Home Office had failed to believe that terrorism was real in the woman's country of origin.

(vi) Other issues

- Some women had received poor quality privately-funded legal advice.

Recent developments at Yarl's Wood

3.141 Given that HM Chief Inspector of Prisons has conducted a recent in-depth inspection of Yarl's Wood and there is the review commissioned by Serco following the Channel 4 exposé, I judge that it is unnecessary for me to offer

separate recommendations. The lessons from what I have reported above are self-evident.

3.142 However, I should also record that the Home Office commendably accelerated its follow-up to the Chief Inspector's most recent report. The Service Improvement Plan, which usually follows much later, was agreed and published on the Inspectorate's website at the same time as the report itself. I note, for example, the introduction of intelligence-led room searching and improvements to healthcare. Amongst many other changes. I understand that NHS England has offered support to Yarl's Wood Befrienders, which has a role in supporting mental wellbeing, and is also exploring support for other relevant groups.

Pre-Departure Accommodation

(i) Cedars (visited on 8 May 2015)

3.143 Cedars is described on GOV.UK in the following terms: "If families fail to co-operate with other options to leave the UK, such as the offer of assisted voluntary return, they could be required to stay in 'pre-departure' accommodation as a last resort. This has been designed as a secure facility which respects the privacy and independence of children and their families."

3.144 Cedars opened in August 2011 and can, in principle, accommodate up to nine families at a time (although the Home Office's agreement with Barnardo's limits this to three, and in practice it is frequently empty). Families may only be referred to Cedars on the advice of the Family Returns Panel, an independent body of child welfare experts. It is run by G4S.

3.145 Each family has its own discrete apartment. I found the standard of accommodation to be very high.

3.146 The grounds were extensive with multiple play areas offering indoor and outdoor activities.

3.147 There was also a cool down area that was reported as having been used very infrequently.

3.148 There was free association within shared areas for the rare occasions on which there was more than one family present. It was reported that most families remained in their rooms, and that the extensive play and entertainment facilities and grounds were not widely used as a consequence. Many of the facilities were barely, if ever, in use (e.g. a well equipped multi-gym).

3.149 Families were free to cook food themselves and ingredients were provided. There was also a canteen that tailored food according to family preferences.

3.150 I was told that all staff, including the chaplain, were actively involved in the centre's activities.

3.151 The Barnardo's site manager said that a number of the detainees had health issues, including women whose mental health issues were exacerbated by female genital mutilation (FGM), risks to their children, and domestic violence. The G4S manager confirmed to me that most of the women detainees suffered from anxiety and depression. When I visited Tinsley House I spoke to the healthcare team, which is also responsible for healthcare delivery at Cedars. They told me that all relevant staff had received a course on FGM and trafficking. There was no on site midwife, though one could be called in when needed. Pregnant women were detained until the point at which airlines refused to take them because of the advanced state of their pregnancy.

3.152 Nothing I saw caused me to doubt HM Chief Inspector of Prisons's characterisation of Cedars as "an exceptional facility" and "an example of best practice in caring for … some of the most vulnerable people subject to immigration control".[40] The IMB told me that the standard of care was "exemplary". However, my overriding impression was of a misdirection of public money that could be better used for other purposes. The centre has had no residents on either of the two occasions I have visited.

3.153 At the time of this visit, around 20 families (the majority, single women and children) had been in residence since the middle of the previous year. Many of these women understandably suffered from stress and anxiety. Half of the adults held at Cedars were placed on open ACRT[41] documents (the equivalent of ACDT in IRCs). This speaks eloquently of their vulnerability.

3.154 At the same time, the cost per family must be many tens of thousands of pounds, yet up to half are actually released rather than being removed. (There is some repeat detention as a consequence.)

3.155 I am aware that the function of Cedars is determined by legislation, but the current use of the centre is simply unacceptable at a time of financial austerity.

Recommendation 5: I recommend that the Home Office draw up plans either to close Cedars or to change its use as a matter of urgency.

Short Term Holding Facilities

3.156 There are holding rooms in most airports and some seaports in the UK, but most are no more than waiting rooms rather than detention facilities. I was able to visit a limited number of sites to review facilities and welfare arrangements.

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[40] HMIP, *Report of an unannounced inspection of Cedars pre-departure accommodation and overseas family escort*, 6-27 January 2014, p.5.
[41] Assessment, care in residence and teamwork, the care planning system based on ACDT for those felt to be most at risk.

(i) Dover dock (visited on 5 June 2015)

3.157 The facility on Dover dock is the second busiest holding room after Terminal 4 at Heathrow (housing over 3,000 people in the past year). It is used predominantly to fingerprint and identify those believed to have arrived in the UK clandestinely. These can include both men and women, family groups, minors, and those whose age is in dispute.

3.158 The main facility is accessed via stairs at the back of the accommodation. Searches are carried out in a dedicated area before the detainee is moved to a waiting room prior to being fingerprinted, etc. All areas were empty at the time of my visit.

3.159 The main room had been risk assessed for up to 50 detainees at a time, but I was told it could be "manic" when full – which I can well believe. The room was very cold but I was assured that the air conditioning had been left on high to eliminate the body odours from a group of detainees who had been held earlier in the day. It was a large space with separate toilets and a shower behind full doors to one side of the room. There were strips of hard seats, some (rather shabby) recliners, and plastic picnic benches available. The ceiling was not in good repair, and there was accumulated grime under the chair fixings.

3.160 A small room to one side, equipped with the basics (air beds and a travel cot could also be provided), was used for families and minors. Some toys were available.

3.161 There was fixed furniture in the interview rooms (I doubt this degree of security is necessary). So far as I could see, there were many copies of the Bible available, but only two Qur'ans. I found cigarette butts in the 'non-smoking' secure area.

3.162 The male toilet in the main area was offensively insanitary. When the toilet was brought to the attention of staff, I was told that the area had been cleaned on the previous day and that it was in any case "better than what the detainees have come from" (with reference to the camps in Calais).

3.163 There was no healthcare on site, and it was reported that anyone who was clearly in pain would be escorted to the local Accident and Emergency. Otherwise the team worked on the presumption that a detainee would be moved to an IRC or to temporary asylum supported accommodation, where health screening was available. I was not certain that this was sufficiently robust, and felt there should be provision for an on-call doctor.

3.164 Evaluation of the detention log for May 2015 revealed that a third of those detained that month had been in the facility for more than 24 hours, with 28 of those detained for more than 36 hours. Given the very limited arrangements, I do not believe a stay of more than 24 hours is acceptable.

3.165 Most detainees had been moved to the Dover dock from police detention having been picked up on the Kent to London motorways. There had been one incident of a pregnant woman being detained at the same time as two men with suspected scabies.

3.166 I am told that, since the time of my visit, significant improvements have been made at Dover including provision of on-call healthcare, additional staff, and physical improvements including a deep clean. This reflects the much greater use of the facility as a result of levels of clandestine entry to the country during July and August 2015. I further understand that HM Inspectorate of Prisons plans to re-visit the Dover holding rooms (having decided not publish a report of an earlier inspection having found, as I did, that it was not being frequently used at the time). In light of these developments, I make no recommendations of my own.

(ii) Heathrow Airport (visited on 13 May 2015)

3.167 All facilities are provided by the airport as part of their contractual obligations (TPF or Trader Provided Free), and all are run by Tascor on behalf of the Home Office. The Terminal 1 room had been closed by the time of my visit. A process of upgrading the facilities was underway. For that reason, I have made no recommendations of my own regarding the physical accommodation.[42]

Terminal 2

3.168 This facility was described to me as the standard that all others should meet. It was light, at a reasonable temperature, and was well. There was a separate room to the main area in which a woman was sleeping. The lights had been dimmed, but she had no bed and slept on a bean bag (I understand that recliners are also available).

3.169 I was told the rooms received between eight and 20 people a day, including families and children.

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[42] In a most interesting submission to the review, Mr John Hutchings and Mr Greg Beecroft of the Heathrow Airport IMB told me they were pleased that the holding rooms at Heathrow were to be upgraded, "albeit after much delay and still not for some months to come", but that they did not regard them as appropriate, even when improved: "They might be considered suitable for adults for just a few hours, but not for a lengthy stay, not for overnight use, and certainly not for the detention of children." They added: "We consider that there should be a wider review of detention arrangements at Heathrow. In particular, consideration should be given to a single, high-quality, airside facility for any people whose case cannot be resolved very quickly at the arrival terminal. This could include proper overnight accommodation, with beds, and appropriate space for children. It could also include separate space for people who had been brought to the airport for removal and who are currently accommodated at Cayley House." I understand that a proposal along these lines has previously been rejected on cost grounds, and I have not had the time or expertise to assess the matter myself in any depth. However, I suggest that the Home Office gives further consideration to this proposal, as it may have benefits both for detainees' welfare and for the IRCs if detainees can be moved to the airport a day or so before their intended departure.

3.170 During my visit, two male detainees were seen to get progressively more direct in their attentions to a female detainee. The female detainee was only moved to the quieter area at my team's suggestion.

Terminal 3

3.171 The holding area itself was a large room with a smaller room to one side, and two toilets and a baby changing facility directly behind doors leading on to the main room. The baby care area consisted of a sink with paper towels. The toilets were smelly and old.

3.172 The facility was unbearably warm.

3.173 There was an office area at the front of the hold that was also used as a bag store, and that had a hot drinks machine. Desk space was cramped.

3.174 While I was visiting, a distressed woman was left alone until she was spoken to after half an hour or so by the person deciding her case.

3.175 A female detainee was searched in front of several people. Interviews with detainees took place in full hearing of everyone present. A detainee was able to go into her bags to retrieve items, and was advised to keep money on her for security reasons.

3.176 The children's area was slightly shabby, had hard seating and bean bags. There was a white board painted on to one wall. Games were generally for smaller children but others were said to be available on request. There was a Wii, and a DVD player that appeared not to work.

3.177 The main area was furnished with rows of bench seats, picnic tables and a chaise longue. There were no beds. The TV was on constantly. Snacks were available in the main rooms and sandwiches and drinks were available on request. A mildly suggestive Marilyn Monroe poster was on the wall.

3.178 I was shown plans to refurbish the area, including an option to split the main area into two separate rooms. These plans had been on hold for a while but I was told that they would start in summer 2015.

3.179 The family most recently held in the room had been there for 4 hours and 20 minutes. Twelve hours was the longest period of detention that the Tascor team could recall.

3.180 There had been two detainees the whole of the previous day, but I was told that on occasions there could be up to 20.

Terminal 4

3,181 This was described to me as the worst of the holding rooms. I felt it was dire and in chronic need of improvement.

3.182 There were two separate rooms used for male and female detainees respectively. Both had relatively hard furnishings; these were shabby, as were the toilets. There were no showers. The lighting was poor and there was very little to do.

3.183 One room housed a mother and her 14 year-old daughter. The mother was clearly distressed and was having difficulty contacting her husband using the phone she had been given. When this was pointed out to holding room staff they were able to help, but there had clearly been little attention paid hitherto to the needs of the woman or her child.

3.184 The other room held a single male who was awaiting a decision about entry, having returned for his passport after being granted temporary admission a fortnight earlier. He seemed to have been waiting for some time. He had a place at a top university as a post-doctoral researcher.

Cayley House

3.185 Cayley House is used to house detainees who are close to their departure time (except if their flight is imminent when they arrive at the airport, in which case they go straight to the plane). It is airside, in a secure area near to the runways.

3.186 The facility consisted of offices fronted by a reception desk. The detainee would move from the desk to a seating area, and then to a separate area for searching. Staff claimed that a modesty curtain was used for searching, but the screen was tied back with a long cord, and it looked as if this had been in place for some time.

3.187 Detainees were searched both at airport security and at Cayley House when they were transferred from Tascor care. The staff were insistent that this was justified because they had sometimes found sharp objects.

3.188 Male detainees were then placed in a holding room with hard chairs and picnic tables, a quiet area sectioned off, and a chaise longue. Snacks were available. It was all clean and graffiti-free.

3.189 Female detainees and families were accommodated in a separate room, which had a child friendly area and a separate quiet space with bean bags. I felt the environment was somewhat barren.

3.190 I checked the log. Waiting times were generally between one and four hours (with the vast majority under three hours). The shortest stay I found was ten minutes; the longest was 14 hours.

3.191 The male toilet had inadequate baby changing facilities, and the female toilets were a health hazard. They stank of stagnant water, and it was clear that longstanding maintenance issues had not been resolved. I was advised that

there were few female detainees going through the centre, but I discovered that in fact one woman had departed that morning and a woman and child were due in the evening.

3.192 One male detainee was trying to resolve how he was to get home from the airport to which would be flown. He had no money for the 800 kilometre journey to his village, but enquiries were met with a blank. I was told that money would be found if he "kicked up a fuss and resisted removal".

3.193 I witnessed behaviour confirming HM Chief Inspector of Prisons's observation that "women could not always be held separately from men or protected from unwarranted sexual attention".[43]

3.194 I understand that it is the Government's view that holding rooms are not residential, and for that reason proper beds should not, indeed cannot, be provided. However, I agree with HM Chief Inspector of Prisons that lounger seats are not adequate substitutes for sleeping facilities, and I wonder if something between a proper bed and a lounger would be possible.

Recommendation 6: Given my observations at each of the Heathrow terminals and at Cayley House, Tascor should arrange for refresher training for its staff on their duty of care, and the need for proper and meaningful engagement with detainees.

(iii) Larne House (visited on 22 April 2015)

3.195 Larne House is a 19 bed residential short term holding facility, located north of Belfast. It is reached via a high security police station complex.

3.196 The facility is operated by Tascor, employing 28 staff of whom 24 are detainee custody officers and four are managers.

3.197 It had a small reception area, two interview rooms, a nurse's room, shop, association room and a dining room. There was a mix of shared and single bedrooms and separate toilets and shower rooms.

3.198 There was a small outdoor area, a prayer room, and a 'management room' used, I was told, when a detainee's behaviour was of such concern that he or she required space to calm down. I was told it was used very infrequently. I note that HM Chief Inspector of Prisons has called for the room to be formally taken out of commission,[44] but this had clearly not been done by the time of my visit.

3.199 The interview rooms were also used for visits (family and official/legal). One of these had furniture that was fixed and bolted (this was an unnecessary measure in my view).

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[43] HMIP, *Report on an unannounced inspection of the short-term holding facility at Cayley House*, 1 October 2014, p.7.
[44] HMIP, *Report on an unannounced inspection of the short-term holding facility at Larne House, 18 November 2013.*

3.200 Overall, the facility was clean, and staff were welcoming and friendly.

3.201 On the day I visited, seven men were detained. Larne can also accommodate women in three rooms that can be locked off from the rest.

3.202 A qualified nurse was on duty 24/7 and on-call arrangements were in place for GP services. On arrival at Larne House, a detainee would see the nurse in the medical room for a health screening. The nurse told me he estimated that 90 per cent of detainees had medical problems. The nurse had a chart listing conditions for which it was recommended that a doctor be called. Unless tired, a detainee would be given a tour of the facilities following the medical assessment.

3.203 The bedrooms were very basic – a bed, space for clothing and a personal safe. There was no additional seating or a television or radio, so there was little choice for detainees but to use the small association room. One bedroom, used to accommodate single women deemed vulnerable, had a television.

3.204 Some natural light was available through frosted windows.

3.205 The outdoor area was more of an exercise yard and the only designated place where detainees could smoke. It was a small space and was caged above, which gave it a claustrophobic feel. Detainees were unable to access the space without an escort because of the number of potential ligature points associated with the netting. I am not convinced that the netting needs to remain; detainees should have free access to outdoor space during the day. The yard would also benefit from being softened with a seating area and plants.

3.206 While detainees were not expected to stay at Larne House for more than a maximum of seven days, there was no space for physical exercise and no exercise equipment. The latter is easily remediable.

3,207 I observed the discharge of a detainee transferring to Harmondsworth in advance of removal from the UK. Two Larne House DCOs were in attendance, one interacting with the detainee and the other observing. Both officers were polite and friendly. The detainee was allowed a cigarette and use of the toilets before leaving.

3.208 The chair of the IMB told me that the Board also had oversight of the holding rooms at Edinburgh and Glasgow airports and Glasgow reporting centre. Board members visited Larne House twice a month but did not carry out night visits. (I suggest the Home Office asks the Ministry of Justice to consider recruiting new members of the Larne House IMB who are locally-based, and thus able to visit more frequently, including at night). I was told the IMB observed very good staff/detainee relationships, and did not have any concerns about the treatment of women; their experience was that women were content to use the association room. However, the Board was concerned that staff did not always complete paperwork fully or correctly, and Tascor staff had commented on the difficulty of persuading immigration staff to attend Larne House.

3.209 I can confirm the good relationships at Larne House – in part, a result of a generous staff/detainee ratio. However, I do not believe that the current contract represents good value for money and it should be reviewed. I am not convinced there is a need for up to 19 places, and the small association room would become hopelessly overcrowded were that number in residence. As a minimum, I suggest that the four-person dormitory is closed, reducing the maximum occupation to 15, thus saving staff and allowing the dormitory to be used for gym equipment or as an art room.

(iv) Pennine House (visited on 11 May 2015)

3.210 Pennine House is a 32-bed short term holding facility located at Manchester Airport and run by Tascor. All accommodation is on the first floor, with eight four-person bedrooms running from a single corridor. At the end of the corridor is a reasonably sized lounge. There are no windows and, therefore, no external light. Access to the outside is through locked doors, on an escorted basis, to one of two small caged areas (one for smokers and one for non-smokers). There is no protection from the rain in these areas.

3.211 At the time of the visit six detainees (five men and one woman) were resident.

3.212 The bedrooms were Spartan, consisting simply of four beds and four plain wardrobes. They were clean but the lighting was harsh. One room was set aside for women. I note the observation of HM Chief Inspector of Prisons from the most recent inspection: "Although women had separate rooms, they could not lock their doors and told us they felt insecure about sharing communal areas with men."

3.213 The toilets and showers were clean, but male and female toilets and showers were next to each other (albeit they were lockable from the inside). The lounge had some soft seating, a Wii, a TV, table football, jigsaws and books.

3.214 The reception area was small and able to receive only one or two people at a time. If reception was being used for an admission or discharge, no visits could take place because the visits room doubled as the admissions waiting room.

3.215 Tascor staff were observed interacting well with the detainees. The minimum staffing numbers were eight staff during day-time and six at night.

3.216 Healthcare was provided by a nurse employed by Spectrum Healthcare Ltd. There was no doctor on site.

3.217 There were no open ACDT cases at the time of the visit. I understand ACDTs average at one per month.

3.218 The absence of natural light, and the poor quality of the outside areas, do not suggest that a concern for detainees' welfare was uppermost when Pennine House was commissioned. I suggest that softer lighting is installed in the lounge and bedrooms of Pennine House to make the environment less uncomfortable, and that partial rain covers are installed in the outside areas. In the longer run, the use of Pennine House should form part of the wider strategic review of immigration detention that I have separately recommended.

3.219 I note that neither Pennine House nor Larne House is governed by statutory rules, and that the absence of short term holding centre rules is of long standing.[45] This is not acceptable as a matter of good public administration.

Recommendation 7: I recommend that a discussion draft of the short term holding centre rules be published as a matter of urgency.

(v) Tascor cross hatch area

3.220 A member of my team also visited what is known as the cross hatch area at Tascor HQ, at Heston near Heathrow. The site houses a hub for vans and staff, as well as a facility for moving detainees from one van to another.

3.221 The area in which detainees were moved from one van to another was basic: a self-contained shed, with no temperature control. However, the toilets and shower were clean and there were some facilities for food and drink. Detainees were held on vans at all times, however, and this could be problematic in temperature extremes. I am told that if it is very hot or cold then the vans' motors are kept running and they are moved to the car park directly outside to avoid asphyxiation. This does not seem a very sophisticated solution, and suggest that the Home Office ask Tascor to consider some form of temperature control within the Heston cross hatch area.

(vi) Reporting centre holding rooms at Lunar House and Eaton House (visited on 29 June 2015 and 16 July 2015 respectively)

Lunar House

3.222 The holding area was refurbished recently and was in good working order. All areas were clean, including the toilets.

3.223 There was a logical movement through the interview rooms, to quieter spaces where people were told they were being detained, to the holding areas. Some rooms were equipped for telephone interpreting.

3.224 Movement to vans was more problematical, with steep stairs or a small lift to a loading bay that is not accessible by Tascor vans as they are too tall.

[45] AVID said in its evidence: "Some 7,000 people each year pass through the Home Office's short term holding facilities. The absence of statutory provision governing these facilities is a huge protection gap which leaves many at risk."

Detainees were therefore placed on vans in view of the public on the street. I suggest that the Home Office redesign the exit to the holding area to provide greater privacy and security.

3.225 There were two holding rooms, again in good condition. The larger of the rooms had three loungers as well as hard seating and picnic benches. The small room had a settee as well as hard chairs. There were TVs in both rooms, positioned behind Perspex boxes. The windows in all rooms were covered in opaque Perspex.

3.226 A variety of hot and cold refreshments was available on request. Clean pillows and blankets were available, as was a prayer mat, Qur'an, and a wide range of reading materials.

3.227 Detainees were searched in an area where they could be seen by others in the main holding room. Staff resisted the suggestion of a screen on the basis that they could be assaulted, but could not remember the last time there was a physical assault on the premises. I believe a screen should be installed to ensure privacy during searching.

3.228 It was reported that detainees were supposed to be moved within three hours from the point that DEPMU sent a movement order to Tascor, but that in practice this rarely happened. There were sometimes delays with internal IE processes regarding the production of movement orders, and there were often delays because of the absence of transport or crews.

3.229 Staff reported that detainees from other holding rooms were frequently shuttled to Lunar House at the end of the day, allegedly for the convenience of Tascor so that they could close other holding rooms to release crews.

3.230 The holding room was often used for Immigration and Compliance Enforcement (ICE) teams to drop off detainees, as well as for those detained on reporting and screening. It was also used for detainees in transit to have a comfort break.

3.231 There were three males in the main room, one of whom had a history of violence against women. One detainee had been there since the morning. All three men were going to The Verne. There were plans to pick up one detainee for movement to The Verne, leaving the other two in the holding room. One man was becoming agitated as he wanted to smoke and could not do so.

3.232 A fourth man was brought into the main area at 6.45pm. It was believed that he was going to Harmondsworth.

3.233 One woman was being held in the smaller room. She had been there for only a short length of time and had been made aware that she could ask for food and drink.

3.234 Three members of staff were on duty. They reported that they were unable to take breaks routinely as they were not able to leave two people in charge when there were detainees present. They reported working a standard twelve-hour shift, with delays in departure because of late pick ups of detainees happening regularly. Very late departures were thought to happen at least once a month.

Eaton House

3.235 The holding room was small, approximately 12' by 14', with toilet cubicles at one end, directly adjoining the room. The toilets had gaps at top and bottom, presumably for safety reasons. Having the toilets in such direct proximity to the room where people are sitting (and eating) is not desirable and should be reviewed.

3.236 The facilities were clean. There were eight fixed wooden chairs in two groups of four behind tables. There was also a bean bag, but there was nowhere to lie down except the floor. Clean pillows and blankets were available. There was a TV in a Perspex-fronted box.

3.237 The only other space was the small ante-room in which staff were located. The staff could view the holding room through a window.

3.238 Hot and cold refreshments were available on request. There was a wide range of reading materials.

3.239 Movement to vans was down a flight of stairs to the parking area at the back of the building. This was not in view of the public.

3.240 A female detainee was searched in the holding room by the Tascor escort who had arrived to take her to Colnbrook. This was in front of a male detainee and a male member of staff. The permanent staff said that there had previously been a curtain for searches in the ante-room but this had made way for a cupboard containing foods and other equipment. Although space is tight, there is no reason why a quarter-circle curtain could not be installed in one of the corners without impinging on operations (I acknowledge that staff were concerned that this would mean it would allow detainees to make accusations about maltreatment if the searching occurred unobserved).

3.241 As at Lunar House, detainees were supposed to be moved within three hours of the movement order being sent, and as at Lunar House this rarely happened. The longest time a detainee had spent in detention in Eaton House was eleven hours and thirty five minutes.

3.242 At the beginning of the visit there was one male in the main room, waiting to be taken to Harmondsworth after having been picked up after reporting to Eaton House, and one woman, also picked up when reporting, who was waiting to go to Colnbrook. The male had been there for forty-five minutes and the woman for thirty. The male spent most of the time on the telephone. The

woman appeared agitated and complained of a stomach ache but declined medication. She was not happy to be handcuffed to be taken to the van, but acquiesced when told that it would only be for a few minutes.

3.243 The staff checked on the wellbeing of the two detainees at regular intervals and asked them whether they wanted food and drink.

3.244 There were two staff on duty, working an 8.00am to 6.00pm shift and who, apart from going to the toilet, had to be present all of the time and could take no breaks. They often had to stay late, if detainees were still in the room when the shift officially ended.

Prisons

HMP Holloway (10 June 2015)

3.245 I met briefly with the Governor, the Head of Offender Management and her deputy, and with five of the seven detainees in residence (there are normally more). One of the two I did not meet was a woman held in the healthcare unit who has been sectioned and was awaiting transfer to a psychiatric hospital. The other was a woman who had served a 56-day sentence (which expired in summer 2014) and who had been transferred back to prison from Yarl's Wood.

3.246 Most of the women were in single accommodation because of their cell sharing risk assessments. Detainees are not held on a specific wing or landing. The prison's resettlement department provides the equivalent of the welfare services seen in IRCs.

3.247 The other women included one who was in the course of female to male transgender, whose sentence had expired in August 2014 and who said he wanted out of the UK. (He was a former asylum-seeker who had cancelled his claim.) He spoke very well of the Holloway staff (his views on the Home Office were less kind: "I would like to know the caseworker really exists and I am not talking to a brick wall"), and there were no signs of any discrimination against him by staff or fellow prisoners.

3.248 Another of the women had served a four-month sentence for pickpocketing that had expired five days before my visit. She said she wanted to go home (she had three children in her home country) and it was not clear to me why she had been detained, let alone was held in prison.

3.249 The others did not wish to leave the UK. One had been granted bail on her extradition case but was held on an IS91. The family of another were in this country and she had had a baby in Holloway (the child was now in foster care). The third had come to the UK at the age of seven, and spoke with a broad London accent. She said her father was a political refugee, and that she had no remaining family in her country of birth.

3.250 All the women indicated they would prefer to be in Yarl's Wood because of access to a mobile phone and because the staff were familiar with immigration issues: "Officers in Holloway don't know anything about immigration." (I understand that most transfers out of Holloway are to Colnbrook, not to Yarl's Wood.)

3.251 There was criticism of the Incentives and Earned Privileges (IEP) system applying to them in prison, of the restrictions on the clothing and other possessions (like a Wii) that they could have, and that the personal officer scheme did not work. It was also alleged that women who did not speak English were treated less well.

3.252 The women also criticised the delays they encountered with immigration processes: "If you want to go, it's hard; if you don't want to go, it's hard."

3.253 I was concerned that Immigration Officer cover at Holloway appeared insufficient given that one-third of the total prison population were foreign nationals. I do not know how far the position in Holloway reflects a wider problem.

Recommendation 8: The Home Office should review the adequacy of the numbers of immigration staff embedded in all prisons.

HMP Wormwood Scrubs (visit of 10 June 2015)

3.254 I met with the Governor and another senior manager, and with members of the embedded immigration team. I toured part of the prison, speaking with prisoners whom I encountered.

3.255 The state of the prisons is not a matter for the Home Office, but it was evident that Wormwood Scrubs was under great strain. One person I spoke to said the gaol was now "maxed out" and reliant on prisoners to do jobs once done by staff. Specialist provision for the large number of foreign nationals was just one of the services that had suffered as a result of staffing reductions.

3.256 One prisoner acted as an informal adviser on immigration and nationality issues. He ran surgeries and facilitated contact with legal services. This filled a gap but was dependent upon the individual's commitment and capability.

3.257 A Home Office immigration team was permanently on site. Its main role was to act as a link between caseworkers and the detainees. The team served decisions on a face-to face-basis and also ran surgeries.

3.258 The two men who had been longest in detention at Wormwood Scrubs as at June 2015 were as follows:

> Mr A – convicted on 18 April 2012 for harassment and breach of conditions, receiving a 10-month sentence. He had been detained under immigration powers since 17 November 2012. There was uncertainty

about his nationality, and I was told that the barrier to removal was that the Home Office had been unable to obtain Emergency Travel Documents as Mr A had not provided sufficient information. He had never applied for bail.

Mr B – convicted of burglary. The sentence details I obtained were inconsistent, but in any event he had been subject to immigration detention since 2 October 2013. Removal directions had been set on three occasions but cancelled each time. The current barrier was said to be checks to see if prescribed medication was available in the country to which he was to be removed. He too had never made an application for bail.

3.259 A particular bugbear of the prison staff (repeated at Holloway) was the allegation that the Home Office's Criminal Casework unit did not make timely decisions, hence many of the IS91s were at the last minute (often on the day before the prisoner's sentence expiry date). This was criticised not least in terms of the potential risk of self-harm. It was suggested that at least 48 hours notice – and preferably more – should be given to the prison. Information on transferred cases on the IS91 and PER was also said to be poor.

PART 4: VULNERABILITY

Vulnerability and its causes

4.1 The concept of vulnerability is central to my terms of reference, but it is not a term whose meaning I have found easy to resolve.

4.2 The Association for the Prevention of Torture/UN High Commission for Refugees document, *Monitoring Immigration Detention: Practical Manual*, 2014, says this:

> "Immigration detainees are vulnerable at many levels. In general, immigration detainees are deprived of their liberty for periods of non-specific duration as a result of a lack of or unclear immigration status. This lack of information about their individual situation increases their vulnerability. They are outside their country of origin or former habitual residence; they often do not speak the language and may not have a strong family or community support network available to them. Quite apart from feeling unsafe in the immigration detention environment, their sense of insecurity is often exacerbated by fear of what the future holds and where that future will be. They may also believe, rightly or wrongly, that those who exercise power over them be detaining them also hold the key to their future. There is a real risk that those on the upside of the power equation may misuse the real or perceived implications of such a power imbalance … Immigration detainees are already in a vulnerable situation and this can be further exacerbated for persons with special needs or risk categories (such as women, children, including unaccompanied or separated children, members of different ethnic/tribal groups detained together, victims of torture or trauma, persons with disabilities, the elderly, LGBTI individuals, or those with urgent medical needs."

4.3 I take this to mean that vulnerability may be pre-determined but may also increase and decrease according to external factors.

4.4 In *The state of detention: Immigration detention in the UK in 2014*, Detention Action argue:

> "… the concept of vulnerability is so vexed that it perhaps makes more sense to speak of a crisis of harm in detention. It seems clear that, more than ever before, detention in the UK is harming people. This harm is frequently severe, whether or not the person was categorisable as vulnerable before they were detained."

4.5 The Detention Forum told me:

> "Reliance on the existing categories of vulnerability (within the current policy guidance, chapter 55.10 of the Enforcement Instructions and Guidance) overlooks individual characteristics and changes over time,

> creating a system where detainees who do not fit within the pre-existing categories remain invisible and at risk … vulnerability is a result of a combination of factors and … these may change throughout time in detention."

4.6 Ms Jean Lambert MEP told me that, during discussions of the Reception Conditions Directive (from which the UK has opted out), there had been considerable debate on the question of vulnerability:

> "It was considered insufficient to simply assess individuals at the time of entry to the process and established that this should be an ongoing process, as certain factors might only manifest themselves over time: these might be health issues, issues related to sexual orientation or others."[46]

Towards a definition of vulnerability

4.7 I have further considered the definitions of vulnerability, considered the views of interested parties, and identified what I believe to be a useful model.

4.8 Dictionary definitions of vulnerability are numerous, but they consistently refer to susceptibility to physical or emotional harm, damage or injury. Thus, an individual does not already need to be suffering physical or emotional harm, damage or injury, to be considered vulnerable; rather, the potential or likelihood of suffering such effects would be sufficient.

4.9 When considering vulnerability in police settings, HM Inspectorate of Constabulary has stated that: "The experience of being arrested and taken into police custody intrinsically disempowers the detainee."[47] The act of arrest is not so dissimilar from the act of immigration detention that those views should be disregarded.

4.10 Moreover, a significant minority of those who presented evidence to the review said that all detainees should be viewed as being vulnerable, and indeed that detention made people vulnerable.

4.11 I have found most persuasive the considerations of the Jesuit Refugee Society in a comprehensive report entitled *Becoming Vulnerable in Detention: Civil Society Report on the Detention of Vulnerable Asylum Seekers and Irregular Migrants in the European Union*. Otherwise known as the DEVAS project, the report is an exhaustive study of vulnerability in detention.[48] At the heart of the

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[46] Ms Lambert was the only Parliamentarian, domestic or European, to make a written submission to this review.

[47] *The welfare of vulnerable people in police custody*, HM Inspectorate of Constabulary, 2015.

[48] Its findings include: "Detention brings very negative consequences for detainees' mental health. Almost half of the entire sample describes their mental health as being poor in detention … Prolonged detention compounds the adverse effects of detention: 71 per cent of persons detained for four to five months blame their psychological problems on detention itself."

report's consideration of vulnerability is what is called 'The Concentric Circle of Vulnerability', a model demonstrating that personal, social and environmental factors can contribute to vulnerability, and that any one of a wide range of issues associated with those factors can contribute to an individual's ability to manage their responses to the act of detention – to be or to feel vulnerable.

4.12 The report argues:

> "The data shows that detention has the potential to harm many types of people: those with pre-existing special needs and otherwise healthy persons. It is important to stress that a person becomes vulnerable from the first day of their detention, as the individual's personal condition is instantly affected due to their disadvantaged and weakened position. Detainees' level of vulnerability fluctuates in relation to the characteristics that they personally possess, the factors in their social network and the determinants in their wider environment.
>
> "This method of understanding attempts to acknowledge the variety of factors that foster vulnerability in detained asylum seekers and irregular migrants. In practice, it shows that every person must be individually assessed for vulnerabilities and special needs that may make it difficult for them to cope in the environment of detention. This is the only way to ensure that detention does not cause unnecessary harm to individuals and is not disproportionate to their actual situation."

4.13 Within its model the inner circle of personal factors includes sexuality 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, personal expectations, nationality/ethnicity and state of physical and mental health.

4.14 Social factors are listed as 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.

4.15 Environmental factors include the rules of the detention centre – 'written' and 'unwritten', staff preconceptions and prejudices, existing EU and national legislation and policies, the architecture of the centre and its geographic location, the terms and length of detention, and living conditions within the detention centre.

4.16 Using this model as a guide, I offer the following views on the identification of vulnerability.

Identification of vulnerability

4.17 It is very difficult to create a checklist of all personal factors that may make an individual vulnerable. Indeed, I have some sympathy with a view expressed by those submitting evidence that checklists of vulnerability are not conducive to proper consideration of individual cases.

4.18 However, the Home Office has in effect attempted to use a checklist approach in the Enforcement Instructions and Guidance (paragraph 55.10),[49] which lists those unsuited to detention as follows:

> "The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons:
>
> - Unaccompanied children and young persons under the age of 18.
> - The elderly, especially where significant or constant supervision is required which cannot be satisfactorily managed within detention.[50]
> - Pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this. [51]
> - Those suffering from serious medical conditions which cannot be satisfactorily managed within detention.
> - Those suffering from serious mental illness which cannot be satisfactorily managed within detention. In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act.
> - Those where there is independent evidence that they have been tortured.
> - People with serious disabilities which cannot be satisfactorily managed within detention.[52]
> - Persons identified by the competent authorities as victims of trafficking."

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[49] UK Visas & Immigration and Immigration Enforcement, Enforcement Instructions and Guidance, chapter 55, (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307995/Chapter55.pdf)

[50] UNHCR Detention Guideline 9.6 (paragraph 64) says: "Older asylum-seekers may require special care and assistance owing to their age, vulnerability, lessened mobility, psychological or physical health, or other conditions. Without such care and assistance, their detention may become unlawful. Alternative arrangements would need to taker into account their particular circumstances, including physical and mental well-being."

[51] UNHCR Detention Guideline 9.3 (paragraph 58) reads: "As a general rule, pregnant women and nursing mothers, who both have special needs, should not be detained. Alternative arrangements should also take into account the particular needs of women, including safeguards against sexual and gender-based violence and exploitation."

[52] UNHCR Detention Guideline 9.5 (paragraph 63) says: As a general rule, asylum-seekers with long-term physical, mental, intellectual and sensory impairments should not be detained."

4.19 Chapter 45 of the EIG is concerned with the removal of pregnant women and of new mothers. Paragraph 55.9.1, which has recently been revised in order to reflect the suspension of the DFT on 2 July 2015, states that women should be detained only when removal is imminent and when confinement is not expected to occur before the date of removal. Paragraph 55.10 lists pregnant women (other than in the circumstances set out in 55.9.1) as one of the groups of individuals who should be detained only in exceptional circumstances. There is nothing currently in the policy in relation to victims of sexual or gender-based violence.

Victims of sexual violence

4.20 I understand the Home Office policy position on the detention of women who have been (or may have been) the victims of rape and sexual violence to be as follows:

- being the victim of rape or sexual violence is not, in itself, one of the published criteria for exclusion from immigration detention (set out in paragraph 55.10 of the EIG)
- however, if it amounted to torture or if it formed part of someone's trafficking experience, or if it had impacted on an individual's mental or physical health, then it might well warrant exclusion under those criteria
- as far as asylum/DFT is concerned, a process for signposting to the appropriate services women who identify at screening as having been the victims of sexual violence has recently begun in the Asylum Intake Unit (AIU). This will be reviewed in September 2015 and, if successful, rolled out to other asylum screening environments
- women who identify as victims of sexual violence through this process will not automatically qualify for exclusion from DFT, but the information may be of interest to the National Asylum Allocation Unit (NAAU - which makes decisions on routing cases to DFT) and might lead the NAAU to conclude that a quick decision in the case is not likely to be possible and that DFT is not appropriate
- there are no existing plans to create a formal exemption from immigration detention for women who claim to have been the victims of sexual violence.

4.21 DFT does not have in place any specific policies in respect of potential victims of rape and sexual violence, and cases should be managed under the NRM[53] or rule 35, depending on the context in which they were raised.

4.22 A number of submissions to the review have said that chapter 55.10 should be amended to include a presumption against detention of those who have experienced rape or sexual violence.[54] This would be in line with UNHCR

[53] I judged that the effectiveness or otherwise of the NRM was wholly outside the terms of this review.
[54] See Women for refugee women, *I am Human: Refugee women's experiences of detention in the UK*, 2015.

Detention Guideline 9.1, paragraph 49 of which says: "Victims of torture and other serious physical, psychological or sexual violence also need special attention and should generally not be detained."

4.23 I was provided with details of 22 women held in Yarl's Wood during the period January-March 2015 inclusive where the detainee had reported being the victim of sexual violence. Of those 22 women, two had been removed from the country by mid-June. All the others were released. I infer from this that victims of rape or other sexual violence cannot generally be removed.

4.24 Having considered the views presented to me, and the evidence on removals, I believe there is a strong case for saying that – in common with individuals who have been trafficked or tortured – those who have been the victims of sexual violence, or (in the case of women) gender-based violence, should not be held in immigration detention. I appreciate that there may be rare cases in which the detention may be appropriate – for example, in criminal cases, or when removal is very imminent. I also appreciate that the Home Office might have some difficulty in establishing the veracity of individuals' claims to have been such victims. However, the presumption should be that victims of sexual violence should not be detained, and I would like the Home Office to put in place workable arrangements for excluding them from detention at the earliest opportunity.

Recommendation 9: I recommend that there should be a presumption against detention for victims of rape and other sexual or gender-based violence. (For the avoidance of doubt, I include victims of FGM as coming within this definition.)

Pregnant women

4.25 In its evidence to the review, the Royal College of Midwives (RCM) strongly emphasised the special vulnerability of pregnant women, and said that appropriate maternity care could not be given to women in detention. The RCM argued:

> "… women who are pregnant are uniquely vulnerable in so far that they (and their babies) will always have specific, and sometimes serious healthcare needs which are time-critical and may impact on health outcomes … The Home Office has acknowledged our concern that some pregnant women have been detained for lengthy periods. They have assured us the guidance for case workers for assessing women for detention will be revised to stress that detention should only be in exceptional circumstances and should only be for a short period. We again are concerned that there has been no time-frame given for this revision."

4.26 The RCM added:

> "Indefinite detention creates problems for healthcare professionals accessing the women, including midwives who are trying to plan and deliver life-saving midwifery health care interventions and treatment. They too are the victims of uncertainty in terms of coordinating quality care. Women may get missed and this poses a risk to the newborn, which conflicts with the recommendations of the All Party Parliamentary Group for Conception to Age 2 – The First 1001 Days in regard to providing the best start in life for long-term benefits."[55]

4.27 HM Inspectorate of Prisons told me that, in its view, there is little to suggest that pregnant women are being detained only in exceptional circumstances. The Association of Visitors to Immigration Detainees (AVID) pointed out that an inspection of Yarl's Wood had found eight pregnant women detained: "Pregnant women had been detained without evidence of the exceptional circumstances required to justify this. One of these women had been hospitalised twice because of pregnancy related complications".

4.28 Women for Refugee Women quoted the most recent annual report from Yarl's Wood IMB, which refers to "four complaints from pregnant detainees or their partners about what they perceived as an uncaring attitude from healthcare; sadly, two of these women had lost their babies while in detention".

4.29 Medical Justice argued:

> "… the healthcare pregnant women receive in detention is inadequate and falls short of NHS equivalence and the National Institute for Health and Care Excellence (NICE) standards. Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy. Stillbirth, miscarriage and acute psychosis are amongst the problems experienced … A Medical Justice audit showed that only around five per cent of pregnant women were successfully removed, raising questions as to the purpose of their detention."[56]

4.30 I have not sought further evidence that detention has an incontrovertibly deleterious effect on the health of pregnant women and their unborn children. I take this to be a statement of the obvious.

4.31 The Home Office's policy, as it stood at the time of my visits, was supposed to restrict the detention of pregnant women but in actual fact seems to have allowed a significant degree of latitude, particularly in DFT cases. I am pleased, therefore, that the Home Office has recently changed the policy in chapter 55 of the EIG (albeit because of the suspension of DFT) to the effect that women can now be detained, in all cases, only if their removal is *imminent* and if they are not *approaching confinement*.

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[55] *Building Great Britons* [redacted]

[56] This was a reference to a 2013 report entitled *Expecting Change: The case for ending the detention of pregnant women*.

4.32 The Home Office should back up this policy change with its practices. Later in this report I have put forward proposals in respect of routing individuals through a single point. As a short-term measure, however, the Home Office should closely monitor any cases in which pregnant women are detained, and arrange for their immediate release if there is any sign of removal not being achievable imminently or if the woman concerned shows any indication of physical or mental distress.

4.33 There are no formally published data on the number of pregnant women placed in immigration detention and/or subsequently removed from the UK. However, figures I have seen suggest that only a very small minority of detained pregnant women are removed when pregnant, except where they are removed from the place of arrival at the border. So far as I can see, the figures suggest that eleven pregnant women were successfully removed from detention in the whole of 2014/15.

4.34 On the substantive issue of detaining pregnant women, therefore, and independently of my proposals in respect of single point routing, I believe that the Home Office should acknowledge the fact that, in the vast majority of cases, the detention of pregnant women does not result in their removal. In practice, pregnant women are very rarely removed from the country, except voluntarily. In these circumstances, I am strongly of the view that the presumptive exclusion from detention should be replaced with an absolute exclusion.

Recommendation 10: I recommend that the Home Office amend its guidance so that the presumptive exclusion from detention for pregnant women is replaced with an absolute exclusion.

Serious mental illness

4.35 The evidence I received criticised the introduction of the clause 'which cannot be satisfactorily managed in detention' into that section of paragraph 10 of chapter 55 that deals with those suffering from serious mental illness. AVID told me this was introduced in 2010. They said that what is meant by 'satisfactorily managed': "has never been defined, and guidance has never been issued on what this management may consist of or look like. The result is that the guidance is often treated arbitrarily." They said it had resulted in a 'watch and wait' approach, "where detention is maintained until the individual deteriorates to the point where she/he can no longer be satisfactorily managed".

4.36 It was further suggested that the term has no clinical meaning – indeed, that its meaning is inexact and obscure. I cannot compare the situation today with that obtaining before 2010 when the clause was introduced. But it is perfectly clear to me that people with serious mental illness continue to be held in detention and that their treatment and care does not and cannot equate to good psychiatric practice (whether or not it is 'satisfactorily managed'). Such a situation is an affront to civilised values.

Recommendation 11: I recommend that the words 'which cannot be satisfactorily managed in detention' are removed from the section of the EIG that covers those suffering from serious mental illness.

Other aspects of vulnerability

4.37 Additional factors that might make people more vulnerable were identified in evidence as:

- little or no family or other outside connections
- little or no command of English
- poor literacy levels
- use of languages that are not well represented in detention
- lack of legal representation
- little understanding of immigration case or status
- little understanding of entitlements
- physical ill health
- learning disabilities
- sexual orientation
- transsexual status
- having been a victim of torture
- having suffered trauma.

4.38 In respect of people suffering from Post Traumatic Stress Disorder (PTSD), the Helen Bamber Foundation pointed out that they often need treatment before they can tell their story. Those with PTSD do not respond well to direct questioning, especially if they perceive the questioning to be adversarial: these difficulties should not be seen as evidence of reduced credibility. The Foundation said that those whose PTSD arises in the context of sexual trauma have particular difficulty in disclosing fully and clearly what has occurred. I am not convinced that these are insights wholly appreciated by Home Office caseworkers.

4.39 The Foundation told me:

> "In 2014, the Helen Bamber Foundation received 790 referrals … from solicitors representing people detained within the Detained Fast Track (DFT). We can confirm that these were investigated case by case by our clinicians and found to involve 2,523 human rights violations. These violations included physical and psychological injuries such as: beatings, cuttings, burns from cigarettes, iron rods, chemicals, being tied, handcuffed, blindfolded, disfigured, raped, head injuries, deprivation of sleep, being held in stress positions, mock executions, electric shocks, finger nails being removed, threats or reprisals against them or their families, debt bondage, witnessing others in prison or a brothel being killed, ritualised violence, and threats of arrest."

4.40 I am particularly concerned by the evidence that detention, as a painful reminder of past traumatic experience, can trigger re-traumatisation. The effects of such re-traumatisation can include self-injury and worsening psychiatric morbidity.

Recommendation 12: I recommend that those with a diagnosis of Post Traumatic Stress Disorder should be presumed unsuitable for detention.

4.41 In two other areas I am also not persuaded that the current list of vulnerabilities leading to a presumption against detention is sufficiently comprehensive.

4.42 First, I am surprised that there is not a specific mention in paragraph 55.10 of detainees with Learning Difficulties as being unsuited to detention.

4.43 According to a letter from the Immigration Minister, James Brokenshire MP, to Sarah Teather MP on 26 January 2015, "A patient specific learning disability and difficulty (LDD) screening tool is also being developed [by NHS England] to ensure that those individuals who fit the LDD criteria are recognised and managed appropriately." The development of this screening tool is very welcome, but in my view the necessary corollary is that to be 'managed appropriately' those with Learning Difficulties should not be subject to the inevitable rigours of immigration detention.

Recommendation 13: I recommend that people with Learning Difficulties should be presumed unsuitable for detention.

4.44 Second, I am sympathetic to the argument that transsexual people are unsuited to detention given what I have seen for myself is the inability of IRCs to provide an appropriate, safe and supportive environment.

Recommendation 14: I recommend that transsexual people should be presumed unsuitable for detention.

4.45 I also think that a more exact definition of 'the elderly' would be beneficial both to caseworkers and to detainees themselves, while recognising that the intention in the current wording is to acknowledge a degree of infirmity. In reality, many people are fit and active at very advanced ages, but this insight does not assist when considering how policy should best be drafted. A useful starting point for the Home Office might be the state pension age – i.e. the point at which Government recognises that an individual is no longer expected to work. Be that as it may, the important point is that there should be a specific upper age limit.

Recommendation 15: I recommend that the wording in paragraph 55.10 of the EIG in respect of elderly people be tightened to include a specific upper age limit.

Victims of trafficking[57]

4.46 In respect of the victims of trafficking, I received most helpful contributions from the Poppy Project, a First Responder within the National Referral Mechanism. They explained that they had first proposed in 2008 that victims of trafficking should not be detained, and that potential victims should not be detained pending an assessment from a specialist NGO. They said they had supported people who had attempted suicide to avoid a return to detention, and added:

> "In our experience, victims of trafficking may be in detention for a variety of reasons. Some women are in detention as a result of a claim for asylum, and have been determined as suitable for the detained fast track (DFT). Others may have been charged and convicted of offences, and are therefore awaiting deportation in detention. A further group may have been detained to facilitate their removal from the UK and have either never disclosed trafficking, or have disclosed but have not been identified as victims of trafficking."

4.47 The Poppy Project said that they had encountered a number of cases where "despite clear indicators during a screening interview, no referral has been made into the NRM and detention has been maintained."

4.48 They said that detention did not assist those who might disclose they were victims of trafficking: "a detention setting in many cases exacerbates mental health distress, and … experiences of detention are reminiscent of a trafficking situation." They reported that a majority of women with whom they worked showed symptoms of PTSD.[58] They said there was a problem in that DFT and NRM timeframes did not coincide, and the DFT timeframe took precedence.

4.49 In a supplementary letter, the Poppy Project referred to the recent court cases resulting in suspension of the DFT. They told me: "There are compelling reasons why victims of trafficking should be given time to disclose what has happened to them without the pressures of a detained fast track, and without being in detention."

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[57] The Council of Europe Convention on Action Against Trafficking in Human Beings, to which the UK is a signatory, gives the following definition: "Trafficking in human beings shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."

[58] On the clinical links between human trafficking and torture see *Trafficking in Human Beings Amounting to Torture and other Forms of Ill-treatment*, Organisation for Security and Co-operation in Europe, 2013.

The category-based approach

4.50 As well as the list in paragraph 55.10 being judged insufficiently comprehensive, more generally there was sympathy in the evidence I received for the DEVAS view that: "a category-based approach to assessing vulnerability is fundamentally flawed, as detention can make anyone potentially vulnerable."

4.51 I agree that vulnerability should be assessed individually and holistically. But I do not think that the categories in chapter 55 of the Home Office Guidance are without value (indeed, I have proposed adding new categories to the list). However, I believe that a further clause should be added to the list in paragraph 55.10 to reflect the dynamic nature of vulnerability and thus encompass 'persons otherwise identified as being sufficiently vulnerable that their continued detention would be injurious to their welfare'. Such a clause would also be helpful in respect of those people with a disability.

Recommendation 16: I recommend that a further clause should be added to the list in paragraph 55.10 of the EIG to reflect the dynamic nature of vulnerability and thus encompass 'persons otherwise identified as being sufficiently vulnerable that their continued detention would be injurious to their welfare'.

4.52 Because vulnerability and its causes can change over time, several organisations have suggested that the Home Office could produce a 'tool' that assesses an individual's current vulnerability. I understand that there have been attempts within the Home Office to design such a tool but that this has proved difficult, if not impossible, in practice. There has also been some recognition that, even if a tool could be produced, ongoing updates and maintenance would make it hard to manage. Although I agree absolutely that evaluation of vulnerability should be a continuing process that lasts for the entire period of detention, I conclude that, for the present, the development of a bespoke tool or algorithm is not the way forward.

Women detainees

4.53 I have discussed aspects of the vulnerability of women detainees in what I have said earlier about Yarl's Wood, in respect of the detention of victims of gender-based violence (most, but not all, of whom are women), and will do so further in a later section on searching.

4.54 Here I simply note that rule 33(10) of the Detention Centre Rules entitles women to be examined by a woman doctor (just as it entitles men to be examined by male doctors). I should also record that the Detention Services Operating Standards manual for Immigration Service Removal Centres contains a section entitled 'FEMALE DETAINEES' setting out a woman's entitlements: to be examined by a female nurse or doctor; not to undress in front of another detainee or within sight of a male member of staff; to eat in a female dining area; to be escorted by a female custody officer; to equal access to activities; and to

single sex gym sessions. (Women are also given the right to be searched by a woman.)

Former prisoners

4.55 Little of the evidence I received focused on former prisoners – whether those held in IRCs or in prison.

4.56 I am not naïve about the reasons why this was the case. Yet those who have spent longest in detention are almost without exception former offenders, and their continued detention after sentence raises evident issues of justice and proportionality.

4.57 I obtained figures from the Home Office showing that the 20 longest stayers in IRC detention were all ex-offenders. At the time of writing, one man has been in immigration detention since March 2010. In 2008 he was sentenced to four years imprisonment, his effective sentence expiring two years later.

4.58 In many such cases, there have been problems related to the identification of nationality and in obtaining Emergency Travel Documents.

4.59 However, nationality does not equate with identity. Many former prisoners have long-standing connections with the UK, or may in some cases have been born here, so for staff as well as detainees the legitimacy of their detention and removal is not self-evident.[59] (Prison history teaches that legitimacy is not a legal nicety but, on the contrary, a core component of institutional stability.) A report from Detention Action (*The state of detention: Immigration detention in the UK in 2014*) includes these passages:

> "Who are these 'foreign criminals' … For one thing, many are not obviously foreign. They have come to the UK as babies or small children, grown up in poverty, and never applied for British passports because they never had the chance of a holiday abroad anyway. Some were raised in care, the responsibility of the British state, whose delegated carers never got around to making a passport application. Their accents are East London or Leeds … When they get into trouble with the police, go to prison and finish their sentences, they are shocked to discover that they are not British.
>
> "Many have British wives or husbands, and British children … They are carers for British parents. They have British friends, from their British

[59] Cf. these extracts from Bosworth, op. cit.: "… some of those who had lived in the UK since childhood either did not appreciate that they were not citizens, or had not realised that they could be treated differently from others …" "In all centres staff differentiated between long-term UK residents and more recent arrivals." "Those who had lived in the UK since childhood could be particularly vexing for staff."

primary schools, British secondary schools, British workplaces. But, suddenly, they are not British."

4.60 I met many detainees who met this description: in one case, a young man, born and brought up in North London but whose mother was not a British national at the time of his birth, was to be 'returned' to Nigeria, despite never having set foot there. However, when I raised the question of his welfare and that of many like him, I was told there was "zero tolerance" for such cases in the Home Office. I do not believe that such language reflects well. Tolerance may not be the soundest basis for public policy, but the total absence of sympathy is assuredly a worse one.

4.61 Most former prisoners are transferred to IRCs. However, notwithstanding the reduction in the number of Home Office places in prisons to 400, this represents a total larger than in some of the IRCs themselves. Moreover, NOMS remains for the present the Home Office's default provider of spaces.

4.62 Despite this, there is no joint NOMS/Home Office policy on the treatment of time served FNOs. BID told me:

> "Detainees held in the prison estate suffer from multiple, systemic, and compounding barriers to accessing justice, with an often devastating effect on their ability to progress their immigration case, seek independent scrutiny of their ongoing detention from the courts and tribunals, and seek release from detention, as well as on their physical and mental wellbeing."[60]

4.63 AVID noted that the Detention Centre Rules do not apply to those in prison:

> "It is a concern to us that detainees continue to be held in such high numbers in prisons when they are not protected by the same safeguards and nor do they have equity of access to information, support or resources particular to their status as immigration detainees."

4.64 Indeed, whatever the rights and wrongs of using prisons for those who are time served, it is clear that there are significant drawbacks in terms of access to legal advice and access to Home Office staff. Unlike detainees in IRCs, those in prison have no access to mobile phones or the internet, and the use of fax machines (which are in short supply) is discretionary.

4.65 However, I am conscious that many of those retained in prison as a consequence of the Service Level Agreement (SLA) between the Home Office and NOMS include very serious offenders: terrorist cases, sex offenders and arsonists amongst them. I think it is for those who oppose any use of prison custody for immigration detainees to justify how the safety of the public could be secured if

[60] BID also noted that rule 35 has no equivalent in the Prison Service (see above): "meaning that vulnerable immigration detainees have very little chance of being identified and brought to the attention of Home Office case-owners …"

SLA offenders were to be held in the much more open conditions of an IRC – with access to the internet, for example.

4.66 Some other detainees have been transferred back from IRC to prison. The SLA rightly says that the Home Office "must consider and exhaust options for transfer within an IRC" and that: "There must be a compelling case for transfer if a detainee has never been in NOMS' prison custody on remand or under sentence." I have not made an in-depth study of such transfers; the two cases whose paperwork I saw were not controversial (one man had assaulted both staff and fellow detainees and had developed an infatuation for a female officer; the other had assaulted fellow detainees, concealed weapons, and had set fire to his mattress). However, the relationship between welfare needs and indiscipline is rarely straightforward: both of these men were on constant observations under the ACDT scheme at the time the IRC made its transfer request.

4.67 NOMS kindly provided me with a list of its establishments in which former foreign national prisoners, held under immigration powers, were housed on one day in Spring 2015. In total, there were 62 prisons in the list holding a total of 399 detainees on the day in question. Twelve prisons had just one detainee, eight had just two, seven had three each, and a further eight had just four. At the other end of the spectrum, Wormwood Scrubs held 37 detainees, Maidstone and Wandsworth 26 each, and Pentonville 25. Well over half of the total were held in just 12 prisons: the four just listed plus Thameside, Manchester, Hewell, Elmley, Huntercombe, Birmingham, High Down and Leeds.

4.68 Most were held as remand prisoners. Some (around 30 per cent) chose to remain in long-term jails, where they had friends and were more likely to have a single cell.

4.69 I do not think it is satisfactory that the rights and regime enjoyed by detainees in prison should be so different from those in IRCs. However, this is not to suggest that all the learning is in one direction: there is no equivalent in the IRCs of the Prison Service's Assisted Prison Visits Scheme or its investment in visitors centres, for example. No less significantly, I noted in most IRCs that the arrangements for those first received into detention compared poorly with what would be found in the Prison Service's better 'first night centres'.

Recommendation 17: I recommend that the Home Office consider establishing a joint policy with NOMS on provision for those held in prison under immigration powers.

Recommendation 18: I recommend that the Home Office consider what learning there is for IRCs from the Prison Service's experience of operating 'first night centres' for those initially received into custody.

Age dispute

4.70 The Home Office policy on those whose age is in dispute can be found in DSO 14/2012.

4.71 Little of the evidence I received concerned age dispute cases. It is manifest that the welfare of children is not protected if they are inappropriately classed as, and housed with, adults. However, the Home Office's policy is to transfer anyone who is identified as being under the age of 18. Moreover, I think the Home Office is entitled to rely on what I understand to be robust arrangements involving what are termed Merton-compliant age assessments.[61]

4.72 For the purposes of the review, I asked for statistics on the number of individuals identified as age dispute case. Figures for the 12 months from July 2014 to June 2015 are shown below:[62]

Ring Fence Owner (RFO)	**Total**
Third Country Unit	13
National Removals Centre	10
Fast Track	4
Special Operations	3
Border Force	1
Grand Total	31

4.73 The Home Office was unable to tell me how many of these people were eventually identified as children. I understand that the number is likely to have been small.

LGBTI detainees

4.74 The UK Lesbian and Gay Immigration Group (UKLGIG) provided me with testimony from detainees who said they had been the victims of bullying and harassment in immigration detention in the UK. UKLGIG said they had serious concerns as to the quality of asylum decision making, particularly on the DFT: "The assessment of credibility in LGBTI cases needs to be undertaken in an individualised and sensitive manner …" They added that "due to their complex nature, claims based on sexual or gender identity are generally unsuited to accelerated processing."

4.75 UKLGIG also said it "was extremely concerned to be informed … that transgender women had previously been placed in segregation as a means of

[61] These derive from the case of *B v London Borough of Merton* [2003] EWHC 1689 (Admin). The Home Office's policy is at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257462/assessing-age.pdf.

[62] As with other Home Office figures quoted in this report, these statistics have been derived from management information and are therefore provisional and subject to change, and have not been quality assured under National Statistics protocols.

'protecting' them from other detainees. This is entirely unacceptable." As I have said elsewhere in this report, I entirely agree.

4.76 UKLGIG argued:

> "… many LGBTI applicants should be considered as vulnerable due (i) to the nature of the acts of persecution frequently experienced, (ii) due to the poor standard of asylum decisions and existing obstacles in the asylum process, which mitigate against them accessing refugee protection, and (iii) due to the increasing use of immigration detention and the bullying, abuse and harassment that LGBTI people frequently experience in immigration detention centres."

4.77 I did not encounter further evidence of such bullying, but the accounts provided by the UKLGIG are powerful (if uncorroborated). The Home Office has in place a very good quality DSO (DSO 11/2012) on the care and management of transsexual detainees that includes reference to bullying issues, and I think that it should consider whether there is scope for a separate DSO on LGBI individuals. In addition, the IRC anti-bullying policies should take LGBTI issues specifically into account when they are reviewed.

4.78 UKLGIG also raised concerns relating to access to breast forms and other prosthetics, and to hormones.

Recommendation 19: The Home Office should consider the need for a separate DSO on LGBI detainees. Anti-bullying policies should include explicit reference to LGBTI detainees.

Screening, routing and a single point of entry

4.79 I should also say something about the stages at which vulnerability can be assessed.

Screening

4.80 The suspension of DFT has meant that, at the time of writing this report, there was no policy available on screening for asylum cases as it had been withdrawn pending decisions on future strategy. I was unable to observe the Asylum Screening Unit in practice as it had been suspended.

4.81 No equivalent exists for individuals who are detained for purposes other than asylum decisions, except that the officer making the detention decision is required to ascertain whether there are any health or other reasons why detention would pose a risk or be unsuitable.

4.82 AVID reminded me that:

> "In 2012 a joint thematic inspection by HMIP and the Independent Chief Inspector of UK Borders and Immigration (ICIBI)[63] found that screening processes were inadequate to identify and respond appropriately to victims of human trafficking. Their report describes one case where a detainee was held for 15 months despite his having been trafficked as a child and the confirmation of this by a competent authority".[64]

4.83 Detention Action recommended: "The screening process and safeguards should be reformed to effectively identify and exclude unsuitable cases."

Routing

4.84 There is no unified policy on routing.

4.85 I obtained information from those Home Office officials responsible for routing decisions in criminal cases and in the National Removals Command, particularly regarding their processes for determining whether to detain individuals in light of any vulnerabilities.

4.86 The NRC process applies some refinements to the categories in paragraph 55.10. For example, individuals who suffer from a confirmed mental or physical health condition, or who are pregnant, or who have reached the age of sixty-five can be detained only with the agreement of an officer at Grade 7 level. In all NRC cases, pursuance of voluntary departure options is the first step. The NRC tries to have a flight booked at the point at which the decision to detain is made in order to minimise the length of detention. The presumption, in both NRC and criminal cases, in line with the published policy, is that individuals will not be detained and that detention will be used only as a last resort and if there is a reasonable prospect of quick return.

4.87 The context in criminal cases is different from that in NRC cases in that there is a legal requirement to detain and remove certain individuals – so the balance in terms of assessing vulnerability is different. If there is an *obvious* vulnerability then the individual will not be detained.

Single point of entry

4.88 As it stands, the immigration detention estate essentially comprises three groups of detainees: foreign national offenders who are being deported; those subject to other enforcement action such as removal; and asylum seekers managed through the detained fast track (currently suspended) or Dublin third country unit (TCU) procedures. The three groups are each managed by separate parts of the Home Office – FNOs by Criminal Casework, which is part of Immigration Enforcement, other enforcement cases by the National Removals

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[63] HM Inspectorate of Prisons and the Independent Chief Inspector of Borders and Immigration (2012) *The effectiveness and impact of immigration detention casework*, http://icinspector.independent.gov.uk/wp-content/uploads/2012/12/Immigration-detention-casework-2012-FINAL.pdf

[64] Ibid.

Command (also part of IE), and DFT and TCU cases by the Asylum Casework Directorate (part of UK Visas and Immigration).

4.89 Until the recent suspension of the DFT process, each of the three groups took up approximately one-third of the space in the detention estate. Each of the three operations has its own processes in place for determining who enters detention and for managing the cases once the individuals have been detained. During the course of this review I have spoken to those responsible for overseeing the management of these cases. While the policy is consistent, it is apparent that different operational approaches are taken across the three commands. This is perhaps not surprising given that they have completely different imperatives – in criminal cases, the focus is on removal and protecting the public; in asylum cases the focus is on removal whilst making sure that asylum applicants receive a fair hearing for their asylum claims; and in NRC cases the focus is simply on removal. However, the three commands also appear to have different approaches to the assessment of vulnerability and risk. For example, the NRC appears to take a more proactive approach whereas the DFT processes are currently under scrutiny because of risks surrounding the safeguards for particularly vulnerable applicants.

4.90 The policy governing detention, set out in the EIG, applies across all three areas, but there is scope for its application to be inconsistent. The initial consideration of an individual's fitness for detention, and the ongoing assessment of their fitness for continued detention, should in my view be managed in a consistent way. With this in mind, there is a case for the Home Office to put in place new generic and cross-cutting routing arrangements, comprising a single 'gatekeeper for detention', whose main purposes would be:

- to ensure consistent application of the exclusion criteria in paragraph 55.10 of the EIG;
- to ensure that vulnerable individuals (those who fall within paragraph 55.10) are not detained;
- to carry out risk assessments prior to detention;
- to maintain strategic oversight of the population mix, including allocating the limited number of beds effectively.

4.91 I am aware that thinking along these lines may already have taken place within the Home Office. But I would like to encourage this approach as a means of ensuring, more systematically and consistently, that those who should not be in detention are not detained, and that individuals' shifting circumstances are acted upon swiftly and appropriately.

Recommendation 20: The Home Office should consider introducing a single gatekeeper for detention.

Rule 35

4.92 What is intended to be a key safeguard in ensuring that vulnerability is identified is provided by rule 35 of the Detention Centre Rules. The rule reads as follows:

> **Special illnesses and conditions (including torture claims)**
>
> **35**.—(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
> (2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.
> (3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.
> (4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
> (5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.

4.93 The Operating Standards for Immigration Removal Centres replicate these responsibilities in the section governing healthcare provision. The Standards use the phrase "healthcare practitioner" specifically with regard to who should report concerns that an individual may have been tortured.

4.94 Paragraph 55.8A of the EIG broadly reproduces the terms of the rule, but wrongly links suicide risk with torture by using the conjunction 'and' rather than 'or'. (I am not sure that this causes any confusion in practice, but as a matter of good housekeeping it should be corrected.) The guidance also changes the wording to make rule 35 a more general responsibility, rather than a concern on the part of healthcare staff.

4.95 Paragraph 55.8A goes on to expand on the purpose of rule 35 reports and to state that the "information contained in the report needs to be considered when deciding whether continued detention is appropriate in each case." It places a requirement on the caseworker to respond within two working days of receipt of the report.

4.96 DSO 17/2012, entitled 'Application of detention centre rule 35', reflects the requirement of rule 35 that reports should be completed by "a person who is vocationally trained as a general practitioner and fully registered within the meaning of the Medical Act 1983" (the definition of "medical practitioner" given

in rule 33 (1) of the Detention Centre Rules 2001). It lays out the standards required for completion of a rule 35 report, and for the consideration of a report by the Home Office, as well as providing a standard form to be used.

4.97 The DSO states: "Rule 35 places medical practitioners at the centre of the process and fundamentally it is for the medical practitioner to decide if he/she has concerns in a professional capacity that a detainee may have been the victim of torture." It goes on to say: "Medical practitioners are not required to apply the Istanbul Protocol or apply probability levels or assess relative likelihoods of different causes but if they have a view, they should express it."

4.98 Guidance issued to caseworkers on how to consider rule 35 reports, and the obligations placed on them in doing so (paragraph 55.8A of the EIG), sets out the basic principles: "to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention" and that "the information contained in the report needs to be considered in deciding whether continued detention is appropriate in each case".

4.99 I arranged for a dip sample of rule 35 reports. There were 34 reports in the sample, all but two of them referring claims of torture to the Home Office (rule 35(3)). The reports proved to be of variable quality in terms of information provided by the medical practitioner, and in the overwhelming majority of cases it was difficult to deduce whether the GP believed that torture had actually occurred.

4.100 Most of the reports detailed physical effects of torture, but a significant minority reported mental health issues relating to abuse.

4.101 I asked for statistics on the number of rule 35 reports that are completed. These are reproduced in the table below.[65]

Rule 35 Raised - Q3 2014 to Q1 2015 inclusive:	Rule 35 Reports - total	Rule 35 (1) Reports	Rule 35 (2) Reports	Rule 35 (3) Reports
No of rule 35 reports made by Medical Practitioner to Home Office	1626	64	14	1548
No of detainees to whom rule 35 reports relate	1589	64	14	1511
of which:				
Rule 35 releases	247	23	2	222

[65] As before, all figures quoted have been derived from management information and are therefore provisional and subject to change. This information has not been quality assured under National Statistics protocols. Figures are based on historical reports taken at the end of each reporting period, providing a snapshot of cases at the time. The data was extracted on 30 March 2015.

4.102 It will be seen that in the period in question just 15 per cent of rule 35 reports actually resulted in release.

4.103 However, further figures I obtained from the Home Office do suggest some changes in the pattern of rule 35 reports and release decisions. For example, in Q2 of 2014 there were 457 reports (ten under 35(1), four under 35(2) and 443 under 35(3)) resulting in 45 releases (ten per cent). Eighty-four of the reports were from Harmondsworth and no fewer than 202 were from Yarl's Wood. In Q4, the number of reports had fallen to 341 but they resulted in 62 releases (18 per cent); Harmondsworth produced 124 reports but Yarl's Wood had slumped to just 30.

4.104 In Q1 of 2015, there were 440 rule 35 reports and 84 releases (19 per cent); 130 were from Harmondsworth and just 37 from Yarl's Wood.

4.105 These figures suggest that the release rate has doubled, but – for reasons of which I am unaware – the number of reports from Yarl's Wood has fallen by four-fifths. The statistics themselves cannot reveal the reasons for those trends, and I suggest that the Home Office should investigate if there are any underlying factors.

4.106 Leaving to one side the detailed trends, it is apparent from the figures I have cited that there is a high volume of rule 35 reports, principally focusing on claims of torture rather than health issues or concerns about the impact of continuing detention.

4.107 I understand that the Home Office is actively looking to improve the rule 35 processes, general practitioner templates and caseworker response templates, as well as the training provided to those involved. There is, at present, no firm timetable for the completion of this work although I have been assured that it is being taken ahead as a high priority. I am also told that the Home Office ran a short review of detained casework information sharing processes at the end of 2014 that reported that there was a "sense of fatigue with some casework teams" with relation to rule 35 reports.[66]

4.108 I have to say that a sense of frustration, rather than fatigue, was evident from the submissions received by my review. No one expressed any satisfaction with the current arrangements.

4.109 Dr Frank Arnold provided an analysis of people held in DFT where a rule 35 report was submitted. He argued that resistance to release by the Home Office "was evident irrespective of the quality of rule 35 reports ... Excellent reports were as likely to be rejected as poor ones, often for reasons which were not compliant with Home Office policy."

[66] Detained Casework Co-ordination Review, 2015.

4.110 AVID reported:

> "Rule 35 has been widely criticised at a range of levels including in case law, in the reports of statutory monitoring bodies and in parliament because it rarely secures release regardless of how vulnerable the person is, leaving them in detention and at risk … NGOs such as Medical Justice have highlighted the lack of training of health staff, poor communication between healthcare and case worker and gaps in the information chains throughout detention which mean that many vulnerable detainees are left, inappropriately and sometimes unlawfully, in detention."

4.111 Asylum Welcome told me: "All too often, requests appear to 'go nowhere', and it is unclear why a decision to release has not been taken. The impact on detainees can be psychological and well as physical damage; with, for instance, heart conditions being exacerbated due to the anxiety brought by the period in detention." BID said that:

> "Unfortunately, despite the existence of the rule 35 safeguarding mechanism, there is evidence of systematic failure of the operation of the rule 35 process in IRCs[67] , and there has been criticism of the Home Office on this issue from, among others, HM Inspectorate of Prisons[68], as well as a number of court judgments.[69] Notwithstanding the effects of the rule 35 process in IRCs, there is no requirement for an equivalent process in the prison estate, meaning that vulnerable immigration detainees have very little chance of being identified and brought to the attention of Home Office case-owners for consideration of their release from administrative detention. Such detainees held in prisons may continue to be detained in breach of Home Office policy".

4.112 Similar points were raised by the solicitors, Deighton Pierce Glynn,[70] Detention Action,[71] the Helen Bamber Foundation, and the Immigration Law Practitioners' Association (ILPA). The latter argued:

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[67] Medical Justice, (2012), *"The Second Torture": the immigration detention of torture survivors*. Available at http://www.medicaljustice.org.uk/about/mj-reports/2021-the-second-torture-theimmigration-detention-of-torture-survivors-22052012.html.

[68] HMIP and the Independent Chief Inspector of Borders and Immigration (2012) *The effectiveness and impact of immigration detention casework*.

[69] For example, *EO & Ors, R (on the application of) v Secretary of State for the Home Department [*2013] EWHC 1236 (Admin) (17 May 2013). Available at http://www.bailii.org/ew/cases/EWHC/Admin/2013/1236.html.

[70] They provided me with case studies in which they have been involved, and criticised the screening process, rule 35, and the effectiveness of 28-day reviews. They told me: "It cannot be said that either the decision making process at the start of detention or the review process during detention are based on accurate information in the case of vulnerable detainees. Even where compelling evidence is provided that detention will damage health, it is often ignored."

[71] *The state of detention: Immigration detention in the UK in 2014*, Detention Action, 2014, says that the common conclusion of anyone who has looked at rule 35 is that "it simply does not work".

> "The Home Office has shown an unwillingness to acknowledge that there is a problem and has only done so as a result of litigation or the threat of litigation and even then there has been a refusal or reluctance to acknowledge the scale of the problem. The changes that have followed have focused on rule 35(3) (the duty to report on survivors of torture) with the result that there has been too little attention paid to rules 35(1) and 35(2) (the duty to report on those whose health is likely to be injuriously affected by detention and those who are suicidal) which are particularly relevant to the mentally ill. We continue to see poor quality decisions by those tasked with authorising detention; in the context of the detention of the mentally ill in particular, even when presented with cogent medical evidence caseworkers demonstrate a fundamental misunderstanding of clinical information."
>
> …
>
> "The standard response to representations and requests for temporary admission based on rule 35 reports identifying the person as a survivor of torture is either no response or that there is insufficient probative value as independent evidence of torture. Another is that the report does not expressly state that the client is not suitable for detention. Some medical centre staff take a view that for the purposes of rule 35 only reports of ill-treatment by state actors can properly be regarded as torture and that only torture can found a rule 35 report. This is contrary to settled case law (R (EO, RA, CE, OE et RAN) [2013] EWHC 1236 (Admin), 17/05/2013)."
>
> …
>
> "The Home Office has produced a new draft template for responses to rule 35(3) reports. This is not, as we understand it, in use and there is, as far as ILPA understands, no start date for its use."

4.113 I discussed the concerns of the British Medical Association (BMA) about the rule 35 process in our meeting on 5 May 2015. The BMA's written submission notes: "Doctors report that on completing and submitting rule 35(3) reports to the Home Office, many are disregarded as being unsatisfactory, often on the basis that the report does not constitute independent evidence of torture, or that the evidence provided is not sufficient." I saw one such report from the Home Office (dated March 2015). The relevant passage reads:

> "The report records that you have a number of scars of lacerations and burns that are in keeping with the history of abuse that you claim to have occurred three years ago. Whilst the Medical Practitioner who compiled the report state [sic] that they have concerns that you may have been a victim of torture it is not considered that the report in itself amounts to independent evidence and you have provided no independent evidence to show that any injuries that you may have sustained are as a result of you

> having been tortured as you claim … It is not considered credible that you would have failed to mention this incident when earlier claiming asylum if it had occurred as you now claim."

4.114 I know nothing about the detainee in question. But it is frankly difficult to understand what other 'independent evidence of torture' he could have been expected to provide thousands of miles from his home country and from inside an IRC. Moreover, a failure to mention torture on a previous occasion is characteristic of many victims (of torture, or of other acute trauma) and does not necessarily speak to the person's credibility.[72]

4.115 The BMA went on to tell me:

> "These reasons for rejecting the detainee's claim that they have been a victim of torture include the perception on the part of the decision-maker that the GP's view is not independent. In addition they also appear to highlight a lack of knowledge and appropriate training and confidence on the part of some GPs who are required to complete these forms. This can lead to reports of insufficient quality to enable the Home Office to reach a decision.
>
> "The identification, assessment, and reporting of injuries inflicted during torture is a highly specialised skill. The UN's Istanbul Protocol sets out internationally recognised standards and procedures for the assessment of symptoms of torture, and clearly identifies the need for reporting physicians to have the required competencies. We have serious concerns that the current rule 35(3) process requires GPs to exercise skills and knowledge which most GPs do not possess. Accordingly, we recommend that rule 35(3) reports should be written only by clinicians with relevant medical experience and appropriate training in identifying, documenting and reporting the physical and psychological sequelae of torture – including but not limited to, forensic medical examiners (FMEs), doctors from university pathology departments and volunteer doctors with organisations such as Freedom from Torture and the Helen Bamber Foundation.
>
> "The current reliance on IRC GPs to complete rule 35(3) reports is not only problematic due to the lack of competencies amongst a number of such GPs, but because the rejection of a rule 35(3) report as not being independent evidence of torture can have a profound effect on the doctor-patient relationship. As is most often the case, when detainees are not released flowing the completion of the report, they often blame the doctor for their continued detention, which can irrevocably damage the doctor-

[72] *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, op. cit., gives advice to doctors on identifying torture victims.

patient relationship and impact on detainees' willingness to access or co-operate with healthcare services.

"In parallel to our concerns about the lack of training for doctors working in IRCs, we are equally concerned about the capabilities of those reviewing these reports within the Home Office, and their ability to interpret and appropriately assess the evidence provided. It is crucial that all individuals involved in the process of reviewing the detention of suspected victims of torture have the necessary training and support".

4.116 Healthcare staff with whom I spoke also expressed concern about the nature of rule 35 reports. They said that on site teams were not sufficiently trained to complete them, and that they felt compelled to submit a report when a detainee requested one, that their reports were frequently questioned, and that the volume of such reports added to already high workloads.

4.117 According to NHS England: "Not all IRCs had robust arrangements in place for ensuring healthcare staff including both GPs and nurses received adequate training in recognising symptoms of torture and using the correct reporting procedures."[73]

4.118 Notwithstanding what appears to be a recent increase in the number of rule 35 reports resulting in release, the vast majority are still rejected by caseworkers. It is abundantly clear to me, therefore, that rule 35 does not do what it was intended to do – that is, to protect vulnerable people who find themselves in detention. The Home Office's approach to has been to focus on whether forms can be made clearer or more user-friendly, and on better training for medical staff. Both of these might help, but they will not fundamentally change the issue at hand, which is – and I put this bluntly – that the Home Office does not trust the mechanisms it has created to support its own policy.

4.119 I do not believe that a further audit of current reports will produce the shift that is necessary to protect those who have been detained, but who are vulnerable and should be released. Nor will improved training for doctors and for the lay caseworkers who make the decisions, desirable though both may be.

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

Recommendation 21: I recommend that the Home Office immediately consider an alternative to the current rule 35 mechanism. This should

[73] NHS England, *Health and Wellbeing Health Needs Assessment Programme: Immigration Removal centres and Residential Short Term Holding Facilities: National Summary Report*, March 2015.

include whether doctors independent of the IRC system (for example, Forensic Medical Examiners) would be more appropriate to conduct the assessments as well as the training implications.

4.121 It has also been put to me that the safeguards (however imperfect in practice) that apply to detainees in IRCs do not extend to those held in prisons. I do not think this is acceptable. If someone is detained under immigration powers then the safeguarding mechanisms that the Home Office has established should be applied whatever the place of detention. I appreciate that this complicates relationships with NOMS, but that is a consequence of the reliance on the Prison Service to house some immigration detainees.

Recommendation 22: I further recommend that rule 35 (or its replacement) should apply to those detainees held in prisons as well as those in IRCs.

PART 5: THE ARTICLE 3 SUB-REVIEW

5.1 Article 3 of the European Convention on Human Rights outlaws torture and inhumane or degrading treatment or punishment. It is one of the most important Articles in the Convention, and the threshold for a finding a breach is understandably a very high one. No domestic court found a breach of Article 3 in the first eleven years after the passage of the Human Rights Act 1998. I was, therefore, acutely concerned to discover that there had been six recent cases involving people in immigration detention where the British courts had found the Home Office to be in breach of Article 3.[74]

5.2 As I am not a lawyer, I sought advice as to the reach of these findings: whether the individual circumstances had been so egregious that there were no implications for wider detention policy and practice or whether, in contrast, there were clear implications of that kind. Mr Jeremy Johnson QC of 5 Essex Court kindly agreed to provide me with a report, and I am hugely grateful to him.

5.3 I have appended Mr Johnson's report as Appendix 4. The principal findings and conclusions are as follows:

- The six cases that have been cited are almost certainly the only cases in which a breach of Article 3 has been found in respect of immigration detention since May 2010. However, it is possible that other cases have been settled, or cases have not been litigated because the individual has been removed from the UK or for other reasons.

- In one of the cases (*R (S) v Secretary of State for the Home Department* [2014] EWHC 50 (Admin)) the judgment was overturned on appeal.

- There are many other cases in which the court has not found a breach of Article 3 but where it found that detention was unlawful. In other words, the lack of other findings of Article 3 breaches in other cases is "very far from an indication that the five cases … are outliers in terms of the substantive factual criticisms of the treatment of vulnerable detainees."

- The nature and pattern of the findings "tend to suggest that these cases may be symptomatic of underlying systemic failings (as opposed to being wholly attributable to individual failings on the part of the clinicians or public servants who were involved in the particular cases)".

[74] In its Further Submission to this Review, the Mental Health and Immigration Detention Working Group said: "… the reason why we are so keen to emphasise these Article 3 cases is that it is extremely rare for the UK Courts to make a finding that there has been a breach of Article 3 of the European Convention of Human Rights. We are not aware of any such cases in the prison context for example."

- None of the findings was attributed to a failing in the legislative framework or policy. Nor was there any finding of a deliberate intention to cause harm.

- The findings focus upon a lack of healthcare assessment and treatment: "The nature and pattern of findings are such that they are more likely to be a reflection of a systemic problem (i.e. insufficient medical – particularly psychiatric – provision) rather than individual failings."

- Explicitly in two cases, and implicitly in others, there are findings relating to a failure in communication between the immigration removal centre and the Home Office: "An important example concerns the compilation and use of rule 35 reports …"

- In each of the cases the detention of the vulnerable and mentally ill claimant was unlawful as chapter 55 of the policy had not been properly applied. This related to a number of detention reviews over long periods of time:

  > "There are two themes that run through the cases. The first is that the person reviewing detention does not always appear to have been aware of all of the relevant evidence (particularly medical evidence) that is relevant to the assessment of whether it is appropriate to detain (so sequential reviews are written in almost identical terms without any reference being made to important developments in the medical picture). The second is that decisions to detain are made without properly engaging with the test that has to be satisfied before a decision is made. The policy makes it clear that the mentally ill should be detained only 'very exceptionally'. In all but very exceptional cases temporary admission should be granted. It almost seems as if some of the decisions are made by rote or mantra, with detention being imposed because of a risk of absconding or re-offending. Both of those features are capable of justifying detention. But they do not necessarily justify detention. Everything depends on the particular circumstances. It is necessary to quantify the level of the risk and the likely consequences if the risk materialises. It is then necessary to assess whether, in the particular circumstances of the case, including the individual's health, those factors are sufficiently weighty to displace the very strong presumption in favour of liberty. But it is difficult to identify a single detention review in any of the cases where that exercise has been undertaken with any real rigour."

- Consideration of the cases: "suggest[s] that there is likely to be a general problem in respect of detention reviews for those suffering mental illness." Such reviews "involve a high degree of analysis and judgement".

- It may be appropriate to establish a particular team of staff responsible for carrying out detention reviews where mental illness is concerned, and to take other measures to establish a proper standard of detention reviews: "the resource implications of applying a more careful approach to these cases ought not to be overly burdensome when compared to the need to protect the vulnerable from inhuman or degrading treatment".

- There is evidence of cynicism and case-hardening on the part of some decision makers.

- It would be rash to adopt policy changes as a result of the judgments alone. Account should be taken of the cases, "as having potential implications for policy in relation to the care and treatment of vulnerable detainees, but it is necessary to cross-check those potential implications against the review's conclusions drawn from a broader evidence base".

- The proposals made in respect of detention reviews could also be taken in relation to rule 35 reports.

- In summary, the areas in which the cases tend to suggest there is a particular need for focus are:
  - healthcare provision
  - communication between the different agencies responsible for detainees (particularly in relation to rule 35 reports)
  - detention reviews and, possibly,
  - attitude and cynicism.

5.4 Mr Johnson concludes his review by saying that his contribution should be considered alongside the findings of this report as a whole, and I am sure that will be the case. However, once published as an appendix to this report, I am equally certain that his review will be widely cited in its own right.

PART 6: REGIMES AND PRACTICES

Personal wellbeing and safety

Preventing self-harm and suicide

(i) Assessment, Care in Detention and Teamwork (ACDT)

6.1 The Home Office process for the prevention of suicide and self-harm is Assessment, Care in Detention and Teamwork. This is closely modelled on the Prison Service's long-standing Assessment, Care in Custody and Teamwork (ACCT) system.

6.2 ACDT processes and policy are intended to ensure that those who are identified as being vulnerable or at risk are given support and assistance to prevent self harm, and to encourage resilience to prevent future set backs. The ACDT system is governed by DSO 6/2008, a document that has been due for review for some time. The emphasis of the document is on support for the principles, with enactment of structures, training, etc, left to service providers.[75]

6.3 The document establishes critical roles, levels of responsibility and associated training requirements. There are, however, no published standards for completion of an ACDT form except those contained in the document itself. Similarly, case conferences/reviews to determine levels of support for the detainee and next steps are not governed by rules.

6.4 I am aware that NOMS is conducting a review of ACCT within prisons, and that the Home Office will be led by that review in terms of ACDT. I am a strong supporter of the ACCT system, which I believe has done much to improve care and save lives in prison. But I am conscious that, if done well, it is a system that is expensive in terms of staff time.

6.5 The strong impression of ACDT that I have gained from my visits to IRCs is that it is invoked too frequently, and that constant observations are put in place unnecessarily, thus reducing the impact of the process itself.

(ii) Levels of self harm

6.6 There is published data on incidents of self-harm in the NOMS-managed IRCs,[76] and internal management information is provided monthly to the Home Office on all incidents of self-harm, categorised into those that required medical attention and those that did not.

6.7 A recently published response to a Freedom of Information request records the number of incidents of self-harm requiring medical attention (they do not

[75] The differences between IRCs, in this as in so much else, were as important as the similarities. Serco has its own care plan system in addition to operating ACDT. In Dungavel, a local policy ensures a routine referral of anyone on ACDT to a registered mental nurse (RMN).
[76] https://www.gov.uk/government/collections/safety-in-custody-statistics.

necessarily equate to the number of detainees requiring medical attention as one individual may have received medical attention on more that one occasion). I reproduce the figures in the table below, although I think it may be fairly said that, of themselves, they are not hugely instructive.[77]

IRC	July 2014	August 2014	September 2014
Brook House	4	1	0
Campsfield House	0	2	4
Colnbrook (inc STHF)	5	4	2
Dover	0	0	2
Dungavel	1	0	0
Harmondsworth	8	13	7
Haslar (now closed)	0	0	0
Morton Hall	3	6	7
The Verne	N/A	N/A	N/A
Tinsley House	2	3	4
Yarl's Wood (incl. STHF)	5	8	6
Larne House	0	0	0
Pennine House	0	0	0
Cedars PDA	0	0	0

6.8 AVID told me:

> "In 2014 figures show that 2,335 detainees were deemed to be at risk of self harm ('suicide watch') and there were 353 instances of self harm requiring medical treatment[78], an increase of 28 on 2013. This includes a dramatic increase in Brook House, where self harm figures are particularly high, from 39 in 2010 to 64 in 2014. Further, the definition of 'requiring medical attention' has been interpreted differently across the detention estate resulting in different recording practices, with some IRCs recording instances which required hospitalisation and others recording treatment for self harm in the healthcare unit.
>
> "Visitors tell us often that they meet people in detention who have harmed themselves.[79] In 2011, the Home Office reported only one instance of self harm in Yarl's Wood, yet Yarl's Wood Befrienders told us their experience suggested this figure was a vast underestimate, even amongst the detainees that they had visited. The figure was revised to sixty in a letter to the *NO Deportations* campaign group. These levels of self harm are particularly concerning in light of the shortcomings in

[77] As elsewhere, I should remind readers that the data quoted have been taken from management information and have not been subject to the detailed checks that apply to publications of national statistics. The figures are provisional and are subject to change.
[78] https://www.gov.uk/government/publications/incidents-of-self-harm-in-immigration-detention-in-2014.
[79] [redacted]

mental health provision and the absence of a thorough mental health assessment during initial screening."

6.9 In the time available to me, I have not been able to explore further the actual levels of self harm, and yet this information is a critical indicator of the health of an institution and of the welfare of the detained population. It should not be beyond the Home Office to record meaningful data and to interrogate that data regularly.

(iii) ACDT sample

6.10 I asked the Home Office for a random sample of ACDT documents. A total of 48 ACDT forms were received for review (including three ACRT forms from Cedars).

6.11 Analysis of whether the documents met defined standards was difficult given the limitations of the guidance as outlined above. In addition, a minority of the documents arrived incomplete.

6.12 What was evident was that different service providers had created their own documentation to supplement the booklet used as the standard for immigration detention. G4S and Mitie Care and Custody include their own records for example, and Prison Service establishments use form letters to document permissions given by detainees (to contact relatives if a care plan identifies this as appropriate, for example). The Verne produces post-closure reports, which is good practice.

6.13 A small minority of the ACDT reports were raised because a detainee had missed meals. The food and fluid policy is covered below, but it is important to note that in these instances there was little evidence that the detainee was attempting to self harm, but was simply of the view that the food on offer was not of interest.

6.14 Generally, the quality of record keeping was a lot higher than for other paperwork I have seen during this review. Care had been taken to record interactions with detainees, although a minority resorted to observations about detainees' sleeping patterns and television viewing habits. Care plans were routinely opened and reviewed, and most had meaningful actions included. References to appointments with healthcare, chaplains, and others, were made frequently, indicating a team approach to the resolution of issues.

6.15 Case conferences were a regular feature of the records (the Prisons Inspectorate separately told me that case reviews were usually conducted well), an important feature given that a number of the detainees said that concern about case progression or lack of travel arrangements was a significant contributor to their anxiety. While the Home Office was represented at such meetings, it did not always attend and, when it did, attendance was invariably by a local team member rather than a case decision maker. A multi-agency approach is critical to the success of the ACDT process.

6.16 There were clear points at which detainees' anxiety or vulnerability was heightened – at the service of removal directions, upon receiving bad news from relatives about family members, if solicitors had withdrawn from cases. These potential triggers should be self-evident as stress points, but in some examples it was apparent that greater care could have been taken in relaying information to detainees. For example, a report from Dungavel showed that a man on constant observations was given information regarding his removal directions three weeks before the flight. It is questionable whether this was necessary or in his best interests.

6.17 Separately, IRC service providers reported management strategies for regular reviews of all vulnerable detainees, whether they were formally on ACDT plans, or on lower level plans that had been developed as centre-specific initiatives. The managers at Tinsley House, for example, reported that they had developed a plan to give support to detainees who were demonstrating early signs of vulnerability before they showed symptoms or behaviours that would trigger an ACDT. (While this was good practice, it would be lost if a detainee on such a plan were transferred to another centre that did not have an equivalent. Good practice such as this should be spread to all centres rather than used in isolation.)

6.18 Campsfield House placed details (including photographs) of those detainees who were of concern in a part of the centre where officer traffic was frequent to encourage observations of those who might be at risk.

(iv) Levels of use of ACDT

6.19 I have already expressed the view that ACDT is over-used. When I spoke to managers and staff during visits to IRCs, the typical response was that they also thought the numbers to be too high, with a risk-averse attitude to closing them being responsible.

6.20 To provide harder evidence, I asked the Home Office to provide me with a snapshot of numbers of ACDT documents open on a given date in July 2015. (I must again emphasise that the responses have not been quality assured under National Statistics protocols, and are for illustrative purposes only.) The table overleaf sets out the response.

6.21 The results are not entirely unexpected as there is a reported practice of moving more vulnerable detainees to Colnbrook or Harmondsworth. Levels of ACDT use are, if anything, lower than I had anticipated given my own observations and reports from IRC staff.

IRC	Number of open ACDTs
Brook House	7 detainees (2.5% of population)
Campsfield House	1 detainees (0.38% of population)
Colnbrook	12 detainees (3.97% of population)
Dover	5 detainees (1.2% of population)
Dungavel House	6 detainees (3.19% of population)
Harmondsworth	19 detainees (3.63% of the population)
Morton Hall	5 detainees (1.33% of population)
The Verne	10 detainees (1.94% of population)
Tinsley House	2 detainees (1.00% of population)
Yarl's Wood	9 detainees (2.52% of population)
STHF	**Number of open ACDTs**
Larne House	0 detainees
Pennine House	0 detainees
PDA	**Number of open ACDTs**
Cedars	0 detainees

6.22 Amongst detainees, I found resentment about the intrusive nature of constant observations, especially at night. This was a particular feature of the ACRT reports provided by Cedars, where whole families were under observation because of concerns about one member of the group.

6.23 As noted earlier, some IRCs have rooms with Perspex doors so that individuals can be observed 24 hours a day. Detainees in Yarl's Wood complained about the consequences of constant observation in shared rooms, where both parties were in effect under permanent review.

6.24 For these reasons and others, constant observations may not be consistent with detainee welfare. However, I understand why IRCs have adopted a risk-averse approach. The fundamental problem is the absence of a more therapeutic environment within IRCs, and delays in releasing or transferring detainees out of detention.

6.25 As I have said, I am aware that NOMS is currently reviewing the ACCT system (the Home Office is involved in this process, alongside NOMS). I trust this will be speedily followed by a bespoke review of ACDT. The context for ACDT is different from that in prisons, and certain aspects are more difficult in parts of the immigration estate – for example, the multi-disciplinary case meetings are less feasible in the short term holding facilities.

Recommendation 23: Once the NOMS review of ACCT is complete, there should be an urgent review of ACDT and DSO 06/2008, informed by the NOMS review and by the findings of this report.

6.26 Lord Toby Harris, chair of the Independent Advisory Panel to the Ministerial Roundtable on Deaths in Custody, told me that the whole concept of ACCT was wrong and that he wanted to see proper care planning for all. He

acknowledged that this would be very expensive. He has recommended an Individual Care Plan for every young person in custody. This may have implications for any Home Office review of ACDT.[80]

Food and fluid refusal

6.27 I did not make a detailed study of food and fluid refusal. Such behaviour may be instrumental, or an expression of mental turmoil, or some combination of both.

6.28 I have, however, received views from two Non-Governmental Organisations about the treatment of detainees who have undertaken food and/or fluid refusal during periods of their detention.

6.29 ILPA referred me to protests involving food or fluid refusal that were reported in eight removal centres in March 2014.[81] They said:

> "Hunger strikes, a term that captures the protest and the purposive nature of the action better than 'food and fluid refusal', are often used by people who see no other way of making their voices heard. In the case of *Muhammad & Ors, R (on the application of) v Secretary of State for the Home Department* [2013] EWHC 3157 (Admin) 17 October 2013, Mr Justice Stewart refused an application for interim relief, in the form of release from detention, of three detainees who were currently refusing to either take food or water, as he held that it was in their power to make the decision to receive the appropriate medical treatment. This must depend upon the facts of the case, for Article 2 of the European Convention on Human Rights imposes a positive obligation on the state to take steps to protect life and this extends to an obligation to prevent self-inflicted death in custody: *Keenan v UK* (2001) 33 EHRR 38.
>
> "Accounts on the blog 'Detained Voices' show examples of the motivation behind the strikes -
>
> > *Dover. Friday March 13: 'We are not eating in Dover Detention – we having a strike. There are half of the people are already on strike. We are organising and talking with all the people. We are human beings.'*
>
> "The causes of hunger strikes must be addressed if hunger strikes are to be managed.
>
> "The procedures that must be adopted for handling food and fluid refusal by detainees in Immigration Removal Centres are set out in the latest

[80] *The Harris Review: Changing Prisons, Saving Lives – Report of the Independent Review into Self-Inflicted Deaths in Custody of 18-24 year olds*, Cm 9087, July 2015.

[81] [redacted]

Detention Services Order on Food and Fluid refusal.[82] The guidelines do place an emphasis on establishing whether or not the person has capacity, however they do not require a proper capacity assessment according to General Medical Council guidelines.[83] Proper mental capacity assessments are rarely carried out.[84] There have been various well reported cases in the media of the Home Office refusing to release immigration detainees despite their appearing too ill to be cared for in detention."[85]

6.30 BID argued:

"Home Office policy on detainees who are refusing food or fluids[86] ('hunger strikers') is that at the point at which an individual is deemed to require inpatient treatment they may be considered for transfer to a prison medical facility.

> '*Such a transfer may be appropriate or necessary for clinical reasons in order to access the more extensive medical facilities available in the prison estate and to ensure the better care and management of the individual in question*.' (DSO 03/2013: paragraph 60.)

"There is no reference anywhere in this policy document of transfer to a hospital for assessment and medical treatment. Prison is not a suitable environment for any immigration detainee, let alone a person who is refusing food or fluids and has reached a point where they require inpatient medical care. BID's experience with clients who have been on hunger strike is that transfer to a prison regime introduces a set of restrictions on communication that delay and frustrate timely communication with legal advisers, the courts, and the Home Office.

"Given that the use of detention by the Home Secretary is optional not a duty, it is not clear why custody must be maintained in such extreme cases."

6.31 Assuming liquids are taken, short periods of food refusal represent no danger to health, and I was therefore pleased to learn from the Home Office that the former policy of automatically imposing constant observations has been

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[82] Detention Services Order 03/2013 *Food and Fluid Refusal in Immigration Removal Centres: Guidance*.
[83] *Mental Capacity Act, http://www.legislation.gov.uk/ukpga/2005/9/contents*. 2005.
[84] Medical Justice, *Briefing for the Home Office on Food and Fluid Refusers. 14th November 2013.*
[redacted]
[85] [redacted]
[86] Home Office, (2013), '*Detention Services Order 03/2013:* 'Food and fluid refusal in immigration removal centres: guidance'). See paragraph 60. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257740/fluid-food-refusers.pdf

halted.[87] I cannot confirm that the use of constant observations has significantly reduced as a consequence, as there were few cases of detainees refusing food and/or fluids at the time of this review. DSO 03/2013 currently states that: "Consideration should be given to placing the detainee on frequent or constant watch …" It would be useful if this wording could be revised to emphasise that any decision about frequent or constant watch should be informed by consideration of the detainee's reasons for refusal.

6.32 In contrast, any refusal to take fluids can rapidly result in serious harm. Transfer to hospital should be inevitable in such (fortunately, very rare) circumstances. I am therefore concerned that the stated practice as per DSO 03/2013 is for a transfer to an IRC with in-patient healthcare facilities for detainees who are refusing food and/or fluid and who need full-time or frequent nursing care as a result of that refusal.

6.33 Given the limited facilities available in IRC in-patient facilities, I do not believe that they are equipped to meet the clinical needs of those detainees who require constant care. Equally, I do not believe that a transfer to a prison is appropriate (except for overriding reasons of security).

6.34 DSO 03/2013 ('Food and fluid refusal in immigration removal centres: guidance') explicitly refers to the need to address any underlying issues of dispute that may be the root cause of food and/or fluid refusals. The Home Office should ensure that guidance in this area is rigorously followed.

Recommendation 24: I note that DSO 03/2013 on food and fluid refusal is currently the subject of internal review within the Home Office. I recommend that the review consider alternatives to treatment within a prison or IRC in light of my discussion of this issue.

Deaths in detention

6.35 There have been 26 deaths in detention since 1989, nine of them self-inflicted (most of these detainees were not on open ACDTs at the time), twelve from natural causes (predominantly heart attacks or conditions that lead to heart failure), one under restraint (an Angolan, Mr Jimmy Mubenga, who died as a consequence of what an inquest found to be an unlawful killing after being restrained on board an aircraft), one murdered, and three where the cause is no longer known or is uncertain. There were 13 deaths in total to January 2006, none then until the death of Mr Mubenga in October 2010, and twelve since July 2011.

6.36 Statistical theory teaches that any clustering of a small number may be random rather than indicating any underlying cause. (This is all the more the

[87] "Some detainees were subject to excessive monitoring that was not related to their care needs, as a result of the requirements of a Home Office detention services order on food and fluid refusal." HMIP, *Report on an unannounced inspection of Campsfield House Immigration Removal Centre, 11-21 August 2014*.

case for any sub-set of a small number, for example of self-inflicted deaths in IRCs.)

6.37 I am grateful to the Prisons and Probation Ombudsman for providing me with access to all recent PPO reports following deaths in immigration detention. The principal findings relevant to this review of welfare concern:

- the use of an emergency code system for alerting staff to the nature of a medical emergency
- the need to ensure IRCs have, as far as possible, up to date next of kin details
- the need for better systems of family liaison following a death in detention
- the poor quality of healthcare records.

6.38 These are findings that I recognise from my own experience of investigating deaths in prison custody between 2004 and 2010, and I strongly endorse the current Ombudsman's recommendations. I attach particular importance to the issue of family liaison, not only for its own sake but as a way of helping ensure that each IRC takes ownership (which is not to be understood as culpability) for the loss of life that has occurred. I welcome the attention given to this and other matters in Detention Services Order 08/2014 issued a year ago.

Sharing information about risk

6.39 There are a variety of processes for sharing information about a detainee or potential detainee. I have reviewed each of them.

(i) IS91(RA)

6.40 The IS91(RA) is the means by which the Home Office gives consideration as to what, if any, level of risk a person may present whilst in detention. Paragraph 55.6.1 of the EIG gives succinct information about the process and outlines the importance of completing the form properly.

6.41 The IS91(RA) in itself contains only limited information, based on what is known at the point of detention. This can be as little as what the person who has just been told they are to be detained is prepared to reveal.

6.42 At my request, the Home Office provided a total of twenty completed IS91(RA) forms for examination. All forms were for those where there were known medical conditions, where an individual had previously been detained and had suffered ill effect as a result, or where there were other factors raised as a risk by the official who was proposing detention.

6.43 A minority of the sample were for criminal casework, and these outlined crimes and sentences as well as any medical conditions.

6.44 Of the sample, eleven people were detained. I have reviewed outcomes to these cases via the IT system used by the Home Office; as of 6 August 2015 only three detainees from the sample of eleven had been removed from the UK. Five had been granted temporary admission or release, and three continued to be in detention.

6.45 Decisions to grant temporary admission or release seem to have been granted relatively quickly, with the longest waiting period being just under two months. Most were well within this time.

6.46 Completion of the forms was of variable quality. Some evidenced a large number of medical conditions.

(ii) Person Escort Record (PER)

6.47 According to DSO 18/2012:

> "The purpose of the Person Escort Record (PER) document is to ensure that all staff transporting and receiving detainees are provided with all necessary information about them, including any risks or vulnerabilities that the person may present.
>
> "In particular it is essential that known risks of escape, assault, suicide/self-harm or harassment are communicated to others into whose custody the detainee is passed in order to protect detainees, staff and the public. The identification of risk of suicide or self-harm is one of the prime purposes of the form and staff should note that it is a requirement to indicate both a current risk and any known past risks.
>
> "It is also essential that any new risks that develop during a movement are recorded and flagged up for others.
>
> "Whenever a detainee is received from the custody of others for, during or on completion of a movement, the risk and vulnerabilities identified by the previous custodian should be noted and acted on; to protect the detainee and other detainees, staff and the public."

6.48 The DSO also lays down quality standards for the completion of the documentation, a carbon paper booklet that is used when detainees are moved to, from, and across the detention estate.

6.49 The PER is also used by the Ministry of Justice, and by police services and the secure hospital estate, except in Scotland and Northern Ireland. In instances in which PERs are not used, I understand that DEPMU relays relevant information by way of a IS91 Part C form. Escorts then open a PER for the move using the information provided by DEPMU.

6.50 The DSO is due for revision, having been produced in 2012, and I am advised that this is in hand. The current documentation is comprehensive in that

it gives guidance on completion of the forms themselves, as well as allocating responsibilities for handling the information that is held on them.

6.51 I asked for a random sample of forms for detainees who were subsequently placed on ACDT plans. This was to determine how well they were completed, and to see whether information on the PERs informed subsequent decisions regarding the risk to detainees.

6.52 I received 57 PER forms relating to 40 detainees. Eight detainees had multiple PER forms.

6.53 There were basic errors on most of the forms sampled. These included escort names not being legible and the ID number of the detainee being missing.

6.54 Custodial history records were variable in quality, with limited or no information being provided on many forms in the sample. One PER had 'no' ringed with regard to prison history, despite the fact that the PER in question was used to record a move from a prison to an IRC.

6.55 Information on risk was not always transferred from one PER to a subsequent one, and there were instances of the risk section of the booklet referring the reader to an IS91 rather than outlining the risk clearly on the separate document.

6.56 Where multiple PERs were completed, subsequent documents were of lower quality than the original, in some instances having no observations other than that Tascor had assumed responsibility for the detainee.

6.57 Information on medical history and prescription drug transfers was variable with some forms having relevant sections left blank. Some of the forms showed that drugs were transferred with a detainee, and were held either by the escort or by the detainee.

6.58 Importantly, in the majority of forms the section used to give the phone number for receiving and departing places of detention or receiving escort was either not completed at all or was only part-completed. This information becomes important if medical or other emergencies happen en route and more care should be taken to ensure that it is readily available.

6.59 There was little evidence that any information provided in the PER was used subsequent to the detainee's arrival, or that any risk then became an issue requiring the opening of an ACDT. There was evidence of ACDT processes being opened when the detainee entered an IRC, but that was because of information provided through the induction process. Further, when a smaller sample of individual cases were reviewed via the Home Office casework system, CID, I could find no indication that further decisions about continued detention took into account the contents of ACDTs or PERs.

6.60 Members of my team observed two night-time shifts with Tascor crews. It was apparent that the more conscientious Tascor staff wrote regular observations during the journey, but others displayed a lack of interest in this aspect of their duties.

6.61 The PER form itself is used widely across organisations involved in justice. Properly completed, the form captures important information about risk, vulnerability and the behaviours of detainees. Its completion should therefore be regarded as an essential task rather than a bureaucratic chore. I am concerned by the findings from my review of a small sample of forms, and conclude that the Home Office should commission a wider review.

Recommendation 25: I recommend that the Home Office commission a formal review of the quality of PERs and that any deficiencies are addressed. In the meantime, all staff should be reminded of the importance of completing PERs fully.

(iii) Detainee Transferable Document

6.62 DSO 12/2005 refers to the use of a document called a Detainee Transferable Document for those entering the detention estate from 1 August 2005. It should apparently be produced at reception in addition to a risk assessment.

6.63 The review team and I have observed no evidence that this document is used routinely. There appear to be no set rules for information to be included, used or shared. I have discounted it for the purposes of this review.

(iv) Conclusion

6.64 I draw two conclusions from this brief analysis of the means used for sharing information about risk. The first is that systems for recording risk are only as good as the staff who complete them. The second is that paper systems are inherently unsatisfactory. There is nothing about the IS91RA or the PER to suggest compliance with the Government's overarching policy of 'Digital by Default'. There is something terribly old-fashioned and frankly rather embarrassing about reliance upon 'a carbon paper booklet'.

Recommendation 26: I recommend that the Home Office consider how rapidly it can move towards a system of electronic record keeping for the PER and IS91RA.

Room sharing risk assessment (RSRA)

6.65 Within each IRC, and once more reflecting Prison Service practice, detainee safety should be buttressed by the completion of a room sharing risk assessment. Compulsory room sharing provides company and therefore protection against loneliness and self harm; it also increases the risk of bullying and assault.

6.66 DSO 12/2012 outlines the policy on RSRA, the form to be used to undertake the assessment, and the types of issues that should be considered when completing the review. The forms themselves include guidance on completion and standards.

6.67 Both the DSO and the form are comprehensive and comprehensible. The documents themselves and the associated paperwork have not been dip sampled as part of this review, but I have noted that they continue to be used widely and apparently diligently. Staff at several IRCs have referred to the importance of completing RSRAs at reception, and to the use of them when deciding on room allocation.

6.68 I received no evidence to suggest that the room sharing risk assessment process is other than a robust one. And I have been pleased to discover that regular audits to ensure it remains so have been carried out by the Home Office. My recommendation endorses that approach, and is intended to ensure that an annual audit remains standard practice.

Recommendation 27: I recommend that the Home Office conduct an annual audit (or ask for an independent audit) of the RSRA process so that it remains an effective means of ensuring detainee safety.

Allocation criteria

6.69 There are no published allocation criteria for detainees. Once the decision to detain is made, any male detainee may in principle find himself at any one of the IRCs.

6.70 In practice, IRC allocation depends on a variety of factors including physical security, healthcare regimes, which casework team is allocated management of the detainee, and the detainee's location at the time they were detained.

6.71 DEPMU told me that it risk assessed everyone who is detained and that its risk assessment/allocation strategy took a number of considerations into account, namely:

- specific case-working requirements (e.g. need to detain in DFT accommodation, imminent removal from a particular airport, participation in a documentation interview scheme at a specified IRC etc.)
- the current location of the individual and their proximity to IRCs
- time and distance constraints (detainee welfare)
- bed-space availability for that day and projected demand for the following day due to enforcement or other operational activity
- whether a movement can be grouped with the movements of other individuals in the vicinity or en route to an IRC or STHF
- availability of escort resource
- accommodation in IRCs where demand is very high: Brook House, Colnbrook and Harmondsworth. Detainees should be allocated an IRC where the level of security, regime and facilities (e.g. medical) matched

their individual needs. In general, the level of security provided by the IRC should be as low a level as possible to offer compliant and cooperative detainees as much freedom as possible
- the requirement to move individuals out of non-residential STHFs, police stations and Northern Ireland prisons within time limits in statute and guidance
- DEPMU's risk assessment of time served foreign national offenders and the need to comply with the timeframes for transfer of TSFNOs in the current NOMS Service Level Agreement.[88]

6.72 In contrast, detention providers reported that they find allocation and risk issues difficult to predict and therefore to manage. On site Home Office teams have confirmed that detainees are moved to centres where their known personal risk factors or personal vulnerabilities cannot be accommodated, forcing further moves in consequence.[89] There may also be informal limits on numbers of particular nationalities, reflecting operational concerns.

6.73 I contrast this with Prison Service practice, where allocation is based on a clear and well-understood categorisation process.

6.74 When I visited DEPMU, I saw that it relied on manual, paper-based processes to balance the detention estate. Every IRC is responsible for providing a bed count list by 7.00am each morning. A second update of bed spaces is sent each evening, but there is nothing between the two – certainly no up-to-the-minute electronic count that one might have anticipated.

6.75 I believe that the current management of bed space is insufficiently supported by technology, and that the manual processes used do not provide a sophisticated detainee-focused system in which decisions are made transparently.

Recommendation 28: The Home Office should consider if the allocation criteria and processes to which DEPMU operates could be strengthened.

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[88] I understand that the DEPMU Manchester team manages all moves from prisons. Every Tuesday, it receives a list of all of the individuals who have become time-expired. They are categorised as RED (not suitable for immigration estate), AMBER (healthcare issues), PURPLE (fully assessed but not enough information available), or GREEN (suitable for the immigration estate). Those suitable for immigration detention are further categorised, with those regarded as the most difficult being sent to Harmondsworth, Colnbrook or Brook House. Those in need of healthcare or drug addiction treatment would be sent to Harmondsworth or Colnbrook. Heroin addicts cannot go to Brook House; men with a history of sexual offences are not sent to Dungavel.

[89] If an IRC wants someone moved, a fax or email is sent to DEPMU after the Home Office staff at the IRC have been consulted. I am told that the criteria for determining whether such a move is agreed are in DEPMU guidance but I have not seen this. The system does involve officials at DEPMU second-guessing the wishes of centre managers and the embedded Home Office staff.

Safeguarding

6.76 For the purposes of the review, I have regarded 'safeguarding' to mean, in the broadest terms, the protection of individuals from themselves and from others. The vast majority of safeguarding issues are dealt with elsewhere in this report within other contexts (the identification of vulnerability, room sharing risk assessments, the prevention of self-harm and suicide, including ACDTs and constant supervision). Here I pick up two issues – bullying, and release arrangements – that are not covered elsewhere.

(i) Bullying

6.77 The 'Safer Removal Centres' section of the Detention Services Operating Standards manual for Immigration Service Removal Centres says that centres are required to have developed and published a policy on the prevention of bullying (and self-harm and drug abuse), to measure the problem, to change the culture, to support victims and to challenge bullying behaviour. DSO 11/2012 says that transsexual detainees may be at particular risk of bullying. DSO 19/2012, which is concerned with children, also contains references to bullying.

6.78 Although I have referred to the incidence of what I have termed prison-like behaviours (including bullying) in some IRCs I visited, in general I was encouraged to find that bullying remains the exception. During my visit to Campsfield House, I was told that, in Campsfield's own surveys and in HM Inspectorate of Prisons surveys, detainees had reported low levels of bullying. Likewise, at Brook House I discovered there was little incidence of bullying and intimidation, although structured plans were in place to support those who were the victims.

6.79 At The Verne, however, it was evident that some detainee-on-detainee bullying was occurring.

6.80 Bullying and the perception of a lack of safety is unacceptable in itself, and – perhaps more worryingly – is known to be correlated with self-harm and suicide. It is therefore of critical importance that anti-bullying policies are robust, and that detainees are empowered to come forward if they are victims. I am content that the Home Office's policy framework in this respect is well-designed and that, so far as I am able to judge, it is implemented effectively.

(ii) Release arrangements

6.81 The primary source of guidance on release is contained in the 'ADMISSIONS/DISCHARGE' section of the Operating Standards manual. The arrangements are primarily concerned with ensuring that detainees being discharged (whether to another removal centre or into the community) have appropriate clothing and that the paperwork is in order. I am not aware of any policy concerned with ensuring that those released into the community are supported, when necessary, by appropriate local authority care regimes.

6.82 I was told by Home Office officials that the release of detainees who require healthcare treatment, and the release of those who require care packages in the community, was difficult because of the conflicting demands and priorities for those managing care in the community. The situation was particularly problematic in respect of non-asylum cases, as asylum cases were often released to supported accommodation.

6.83 When I visited Campsfield House, I was told there was a lack of support mechanisms for those released. Examples were given of an Australian man of no fixed abode who had been released with less than £2 in his pocket, of late night releases when no trains were running, and of a detainee released with a travel warrant over Easter when there would be no trains for another three days. (Campsfield House had paid for a taxi on that occasion.)

6.84 Medical Justice argued that:

> "IRCs often fail to work with health and community agencies to ensure proper continuity of care for vulnerable detainees released from detention. Medical Justice sees cases of seriously ill detainees being released without proper referral to specialist care (e.g. HIV, antenatal care) in the community and proper s.117 MHA 1983 aftercare packages are not put in place. Vulnerable and extremely ill detainees have died within hours of being released from IRCs without adequate follow up."

6.85 ILPA said:

> "Persons who are very ill have been released from detention without accommodation being put in place, without appropriate care plans or referrals to community mental health services or without medication or prompt access to medication being organised, giving rise to risks to the person on release. Legal representatives, having fought for release, have had to bring an injunction to *prevent* the Home Office releasing a client at night without support."

6.86 The Poppy Project told me:

> "We note that Detention Service Order 07/2013 on welfare does not make any provision for assistance to victims of trafficking following their release from detention and that welfare services are not equipped to address their specific needs."

6.87 The Home Office and its contractors face difficult decisions when it comes to release. They are heavily criticised, and may be subject to litigation, if anyone is detained for a moment longer than allowed. But releasing a detainee immediately may place the individual at risk. As noted earlier, I have been told that the Prison Service takes a more flexible approach.

6.88 To the objective observer, it is unacceptable that IRCs are *required* to turn someone out onto the streets when that person's best interests are clearly served

by being able, voluntarily, to stay in the IRC for a few hours, or even a few days. I appreciate that this may be difficult to achieve legally, and that appropriate safeguards would need to be in place to prevent abuse, but I would like the Home Office to look at building some flexibility into the system.

6.89 A further issue raised with me is that relationships between IRCs and Safeguarding Adult Boards (SABs) remain in their infancy. Indeed, it has been suggested that there is reluctance on the part of some SABs to engage with IRCs or to accept a need to provide ongoing support to those released from IRCs. (Section 76 of the Care Act refers to prisoners and those in approved premises and bail hostels but not to those held in IRCs. I do not know whether this omission was deliberate or by oversight.) This suggests that there is a safeguarding gap that needs addressing.

Recommendation 29: I recommend that the Home Office and the Department of Health work together to consider whether current arrangements for safeguarding are adequate.

Support and advice

Provision of welfare support

6.90 The minimum standards for the provision of welfare support in immigration removal centres are set out in Detention Service Order 07/2013.

6.91 In summary, the minimum practical requirements are that welfare provision must be:

- available seven days a week (for a minimum of five hours on weekdays and three hours on weekend days)
- overseen by a member of the centre's management team
- easily accessible to detainees
- well-publicised
- part of the detainees' induction programme
- available to individuals in the DFT process.

6.92 The DSO sets out the issues with which the welfare service will help detainees, namely:

- financial signposting (e.g. managing their accounts, contacting banks)
- domestic issues (e.g. housing issues, pets, contacting utility companies)
- educational issues (e.g. cancelling enrolment with colleges, retrieving certificates
- contact issues (e.g. maintaining contact with friends in the UK, contacting embassies, contacting support services)
- property issues (e.g. shipping property abroad, retrieving property seized during immigration enforcement operations)
- legal issues (e.g. signposting to solicitors and other legal services)

- voluntary departures (providing advice on how to depart voluntarily)
- preparation for return (e.g. contacting relatives; sourcing assistance from charitable organisations)
- IRC regime (e.g. providing advice on available facilities and complaints procedures)
- release (helping detainees to prepare for life in the community (e.g. housing provision, access to services)).

6.93 Welfare provision in detention is governed through Home Office Detention Operations (part of the Immigration Enforcement directorate) which requires the welfare leads in each of the detention settings to:

- attend quarterly meetings of a Joint Welfare Group; and, in advance of meetings
- provide the Group with a quarterly report detailing welfare activity.

6.94 The detention centre providers are contractually obliged to provide welfare services in line with the DSO.

6.95 I have observed the provision of welfare support in a number of the IRCs I have visited, and have been provided with copies of the quarterly reports covering the first three months of 2015 submitted by the IRCs. I have been represented at a meeting of the Joint Welfare Group.

6.96 On the basis of the quarterly reports provided by the IRCs, it is apparent that all are in compliance with the requirements of the DSO in terms of the availability of welfare services except Dover, which is only partially compliant as its welfare service is not available at weekends – although I understand that this is under review.

6.97 There is no set format for the quarterly reports (although the intention is that a standard form will be used in future). Thus it is not possible to make a full assessment on the basis of the reports alone of the quality and depth of welfare support provision across the estate, and of whether there is consistency of provision. However, on the basis of the current reports it appears that:

- Home Office Detention Operations has a clear process for seeking to ensure that the service providers take welfare (at least the concept of welfare as set out in the DSO) seriously; and
- all the providers, on the basis of self-assessment, meet the standards required in the DSO (and some go further) except for (temporarily at least) Dover.

6.98 Welfare at Yarl's Wood is provided through an open surgery that detainees can access by email or by calling in. The main issues relate to property, immigration updates, and outstanding wages, but more personal issues, such as children left behind and domestic violence, are also raised. Welfare officers often refer detainees to other support sources, such as religious leaders. At the time

of one of my visits, the welfare office was closed and detainees were signposted to the library.

6.99 At Harmondsworth there is a reasonably sized welfare room with a number of desks. It operates on a drop-in basis. My team and I observed the room twice during my visit. On the first occasion it was very noisy, with a number of detainees milling around and waiting for an opportunity to speak to a welfare officer. There was a queue for the fax machine. On the second occasion the room was much quieter. A TV screen provided detainees with information about the IRC and about what was available to them. This is a useful resource but it was not being used to its best advantage. The information was in English only and a large number of subjects were covered far too speedily for detainees to take in properly.

6.100 Also at Harmondsworth I spoke to a representative of the organisation Hibiscus, which provides additional welfare support to detainees on the Heathrow estate and in some other IRCs. I was told that Hibiscus tries to reduce the time detainees spend in detention by facilitating their cases through immigration processes, and by assisting with resettlement in countries of origin. Hibiscus provides this service four days a week and helps supplement the support provided by Mitie Care and Custody. I judge that Hibiscus performs a very valuable function.

6.101 The welfare office in Colnbrook is, like the one in Harmondsworth, of a reasonable size. I observed it during a morning session, when it was well used, but was told that its busiest period was in the afternoon. There was no natural light in the room. One of the welfare officers said that he worked thirteen-hour days but did not get tired because he enjoyed the work. He said that he dealt with a vast range of queries, including helping people with their domestic finances and assisting others to trace lost family members after the Nepal earthquake.

6.102 In Campsfield House the welfare service provides legal advice contact details, runs legal surgeries three times a week and arranges support groups. BID also provides advice to detainees.

6.103 Asylum Welcome told me that its experience of the welfare office at Campsfield House had been "variable". It went on to say:

> "There have been periods of stability where staff has been in post for extended periods, and we built good working relationships with them. Equally there have been periods of upheaval with frequent changes in the staff in the welfare office and those staff being unclear about procedures and responsibilities. We have gained the impression that regular staff are 'slotted in' to the welfare office roles without requiring any specialist knowledge or skills. We believe that there is a commitment for the welfare office to offer an effective service, and to work in partnership with us, but a lack of clarity about the scope of the welfare office and what it can achieve. Asylum Welcome is also aware of cases which suggest that

the welfare office carries insufficient weight relative to other authorities in Campsfield."

6.104 The Bail Observation Project and the Campaign to Close Campsfield suggested that: "there is currently little guidance on the training of welfare staff, their experience, the ratio of welfare staff to detainees, or the range of support they should give".

6.105 In Tinsley House, 60 to 70 per cent of welfare queries relate to the progress of a detainee's immigration case.

6.106 In Brook House, the welfare room is small compared with those in other centres. It has capacity for only two desks and this is not sufficient to meet demand. I was told that there are now two G4S welfare officers in post and that this allows for welfare provision every day of the year. This is supplemented by other organisations. BID attends once a month and uses the English classroom as its base. Migrant Help provides a surgery every Thursday. The Red Cross attends twice a month. The Red Cross is invaluable in certain circumstances – for example following natural disasters in home countries – but is the least in demand of the supplementary providers.

6.107 In HMP Holloway, it was explained that the prison's resettlement department provided the equivalent of the IRCs' welfare services.

6.108 I am satisfied that an appropriate framework is in place, through DSO 07/2013, for the provision of welfare support in IRCs. From what I have seen, the IRCs are providing at least the minimum level of welfare support required (subject to the caveat about Dover, above). I am also satisfied that the Home Office is taking appropriate measures through, for example, facilitating meetings of the Joint Working Group, to underpin the DSO with practical measures. This approach seeks to promote consistency in delivery of welfare support whilst also raising standards through sharing best practice.

6.109 The welfare officers to whom I have spoken have all appeared to be committed to helping detainees and to have a clear understanding of their responsibilities. There are also very good examples of the Home Office and the service providers working together to improve the process. For example, Home Office staff in Brook House have recently been working with the G4S welfare team to effect some detailed changes – making it easier for detainees to buy their own plane tickets, simplifying the procedure for requesting a meeting with immigration staff, better communication of information to detainees about cancelled removal directions, making inductions more informative, and dealing with transfer effects more efficiently. These are all positive steps.

6.110 However, the comments made by stakeholders raise serious issues about welfare staff having the necessary levels of experience and training, whether the welfare service has a sufficient profile within the IRCs, and whether it is seen as the 'poor relation' in comparison with some other functions. In some centres

too, I have seen that the accommodation given over to the welfare function is insufficient for the need.

6.111 I welcome the involvement of outside organisations in these functions. The approach I have commended to centre managers is that there should first be an assessment of need, followed by the commissioning of appropriate outside organisations. In some cases, I have sensed that organisations have been accepted because they have offered to assist, rather than because there has been a detailed assessment of what is required.

6.112 I am also aware of the funding pressures faced by many third sector organisations, and the danger that this may limit the contribution they are able to make in the future.

6.113 An issue mentioned at many of the IRCs concerned delays in transferring property from prisons. I have not explored the actual incidence of such problems.

6.114 These observations aside, I have no formal recommendations on the issue of welfare provision.

Legal advice

6.115 It is an article of faith amongst officials working in Detained Fast Track that the quality of legal advice to detainees is variable, and that private solicitors often give detainees unrealistic expectations as to the likely outcomes. Detention is therefore prolonged as a consequence of appeals with little prospect of success.

6.116 Other witnesses acknowledged that some legal advisers offered a poor service, at considerable financial cost to the detainees or their families.

6.117 The organisation René Cassin was concerned that current contracts for the provision of legal aid advice in the IRCs were failing to meet the needs of detainees, and that they did not give legal practitioners the necessary time and resources they needed in order to represent their clients adequately.

6.118 BID suggested that:

> "There are unacceptable delays for detainees who wish to obtain an initial appointment at IRC legal advice surgeries. In May 2014 two out of three of the detainees BID spoke to had waited more than one week to see a duty solicitor, and of these one in six had waited three weeks or more. Poor communication by legal advice provider firms after initial appointments leaves nearly 20 per cent of detainees BID spoke to unsure of whether or not they have a legal advisor. Longer-term detainees with arguably the greatest need for legal advice on the fact of their detention are commonly left without ongoing legal advice due to contradictory elements in current legal aid contracts. Transfers around the IRC estate

> are common, and disrupt the ability of detainees to retain a legal advisor and progress their case."

6.119 BID also reported that individuals with mental illnesses had particular difficulties in seeking and receiving legal advice.

6.120 Since November 2010, BID has been running a survey of detainees on access to legal advice in detention. Some of the findings of the survey – particularly those regarded by BID as being the result of legal aid funding changes or of the way in which legal firms operate – are outside of the scope of this review. However, BID also told me that:

- IRC staff were reported to be preventing detainees from obtaining appointments at legal advice surgeries; and
- transfers around the IRC estate affected the ability to retain a legal advisor and might increase detention periods.

6.121 ILPA expressed concern about the proportion of detainees who do not have legal representation and about the length of time detainees have to wait for a legal appointment.

6.122 Many of the issues raised by the NGOs are not within my purview. I recognise, however, that there is potentially a strong correlation between the welfare of detainees and the progress of their immigration case/the perception that they are receiving good advice on that case.

Access to the internet and social media

6.123 Unlike prisoners, detainees have permanent access to a mobile phone and enjoy restricted access to the internet. The question for me is whether welfare needs would be better met through a reduction in the current restrictions on internet use, subject to necessary risk assessments.

6.124 A study of detention in over 20 European countries found as follows:

> "More than anything, detainees either want activities that enable them to connect to the 'outside world', or they want nothing at all. Asylum seekers and minors especially wish for greater access to the internet and telephone. When asked which activities they would like to have, a startlingly large minority of detainees said that they want 'freedom' or 'nothing'."

6.125 The initial copy of the in-house detainee magazine at Harmondsworth, *Heathrow In-site*, contained an interesting article on the potential benefits of Facebook. A representative contribution reads:

> "Many times we detainees get upset, fed up living stressful life in detention. Facebook [would be] helpful to spend some good moments

having talk to family and friends. This feeling help out to change the mood and release the stress."

6.126 René Cassin reported that detainees were often prevented from accessing sites including those of Amnesty International, the BBC, IRC visitors groups, foreign language newspapers and other NGOs. René Cassin suggested that such restricted access contributed to detainees' sense of isolation and also limited their ability to access support services and legal assistance.

6.127 Other submissions also expressed concern about detainees' restricted access to the internet, and that they cannot make use of internet-based communication services (such as Skype and Facebook). It was suggested that wider access to social media sites would help detainees keep in touch with families abroad, and better prepare them for their return.

6.128 The issues raised in evidence on these matters were borne out by my own observations. In respect of internet access, I discovered for myself – as had HM Chief Inspector of Prisons previously[90] – that legitimate sites were blocked inappropriately, and that staff were often as bemused as detainees as to why certain sites were unavailable. I also discovered that there was no security objection on the part of centre operators to Skype or social networking services, assuming local risk assessments remained in place.

6.129 I fully appreciate the need for appropriate security measures, but I do not believe there is any rational case for continuing the blanket ban on Skype and Facebook and like services, or for preventing access to websites that support detainees in their immigration claims, help prepare them for return, or facilitate contact with their families and friends. Indeed, from that point of view the current restrictions are actually counter-productive.

6.130 Amending the current approach to one that is based on an individualised risk assessment would, in my view, immediately help to enhance welfare provision. It would also have the potential to facilitate returns by helping to restore, maintain and strengthen links between detainees and their countries of origin.

Recommendation 30: The internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, to prepare for their return home, and which enable them to maximise contact with their families. This should include access to Skype and to social media sites like Facebook.

[90] HMIP, *Annual Report, 2013-14*, p.76.

Day-to-day life

6.131 This part of the report looks at the way in which detainees occupy their time whilst in immigration detention – or, more accurately, what opportunities there are for them to get involved in activities providing them with work, education, recreation or diversion.

6.132 I have observed the availability of activities in the IRCs and other detention settings I have visited. I have also taken the views of non-Governmental organisations, Immigration Monitoring Boards, IRC staff, detainees themselves and other stakeholders on activities issues.

6.133 I note Professor Bosworth's observation:

> "In contrast to the prisons they resemble, immigration removal centres are only contractually obligated to offer a limited amount of arts and crafts, English language training and IT support. They offer no courses in anger management or drug treatment, and provide no sentence planning, very little paid work other than cleaning and no preparation for release." (Mary Bosworth, 'Subjectivity and identity in detention: Punishment and society in a global age', *Theoretical Criminology*, 16(2), 2012.)

6.134 I note too the comments of the Council of Europe's Committee for the Prevention of Torture in its *Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 17 to 28 September 2012*:

> "… there should be a broader range of purposeful activities (vocational and work) for persons staying for more than a few months; the CPT invites the United Kingdom authorities to develop such activities for the detainees concerned."[91]

6.135 I found particularly helpful a conversation with Ms Claudia Sturt of NOMS on what would constitute a decent life in detention. She identified:

- family ties
- dealing with Embassies
- employment
- access to the internet
- day to day stresses
- supportive staff.

6.136 It would be useful for all IRCs to consider how they perform against these criteria.

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[91] [redacted]

6.137 The Home Office's policy on activities is set out in rule 17 of the Detention Centre Rules, in the 'Activities' section of the Detention Services Operating Standards manual, and in Detention Service Order 01/2013. The Rules require that:

- "All detained persons shall be provided with an opportunity to participate in activities to meet, as far as possible, their recreational and intellectual needs and the relief of boredom";
- "Detained persons shall be entitled to undertake paid activities to the extent that the opportunity to do so is provided by the manager";
- "Every detained person able to take part in educational activities provided at a detention centre shall be encouraged to do so";
- "Each detained person [shall] have the opportunity of taking part in physical education or recreation"; and
- "A library shall be provided in every detention centre."

6.138 The manual mandates detailed minimum standards for the provision of education, library services and physical education, and also imposes a requirement for electronic diversions (TV, CDs) to be made available.

6.139 Senior managers of the contractors told me that, in their view, detainees would benefit from the opportunity to undertake more purposeful, constructive and therapeutic activities in detention, such as painting and decorating or working on a vegetable patch, with a higher wage than was currently possible.

6.140 The deputy chair of the IMB in Campsfield House said that the increase in the number of detainees in Campsfield House has had an impact on educational and recreational activities. Both were now over-subscribed.

6.141 Dr Nick Gill and Dr Rebecca Rotter of the University of Exeter, in their submission to the review, suggested that: "Some IRCs have better facilities including more hours of free association and better gyms, food, health facilities, libraries, internet provision and better relations between officers and detainees." They added that: "The prospect of being moved to an IRC that is lacking provisions is distressing for many of the detainees." Dr Gill and Dr Rotter also argued that an apparently faster turnover of detainees was having an impact on service provision including in English classes, where class cohesion was now almost impossible.

6.142 The Poppy Project, in its submission, suggested that work within IRCs was paid at an exploitative rate and that "This mirrors the exploitation that some victims of trafficking may have experienced …".

6.143 ILPA implied that the paid work arrangements in detention were linked to the profits of the contractors running the IRCs. ILPA argued that:

> "The use of contractors … highlights the question of profit. Details of contracts are not made public or discussed, with 'commercial confidentiality' pleaded … The private contractor's model is dependent

> upon the use of their labour, for which they are paid nominal rates, far below the minimum wage. Those in immigration detention are subject to immigration detention. Not to pay them the minimum wage is to allow them to be exploited".

6.144 Almost all the detainees to whom I spoke focused much more upon their immigration case, regarding their treatment in detention as at best a subsidiary matter if not wholly irrelevant. However, the opportunity to be distracted and to do something relatively meaningful whilst in detention is a vital factor in the nature of a detainee's experience, and it is important that the contractors providing detention services take it seriously. As Professor Bosworth has written:

> "Many are frustrated by the limited amount of paid work and education in detention, particularly if they have served a prison sentence during which they have taken advantage of a wide range of courses and programmes."
>
> "Much of what I witnessed and was told about detention was negative. Some of it was shocking … however, many staff members sought to alleviate the anxiety of those whom they hold. Detainees also found some relief and levels of support … in the religious services, in the friendships they forged, in some of the classes they attended."[92]

Paid activities

6.145 Nothing I have seen supports ILPA's view that paid work is used by contractors to increase their profits. I understand the view of some Non-Governmental Organisations – primarily ILPA and the Poppy Project – that the rates of pay are exploitative. However, the rates are set by the Home Office, and – more to the point – I am told there are no plans to review them at present. However, if this is indeed the case, I think it should reconsidered.

6.146 Some contractors have indicated to me that they would be willing to pay more but are restricted by current rules, and I share their view that there should be greater flexibility to encourage innovation. This is not to say that any increase in the rates would assuage the concerns of those who regard the pay as exploitative unless it were to reach, or at least approach, the minimum pay rate (I think that that would be an unrealistic expectation, for a number of reasons, legislative, political and financial). But a maximum wage centrally imposed neither assists detainee welfare nor encourages contractors to innovate (which is a key purpose of a competitive structure).

Recommendation 31: I recommend that the Home Office reconsider its approach to pay rates for detainees in light of my comments on the benefits of allowing contractors greater flexibility.

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[92] Mary Bosworth, *Inside Immigration Detention*, op.cit.

6.147 Leaving pay to one side, I would like IRCs to review the activities they provide and consider the scope for broadening their range, with a focus on activities that are therapeutic and productive, and that are directed towards successful resettlement following removal. I think there is particular scope for work/educational opportunities that provide skills to detainees that would be useful on their return to their home country (First Aid courses, How to Run a Small Business, for example).

6.148 What I saw in the workshops at The Verne also convinced me of the benefits of industrial activity of the kind found in prisons, wherever that may be possible. However, I also acknowledge that in most IRCs putting in the capital goods necessary to run industrial workshops would be neither feasible (as there is no room) nor financially prudent (as there would be no economic return on the investment).

Recommendation 32: I recommend that all IRCs should review the range of activities offered to detainees; in particular, those that could provide skills to detainees that would be useful on their return to their home country.

6.149 I also note that, as set out in DSO 01/2013, there is a link between compliance with the immigration process and being allowed to undertake paid work. This effectively turns paid work into a privilege, redolent of the prison system. No such link is in the Detention Centre Rules. It would be sensible for the Home Office to review DSO 01/2013 to ensure there are no unnecessary limitations on those eligible to undertake paid work.

Recreational and educational activities

6.150 From what I have seen, there are no obvious examples in any of the centres of the policy requirements not being complied with. Many detainees clearly enjoy and value both the educational and recreational opportunities open to them. However, the quality and scope of available activities appears to be contingent on the space available and on the enthusiasm, energy and priorities of the service providers.

6.151 I think there is an opportunity for the range of activities to be improved, not least by spreading best practice between site managers across the estate. Although these activities are not part of its core business, a suitable vehicle might be the Joint Welfare Group that is managed by Home Office Detention Operations.

6.152 I have also been concerned during some of my visits to the detention estate about detainees' access to natural light and to the open air. This is particularly the case in the short term holding facilities, where access to the outside is very limited. This is an important aspect of welfare, and one where I believe action should be taken across the estate.

Recommendation 33: I recommend that the Home Office review detainees' access to natural light and to the open air, and invite contractors to bring forward proposals to increase the time that detainees can spend outside.

Religion

6.153 In the course of conducting this review, as on previous occasions, I have seen for myself the central role that religious observance and the pastoral care offered by religious leaders play in the life of each IRC. At a personal level, I have also been impressed by the commitment and compassion demonstrated by each imam, minister, and other religious leader I have met.

6.154 Rules 20-25 of the Detention Centre Rules set out the general and specific duties on IRCs in respect of religion. IRCs are required to take account of the diverse cultural and religious backgrounds of the detainees, and to record the religion of detainees at the point of reception. All IRCs must have in place a manager of religious affairs, appointed by the Secretary of State and, where the numbers of detainees of a particular religion warrant it, a minister of that religion (also appointed by the Secretary of State). The minister is required to meet with all detainees of that religion (if they wish to see the minister) and to visit those who are sick, in temporary confinement or removed from association. The manager is required to secure access to a religious leader for those detainees where no in-house minister has been appointed. The manager is also required to make arrangements for the conduct of religious services, and "so far as is reasonably practicable", religious books must be available for detainees' personal use.

6.155 The Detention Services Operating Standards manual for Immigration Service Removal Centres sets some timescales for visits by ministers of religion. The manual also requires the establishment of a multi-faith team in each IRC and the publishing of a calendar of religious festivals and observances.

6.156 I have observed the provision of religious facilities in the IRCs I have visited. I have not received any views on religious provision from other sources.

6.157 During my visit to Colnbrook I was told by the IMB representative that detainees had good levels of access to religious leaders. However, I was not certain that sufficient space was available to accommodate all those who wished to attend Muslim prayers.

6.158 At Brook House I was told that the mosque was not big enough to meet demand and that the visitors hall had to be used for Friday prayers, and on observation I concluded that it was too small. Fifty per cent of the centre's population was Muslim. Even at Campsfield House, which as I have reported earlier had the best appointed mosque, I was told by the IMB there that the sports hall had sometimes to be used for Friday prayers as the mosque was too small – its capacity was approximately 75 and there were often twice as many Muslims in the IRC.

6.159 At Tinsley House I was advised that the centre was planning to change current facilities to create a larger multi-faith area. I note that multi-faith centres must be carefully designed and managed to ensure that only appropriate iconography is in place for the practice of each religion.

6.160 I have found no evidence to suggest that the IRCs do not take seriously the need to enable detainees to observe their religions or that they fail to comply with the policy requirements. Quite the contrary. Respect for the practice of religion is one of the most characteristic motifs of immigration detention.

6.161 It is instructive too that no detainee has complained to me about this aspect of life in the IRCs. All of the spaces for religious observance I have seen have been clean and well cared for. Appropriate diets are provided for those with particular needs.

6.162 Individuals who practise their religion in shared accommodation can present difficulties for room-mates, especially at night, but the main issue that has come to the fore is the size of the mosques in relation to the number of Muslim detainees, and the fact that Friday prayers cannot be easily accommodated. The IRCs have put alternative arrangements in place by using available larger spaces such as sports halls and visitor facilities. In the short term, that seems to me to be the appropriate and proportionate response, but in the longer run there is clearly a case for further investment.

6.163 That aside, overall I am very satisfied with the management of religious issues in the immigration detention estate and have no formal recommendations to make.

Incentives and Earned Privileges (IEP)

6.164 On a separate matter related to detainees' lives in detention, I understand that an Incentives and Earned Privileges scheme (of the kind used in prisons) is required under the Home Office's contracts with its IRC providers. I have not made a special study of its actual use in the immigration detention estate (I expect it is largely nominal), but in any event I am not persuaded that IEP is an effective or appropriate behaviour management tool in an IRC context. Indeed, that is what I was told by IRC managers to whom I spoke.

6.165 The fact that IEP is contractually required is a further example of the perhaps unthinking application of Prison Service practice into immigration detention. I suggest that contractors should be free to dispense with IEP should they so choose.

Recommendation 34: The Home Office should no longer require contractors to operate an Incentives and Earned Privileges Scheme.

Security and searching

6.166 This part of the report looks at security and searching. From a welfare perspective, I am interested in the physical measures that are taken to prevent detainees from hurting themselves or others, and to stop them from escaping, or to restrict their free movement.

6.167 Security issues cut across a range of policy documents. For example, the Detention Centre Rules set out the broad arrangements for carrying out searches of detainees. The Detention Services Operating Standards manual for Immigration Service Removal Centres contains more detailed guidance on searching, along with prescriptive guidance on the mechanics of maintaining security. Several Detention Service Orders deal with security issues related to the protection of detainees and others, the prevention and management of violent behaviour, and the prevention of escape.

6.168 In the broadest terms, the policy intentions are simple. Detainees should be prevented from escaping, and their safety and that of others around them must be protected. Whilst in detention, they must be treated in a way which respects their needs but which ensures order and safety for all. Those are the aims of the policy. To give effect to those aims, there are detailed requirements in respect of, for example, the hours when detainees may be locked in their rooms, and the way in which searches are carried out. All of these issues – the broad and the detailed – have a potential impact on welfare.

6.169 In practice, each IRC has developed its own security regime. At Dungavel, physical security is less intrusive. Inside the centre, there is no restriction of movement, other than male and female detainees not being allowed on each other's blocks. Detainees are free to move around within their own blocks at night-time. The advent of roving patrols means that previously restricted items such as pool balls and razor blades are now widely available following a risk assessment. Levels of self harm involving razor blades have actually fallen since the introduction of the new system.

6.170 However, as a consequence, security issues may not always be dealt with in-house. I was also told that a known drug dealer had been moved on because Dungavel was vulnerable to drugs being thrown over the walls.

6.171 When I visited Harmondsworth, I was told that the contractor had recently ended day-time lock-ups. Night-time lock up was from 9.00pm to 8.00am. Those in the new-build part of the centre were kept in their rooms for all of that time, whilst those in the older part were restricted to their rooms and the connecting corridor. After detainees had been through induction (which was in the new build), it was serendipity whether they were housed in the new build (with a more restrictive regime) or on one of the older wings.

6.172 Colnbrook's regime was essentially the same as that at Harmondsworth, and all male detainees were locked in their rooms from 9.00pm to 8.00am. Mitie

told me that they were hoping to move to a more open regime, with more movement across the wings, at least in the day-time hours.

6.173 The centre manager at Campsfield House told me that detainees had open access between 6.00am and 11.00pm, with access to their wings throughout the night. The manager suggested that problem behaviours became more prevalent when the proportion of FNOs increased. High risk individuals tended not to be allocated to Campsfield House because of the low roofs.

6.174 I received relatively little evidence on these matters in submissions to the review, save for the issue of male staff searching women's rooms and their possessions at Yarl's Wood to which I have referred earlier.

6.175 Any detention for the purposes of immigration control requires a certain level of perimeter security and internal zoning. This inevitably means that the resulting environment will resemble a prison environment. Such an environment may well have a negative effect on the welfare of those living within it – either by bringing back memories of past incarceration, especially if they have been the victims of maltreatment, or through a sense of injustice if their route into detention was as an asylum-seeker or overstayer.

6.176 But while I think some of these aspects of detention are unavoidable, I believe there are ways that would allow for a more relaxed environment without damaging overall security. I would like to see each provider give real thought to mitigating the appearance of the internal security regime, and for all risk assessments in this context to be carried out on the basis of a presumption of relaxation.

6.177 So far as searching is concerned, I think there is much to be said for the approach at Campsfield House (see paragraph 3.23 above) where searching is intelligence-led rather than routine.

6.178 Moreover, the evidence I have received suggests that the approach to the searching of women, and their rooms, in Yarl's Wood is not necessary or conducive to welfare. I also have concerns about some of the searching practices in the Heathrow, Lunar House and Eaton House holding rooms.

6.179 As far as the claims about Yarl's Wood are concerned, the most serious is that women have been strip-searched by male members of staff. I have not been presented with any evidence corroborating this.

6.180 Strictly speaking, Home Office policy actually amounts to the following: all searches involving the removal of clothes must only be undertaken by officers of the same sex as the detainee and there must not be members of the opposite sex present or anyone not directly involved in the search. In the case of rub down searches of women not involving the removal of clothes (other than shoes), the search must be carried out by a woman officer and, *where possible*, only female members of staff should be present. When the room of a detainee is searched, the detention centre is required to *aim* to ensure that the staff members

conducting the search are female and that, *where possible*, all other staff members present are female.

6.181 Thus it is not true to say that it is not in line with policy for men to be present when a female detainee is subject to a rub down search. However, the thrust of the policy is that men should only be present when there is an operational need. So the issues are (i) whether the policy needs to be changed and (ii) whether under the current policy Yarl's Wood is making sufficient effort to ensure that female officers are available to conduct the searches and that men are only present as a last resort.

6.182 So far as the first issue is concerned, I conclude that the Home Office needs some flexibility in its searching policies (at least in terms of the less invasive searches) to allow for situations in which an urgent search is needed but in which a female member of staff is not available. I do not recommend any change in the wording of the policy, therefore. However, so far as the second issue is concerned, it appears that at times staff at Yarl's Wood have been operating outside the *spirit* of the policy. It is of the greatest importance that the proportion of female staff at Yarl's Wood is increased (see paragraph 3.136 above). In the meantime, Serco should only conduct searches of women and of women's rooms in the presence of men in the most extreme and pressing circumstances, and there should be monitoring and reporting (to Home Office Detention Operations) of these cases.

Recommendation 35: I recommend that the service provider at Yarl's Wood should only conduct searches of women and of women's rooms in the presence of men in the most extreme and pressing circumstances, and that there should be monitoring and reporting of these cases.

6.183 As far as the practices at Heathrow, Lunar House and Eaton House are concerned, the evidence of this review is that the Home Office's policy that detainees (especially women) should not be searched in view of other people is not always followed. All detention settings need to comply with this policy, and Home Office Detention Operations should carry out an audit of reception and holding environments to ensure that they do.

Recommendation 36: I recommend that Home Office Detention Operations carry out an audit of reception and holding environments to ensure that the policy on searching out of sight of other people is properly followed.

Handcuffing

6.184 I am also aware that approaches to security on escorts outside the IRCs have differed markedly from centre to centre (despite their all working to the same DSO). The most extreme example that has been reported concerns the death of a confused 84-year-old Canadian detainee, Mr Alois Dvorzak, who died in handcuffs in outside hospital after being transferred from Harmondsworth in February 2013. I have seen the Prisons and Probation Ombudsman's report on Mr Dvorzak's death. Harmondsworth's use of restraints on an elderly man who

had been in this country for little more than a fortnight was shocking (as HM Chief Inspector of Prisons has commented: "a sense of humanity had been lost in the use of handcuffing on detainees who were dying"[93]). But this appalling story can also be read to suggest that, in the absence of other authorities taking any responsibility, in some circumstances even the most vulnerable people may be 'better off' in detention.

6.185 A review of issues arising from the death of Mr Dvorzak conducted by the Home Office found that the then operator at Harmondsworth used restraints in 82 per cent of cases for detainees going out under escort, whereas at Colnbrook the figure was 39 per cent. Variation on this scale between IRCs with similar populations could not possibly be justified.

6.186 I have been very pleased to learn, therefore, of the significant efforts taken by the Home Office to ensure that risk assessments are in fact conducted on the same basis and to the same standards by each contractor. The use of handcuffs is now monitored on a monthly basis and the proportion of detainees being handcuffed has fallen across the estate. Management information for escorted moves from Harmondsworth for the month of June 2015 show that in 56 per cent of cases no restraints were used, and for the estate as a whole the figure was 59 per cent. This compares with just 9 per cent of moves without restraints for Harmondsworth and 42 per cent for the entire estate in September 2014. This is a very welcome turn-around, and means I have no need to make a formal recommendation.

Segregation

6.187 In this section I consider the rules governing the use of segregation (removal from association under rule 40 and temporary confinement under rule 42). I also offer my observations from my visits to the immigration estate.

6.188 In summary, Detention Centre Rules outline:

- authority levels for the decision to remove someone from association or place them in temporary confinement – the Secretary of State (for contracted-out centres), or the manager (directly managed centres)
- that an individual shall not be removed for more than 24 hours without the authority of the Secretary of State
- maximum periods of confinement – 14 days for removal from association, three days for temporary confinement
- those to be notified of the decision taken – a member of the visiting committee [i.e. the IMB], the medical practitioner and the manager of religious affairs
- that a detained person will be given written reasons for the decision made – within two hours for removal from association, before the 27th hour of the confinement for temporary confinement

[93] HMIP, *Annual report 2013-14*, HC 680, 2014.

- that records of every event shall be kept in a manner to be directed by the Secretary of State
- mandatory daily visits by the manager, the medical practitioner and an officer of the Secretary of State.

6.189 Detention Centre Operating Standards are separate and brief. The only point that is duplicated for both rule 40 and 42 is that no room should be used for either purpose unless it is certified in writing that "its size, lighting, heating, ventilation and fittings are adequate for the maintenance of health", and that a detainee can communicate with an officer at any time.

6.190 Operating Standards for rule 40 say:

- where removal from association is being considered and the detainee may be at risk of self-harm or suicide then this must only be as a last resort and with the authority of the contract monitor [i.e. Home Office manager] (contracted out centres) or the centre manager (directly managed centres)
- rule 40 may be used with the agreement of, or at the request of, the detainee where he/she feels vulnerable
- visits are required as per the Detention Centre Rules
- association with others held under rule 40 and a staged return must be considered
- the centre must maintain records
- the centre must ensure that a representative of the IMB is advised, and that a record is kept.

6.191 Operating Standards for rule 42 state:

- where a centre has a discrete unit the staff employed there must be selected on the basis of their competency to fill the role
- that all details of use of rule 42 must be recorded, and thereafter "all actions relating to visits to detainees, when the detainee was removed from the accommodation and any other relevant information"
- the centre must have a published routine for temporary confinement, which "is made known to detainees and observed by staff and which takes account of security and control requirements and the statutory entitlements and needs of detainees".

6.192 The principal difference between the two rules is that rule 42 is intended to provide a temporary 'cooling off' mechanism, while rule 40 represents potentially longer term segregation. However, it is arguable that it would be better to have a single rule governing both circumstances and with shared safeguards. For example, the requirement to advise the IMB of removal from association does not apply even when a period of temporary confinement exceeds 24 hours. And while rule 40 must only be used as a last resort when a detainee is at risk of self-harm or suicide, no such standard applies to rule 42.

6.193 As I have noted in my foreword, rule 42 (1) includes a reference to "refractory behaviour" – an antiquated phrase that has outlived its usefulness. The rule should be amended to use more contemporary language.[94]

Recommendation 37: I recommend that the Home Office consider amalgamating and modernising rules 40 and 42.

6.194 Pleasingly, the accommodation set aside for rule 40 and 42 (usually labelled the Care and Separation Unit, CSU or CASU) was not in much use at the times of my visits to IRCs and STHFs. But observation of the facilities showed them to be of variable standard, with some in poor condition. For example, it is questionable if Campsfield House's CSU met the requirement that "size, lighting, ventilations and fittings are adequate for the maintenance of health". I note that these standards are not further defined, and it would be useful if they were.

6.195 Indeed, none of the units I visited had considered what differences to design and function might follow from the designation of places of segregation as 'care and separation units'. The facilities were barren and in some cases very poor. They provided separation; it was less apparent that they provided care.

6.196 More happily, the rule 40 and 42 reports that I examined showed that detainees are generally in segregation for limited periods of time. This is corroborated by statistics for January 2014 to December 2014 inclusive, provided by the Home Office:

- Colnbrook, Harmondsworth and Brook House had the highest numbers of individuals in rule 40 accommodation, with Yarl's Wood having the longest average stay per person (3.24 days)

- Colnbrook, Harmondsworth and Campsfield House had the highest number of individuals on rule 42, with Yarl's Wood again having the longest average period of stay per person (2.17 days).

6.197 I am aware, however, that some detainees have been segregated for prolonged periods of time, in particular when waiting for transfer to secure psychiatric hospital.

6.198 My examination of records of those held under both rule 40 and rule 42 revealed significant variations in the quality of record keeping. There was evidence too that different forms were used at different IRCs, meaning that information was not uniformly available.

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[94] The full text of rule 42(1) reads: "The Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may order a refractory or violent detained person to be confined temporarily in special accommodation, but a detained person shall not be so confined as a punishment, or after he has ceased to be refractory or violent."

6.199 From the 46 reports that I considered, I identified poorer record keeping processes in three IRCs. Records from Harmondsworth appeared to switch between rule 40 and rule 42 decisions against the same detainee within one time period. Harmondsworth also failed to record whether notifications of the reasons for use of segregation were given to the detainee, or whether visitors attended. Campsfield House's records showed evidence of overwriting, with limited evidence of engagement with the detainees rather than observations of behaviours. Colnbrook provided no evidence that detainees had been given written reasons for segregation, nor evidence of contact.

6.200 There were a number of examples of detainees being moved from rule 40 to rule 42 and vice versa, sometimes within half an hour of the initial decision to remove them from the wider population. There may have been good reasons for such decisions, but they were not apparent from the paperwork I was given.

6.201 I also found examples of the decision to remove a detainee from the general population being made by a named person but with no indication of the level at which the decision was made. There were others where it was not clear whether the detainee had received written confirmation of the reason for their segregation, and where notes about communication between staff and detainee were either limited or accurately reflected that communication was indeed poor.

6.202 On the basis of my examination of rule 40 and rule 42 records, the Home Office cannot be confident that all centres operate faithfully to the Operating Standards, or that record keeping supports good decision making.

6.203 I am particularly concerned that segregation may on occasions become the default location for those with serious mental health problems. ILPA told me:

> "Mental illness is often treated as 'behavioural' and dealt with through disciplinary measures such as the use of force and segregation. The use of these measures on the mentally ill will have disproportionate effects. In the case of *MD*[95], in which a breach of Article 3 of the European Convention on Human Rights was found in relation to the lack of measures or ineffective application of measures to ensure that MD's mental health was properly diagnosed, treated and managed, MD suffered from major depression with psychotic features and generalised anxiety disorder and was held at Yarls' Wood. The response to her distress, self-harm and aggressive outbursts was to remove her from association and isolate her, actions that an independent doctor identified as liable to make her condition worse. The independent physician also identified that physical force was used in response to her distress, frequently increasing her anxiety and experienced by her as traumatic."

[95] *R (MD) v* Secretary of State for the Home Department [2014] EWHC 2249 (Admin) (8 July 2014), [redacted]

6.204 It needs hardly stating that removal from association and temporary confinement should be used in exceptional circumstances only, and for a limited period of time, and when all other options have been considered.

6.205 Although I was pleased to note that most of the CSUs I visited had few occupants, there is evidence that temporary confinement is sometimes used in the absence of access to appropriate mental health care. Discussions with Home Office staff have confirmed me of this view. Use of segregation under these circumstances (and particularly any extended use) is not consonant with detainees' welfare, and in some situations it may represent cruel and unusual punishment.

6.206 Given the importance of getting these decisions right, record keeping must be meticulously completed. My inquiries have shown this is not always the case.

Recommendation 38: The Home Office should review all the rule 40 and rule 42 accommodation to ensure that it is fit for purpose. All contractors should be asked for improvement plans to ensure that the name Care and Separation Unit is something more than a euphemism.

Transfers and logistics

6.207 This section of the report looks at logistics relating to the movement of detainees, both within the detention estate and for flights for removal to other countries.

Volume of moves

6.208 Published immigration statistics do not capture information about the number or times of transfers of detainees, but reports of short notice, inconvenient and seemingly unnecessary moves by detainees are frequent and compelling.

6.209 I have received numerous accounts from detainees of moves that were said not to have been necessary, or that had not been properly planned or executed. Many detainees have also told me that they have been moved several times, often at short notice or with no notice at all.

6.210 A team member, who was observing a night shift in Yarl's Wood, observed the arrival of a detainee who reported being detained at Belfast for three days, moved from a STHF to Gatwick Airport, from there to Colnbrook, and then on to Yarl's Wood, all in a short time frame. The move from Gatwick to Colnbrook involved other pick-ups around London before arrival, and took a long time.

6.211 Representatives of the IRC contractors and of Tascor (the company with the escort contract) acknowledged that movement numbers are high, and that the volume of moves can cause logistical challenges to the smooth running of the system.

6.212 NHS England in its healthcare needs assessment for IRCs estimated that up to 40 per cent of admissions to IRCs were of detainees moving around the system (based on the known number of people in detention and admission rates in 2013).[96]

6.213 The submission to the review from Dr Gill and Dr Rotter of Exeter University reported answers to Parliamentary Questions in 2005-06 showing that £6.5 million was spent on moving detainees from one facility to another. I am not aware of a more recent estimate; I assume that the current cost to the public purse must be significantly higher.

6.214 The Home Office reports a variety of reasons for the transfer of detainees between IRCs, and some transfers are clearly unavoidable. Transfers on security grounds speak for themselves (which is not to say that some IRCs could not do more to 'consume their own smoke'). Likewise moves to facilitate access to flights (although I am surprised that more use could not be made of airports in Scotland closer to Dungavel).[97] Likewise, transfers to enable a detainee to take part in an interview with an Embassy or High Commission. Nor do I question the need for the Home Office to create a balanced estate (indeed, I have been critical of the apparent lack of sophistication in allocation decisions).

6.215 However, all transfers are potentially disruptive and harmful to welfare. Dr Gill and Dr Rotter told me:

> "... detainees who are repeatedly transferred between IRCs often face barriers to maintaining ties with support networks within and outside detention; accessing former legal representatives and potential sureties whose assistance is crucial in their asylum/immigration/bail applications; and receiving adequate health care from staff who are properly informed about and equipped to treat their medical conditions. Furthermore, transfers impact upon IRC staff perceptions of detainees and limit their capacity to deliver stable, continuous services to detainees, but also appear to prevent detainees from utilising formal complaints procedures to report unacceptable staff conduct."

6.216 Dr Gill and Dr Rotter proposed a cap on the number of transfers, but I am not persuaded that would be operationally possible. I am more convinced by another of their suggestions, however, that the Home Office should routinely publish statistics on the number of transfers between centres, thus providing better oversight and greater transparency.

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[96] *Health and Wellbeing Needs Assessment Programme Immigration Removal Centres and Residential Short Term Holding Facilities National Summary Report*, August 2014.

[97] Positioning moves for flights have been the subject of some discussion during the course of this review, with service providers questioning whether tickets for departure from local airports, though more expensive in themselves, could still represent better value for money than the combined cost of a detainee move to a London IRC, then a further move to the airport in addition to a flight ticket.

Recommendation 39: I recommend that the Home Office should routinely publish statistics on the number of transfers of detainees between IRCs and STHFs.

6.217 Transfers over long distances raise questions both of detainee welfare and of cost. Decisions about flights should have consideration both for the impact on the detainee, and the total cost to the taxpayer. I am convinced that greater use could be made of airports other than those in the South-East.

Recommendation 40: The Home Office should review the use made of regional airports for removals.

Transfers at night

6.218 I have been particularly concerned by the welfare implications of transfers that take place at night. However, there is no set definition of what constitutes a transfer at night, and there is no routine monitoring and reporting of the number of times this occurs.

6.219 A team member observed reception at Yarl's Wood at night, and saw several moves that could have taken place during the day. The most compelling case was that of a 58 year old detainee who arrived from a holding room at Birmingham Airport, having arrived there at 8.25am that morning.

6.220 Two team members who observed night transfer operations with Tascor have also reported moves that could have happened during daylight hours. For example, one detainee was picked up at Tinsley House just after midnight and taken to Harmondsworth. The only reason for the move occurring at night was that it could be combined with airport pickups and was therefore administratively convenient for Tascor. No account was taken by the logistics managers of the inconvenience caused to the individual detainee.

6.221 At Brook House I was told of a man who had been taken from HMP Maidstone for a hearing at Taylor House in London. He had arrived at Brook House at 1.00am. It was not known where he had been in the interim, but it was assumed he had simply been sitting in the van. On arrival at Brook House he was desperate for a cigarette and threatened to assault a member of staff. The next morning he had been transferred back to Maidstone where he had tried to kill himself and was now under constant supervision.

6.222 The Brook House IMB report for 2014 records: "The Board continues to be concerned about the number of detainees being moved at night for routine transfers including those between centres, and this is echoed by colleagues at other centres."

6.223 Quoting from a report he submitted in April 2014, the chair of the North and Midlands IMB told me in respect of unsocial hour moves to and from Pennine House:

> "[none] of these moves are done with the welfare interests of the detainee as the first consideration … all of these moves have everything to do with the operating policies of the organisation planning the moves in order to maximise the use of their transport."[98]

6.224 Detainees raised the matter with me in my meetings in IRCs, saying they found the process to be deeply unsettling. They reported being woken up to pack and move at short notice, with little time to orientate themselves before being placed in a van and driven across country.

6.225 Transfers at night are justified by the Home Office as being logistically necessary to enable the volume of moves on any given day, or as being required by police forces in order to free up police cells. I have also been asked whether I would prefer a night move that took a short amount of time with quiet roads or a day move that took a long time because of busy roads. I do not think this is to the point as the detainees themselves have no choice about their moves, when they are made, or who is inconvenienced by them.

6.226 Moreover, a DEPMU survey of moves, covering a period of a week, revealed that eight per cent of night moves had not been time-bound. (This is eight per cent of a large number, and represents a lot of people.) In these cases, there had been no rationale for making the moves at night other than that it was convenient for Tascor to do so.

6.227 From a welfare perspective, it is common decency to move people only in those hours when they are more naturally alert and aware of what is happening to them. I also believe that this is more likely to result in their participating more openly in healthcare and other screening.

6.228 I am aware that both Inspectorate and IMB reports often recommend that transfers at night are ceased, and that these recommendations have been repeatedly rejected by the Home Office on cost and logistics grounds. I acknowledge that there may be challenges to Tascor, and that some detainees might spend slightly longer in police custody if they are picked up after a lorry drop, or perhaps longer at the airport before their flight. However, I do not believe these objections are ones of principle or should outweigh what has been said by the independent inspector, independent monitors, and in evidence to this review. The logistical advantages to the Home Office and its contractors are not sufficient reason for routinely moving people in the middle of the night.

6.229 My preferred option is not a blanket ban, but that IRCs should cease to accept transfers on a 24/7 basis. In line with this, contractors should introduce hours of closure except in emergencies. This would mirror Prison Service practice. The exact hours of closure would depend upon local circumstances

[98] Tascor suggested that they were sometime kept waiting outside the gate, but that there was more waiting outside the courts than outside IRCs.

including proximity to airports for early flights, but I would expect that each could close for a period of no less than four and preferably six hours each night. There would be consequential savings to the taxpayer in the time of both DCOs and healthcare staff. (I appreciate that this will also require contract renegotiation with Tascor, NOMS and IRC providers.)

Recommendation 41: I recommend that the Home Office negotiate night-time closures at each IRC, the times of which should reflect local circumstances.

Charter movements/overbooking of flights

6.230 The use of chartered planes to remove large numbers of co-nationals at one time is an established part of immigration enforcement. The costs and benefits of this practice are not a matter for this review.

6.231 However, it is also established practice for the Home Office to set removal directions for more detainees than can be accommodated on a charter to allow for attrition rates due to legal challenges against removal. There is no policy document or operational instruction that lays out instructions for this practice, but the Home Office has confirmed that this is done to try to ensure that charter flights leave at capacity. There are clear welfare implications of such overbooking.

6.232 The Home Office has been repeatedly criticised for this practice by HM Inspectorate of Prisons, and there have been successive recommendations that it should be abandoned.

6.233 The Home Office response is that it undertakes a balancing act between maximising the capacity of the charter and ensuring that detainees are not unnecessarily readied and moved for a flight on which ultimately they do not depart. The Home Office has confirmed that the number of 'reserves' is based on historical attrition rates to limit them to the minimum necessary, and that this is kept under regular review. It has cited the Kosovo/Albania charter as an example where the number of 'reserves' taken to the airport has been reduced to five.

6.234 It is of course encouraging to see any reduction in the number of people who are moved unnecessarily to and from a charter flight, but this must still be little comfort for the detainees who are moved and unsettled by the process. I find the whole practice to be unsavoury and inconsistent with a welfare-centred approach.

Recommendation 42: I recommend that the practice of overbooking charter flights should cease.

Escorting

6.235 Little of the evidence I received focused upon escort arrangements.

6.236 One of the team members observed the escort of detainees on a coach from Brook House to the departure point of a charter flight. The behaviours of escorts were thought to be positive, with escorts engaging with detainees in line with the Home Office Manual for Escorting Safely (HOMES).[99] However, I believe that the guiding hold may still be used too frequently, and this should be kept under review. HOMES does not mandate routine use of the guiding hold.

6.237 Transfers onto and from buses were unexceptional, but there was a very long gap (for a small number of detainees, this was seven to eight hours) between joining the coach at Brook House and leaving it at Stansted.

6.238 I was surprised to learn that there were no books or DVDs on the coach. This should be remedied.

6.239 Team members have also observed the pre-departure process at Harmondsworth (for a different charter flight). The departure point for charters was behind the secure possessions store, which was cramped and not conducive to a smooth process. It was explained that departures could not take place via the usual reception as the coach was too large to enter the secure area.

6.240 While every effort was made to prepare for re-uniting detainees with their property, there were periods when detainees could not be found within the centre, and these added to the waiting times of those already sitting on the coach.

6.241 Moving large numbers of detainees out of an IRC and onto a coach will always take much longer than individual moves onto a van. However, all IRC service providers should consider if there are improvements that could be made to speed up the process.

6.242 In addition to these observations of movements for charter operations, two team members were assigned to crews for observations of whole night shifts.

6.243 My colleagues found that Tascor interactions with detainees were polite and respectful, and that immediate welfare needs in terms of food, drink and toilet breaks, were met. Both observations took place over Ramadan and Muslim detainees were advised when they were able to eat and drink, and when the fast period was starting, so that they were able to time their meals accordingly.

6.244 Logistics on the shifts in questions were somewhat haphazard. It was observed that crews were despatched to pick up uncertain numbers of detainees, with final details relayed later. Some jobs were cancelled whilst the crew was on its way.

[99] I chaired the Independent Advisory Panel on Non Compliance Management that monitored the development of the HOMES manual.

6.245 Detainees who knew each other (and had been encountered on the same enforcement operation) were moved to different IRCs for no discernible reason.

Logistics

6.246 A team member also spent time with Tascor to try to understand their approach to logistics. One member of staff reported that the electronic system would prioritise the movement of a detainee who was flagged as being at risk. However, a manager in the same unit stated that prioritisation was based on contract penalties, and that movements for removal were nearly always top of the list.

6.247 It has been a feature of this review that apparent failures in planning and logistics have been criticised by almost everyone I have spoken to. The criticisms have included failure to plan for moves of more than one individual at a time, and detainees being required to remain in vans for long periods as others are picked up en route to an IRC.

6.248 There is a balance in all these things. What is clear is that the current arrangements do not seem to work as well as they might either for Tascor or the Home Office. More importantly from the perspective of this review, welfare issues are evidently not paramount. In an ethical system, they would be.

Redress and oversight

Complaints systems

6.249 A new DSO (DSO 03/2015) on the handling of complaints in IRCs, STHFs, pre-departure accommodation, and during escort, was issued by the Home Office as I was completing my report.[100] It emphasises (at paragraph 6): "Detainees are to be treated fairly, openly and with respect at all times and must not be penalised for making a complaint. The fact that a complaint has been made and is under investigation will not interfere with the consideration of the immigration aspects of a detainee's case."

6.250 Indeed, if detainees are to have confidence that their welfare is to be protected, a successfully functioning complaints system is essential. However, most detainees make little or no use of the formal complaints process. This can be interpreted in a number of ways – it may mean they feel there is nothing to complain about. More worryingly, it may reflect a lack of trust that complaints will be dealt with confidentially and respectfully by receiving bodies, difficulties of access to the complaints mechanism, or a belief on the part of detainees that making a complaint will affect their casework decision and treatment by the Home Office.

[100] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454297/DSO_03_2015_Handling_complaints.pdf

6.251 Even the level of healthcare complaints is very low. Figures obtained for this review showed a total of 294 such complaints in 2014-15, 70 per cent of them from just three IRCs: 111 at Yarl's Wood, 56 at Colnbrook and 44 at Harmondsworth. Two-thirds of the Yarl's Wood complaints were in the second half of the period, and a similar pattern was observed at Colnbrook and Harmondsworth (although the latter may not be statistically significant as the monthly totals are much lower). (See also paragraph 7.55 below.)

6.252 Medical Justice told me:

> "The complaints process is complex and inaccessible, especially for those with limited English or familiarity with complaint systems. Many detainees are afraid to make complaints fearing negative repercussions in detention or on their immigration claim. Of those complaints that are made, very few are upheld, compared to the PPO's substantiation rate of 80 per cent, which raises concerns about the diligence and impartiality of the process. In addition, the Home Office closed down the Complaints Audit Committee after it found that 83 per cent of complaint investigations were inadequate, subsequently there is no systematic overview of complaints to identify trends or to ensure lessons are learnt."

6.253 Asylum Welcome put it this way:

> "… a robust complaints handling system is fundamental to ensuring the welfare of vulnerable individuals … Asylum Welcome is aware that detainees are deterred from making complaints by a fear of repercussions. This is not simply fear that they will be harshly treated. Campsfield is widely thought of a as a more pleasant environment than other detention centres and it is a strongly held view among detainees at Campsfield that if they complain they will be moved to another centre … Even more serious, detainees tell us that they believe that if they complain the Home Office is able to respond by speeding up their removal from the UK … Asylum Welcome recommends a renewed culture of openness which makes it easier to communicate externally about experiences in detention, the option of raising a complaint with an external organisation and having that complaint investigated promptly and thoroughly, and a system for monitoring outcomes for those who complain to prevent unreasonable outcomes."

6.254 I hope that the new DSO may help to reduce detainees' fears of suffering adverse consequences as a result of complaining, but I am aware that such suspicions are deeply embedded. Asylum Welcome is right to argue that this is as much an issue of culture as it is of formal rights and procedures.

6.255 I am also conscious that other mechanisms for resolving complaints are far from perfect. The Bail Observation Project and the Campaign to Close Campsfield told me in their joint submission that they felt the IMB was not sufficiently 'independent', and that Ombudsman processes were too lengthy.

6.256 The evidence I received during this review certainly suggested that relatively few complaints are made to the IMBs. Moreover, during my time as Prisons and Probation Ombudsman, I was well aware of the limited service I offered to immigration detainees. I sympathise with my successors that little more has been achieved in the years since I stood down.[101]

6.257 There are objective reasons why a traditional Ombudsman role is of little relevance to those in detention. The principal focus of detainees is upon the fact of their detention, not the quality of it. The language barrier is another important element. And there is a cultural barrier for those detainees who hail from countries where suspicion of the authorities is deep rooted and well deserved. Finally, and most importantly, the indeterminacy of immigration detention is not consistent with Ombudsman procedures that can often be protracted.

6.258 Given my previous responsibilities in this area, I am loth to suggest greater insight today than I showed in the past. It may be helpful, however, to reproduce the principles of good complaint handling in IRCs that I outlined when Ombudsman:[102]

- there are clear and easy procedures to complain
- there is a simple investigation process which everyone can understand, free of unnecessary bureaucracy
- complaints are investigated in a timely manner
- the confidentiality of complaints and investigations is respected
- there are no penalties for complaining
- complaints are dealt with by the most appropriate person
- staff should take responsibility for their actions and be prepared to explain them, with redress as necessary
- there is a right of appeal to an Ombudsman.

6.259 Since the Complaints Audit Committee was abolished in 2008, there has no longer been any specific overarching oversight of the IRC complaints process, responsibility now resting with the Independent Chief Inspector of Borders and Immigration. I understand that the detention complaints system is included within a wider inspection currently under way.

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[101] Between April 2010 and March 2013, the PPO received 397 complaints relating to IRCs, investigating just under 200. Learning Lessons bulletin 2, *Immigration removal centres*, Prisons and Probation Ombudsman, March 2014. The number fell sharply in 2013-14 (Prisons and Probation Ombudsman, *Annual Report 2013-2014*, Cm 8930, 2014).

[102] Reproduced in *Handling of complaints in immigration removal centres, short term holding facilities, holding rooms and during escort guidance: Manual for UKBA staff and contractors working under contract to detention services*, (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257728/complaintsIRC.pdf).

Inspection

6.260 In the course of assessing the welfare of people in detention, I have concluded that the national oversight mechanisms – HM Chief Inspector of Prisons, the Prisons and Probation Ombudsman for England and Wales, and the local Independent Monitoring Boards – represent a robust and effective system of independent audit. In particular, the office of HM Chief Inspector of Prisons has a deserved international reputation for the rigour of its reports and its commitment to human rights. However, in line with a theme of this review that the Home Office should take greater charge of the immigration estate, I find it strange that the Independent Chief Inspector of Borders and Immigration is not involved in the inspection of IRCs. All the more so when, as this review has shown, issues within the IRCs cannot be separated from those that clearly come within the ICI's responsibilities like the quality and timeliness of caseworking decisions.

Recommendation 43: I recommend that the Home Office consider if the inspection arrangements for IRCs can ensure the involvement of the ICI.

6.261 I suggest no changes in respect of the PPO or IMBs, beyond noting that the sponsorship arrangements for both lie with the Ministry of Justice. However, it has concerned me to find on my visits that one IMB was not functioning at all properly, and that more than one other was significantly below its complement.

Recommendation 44: I recommend that the Home Office liaise with the Ministry of Justice to ensure that all IMBs in IRCs have sufficient membership at all times.

Staff conduct

6.262 In any closed institution the behaviour and moral resilience of staff is of critical importance. However, I have not considered that the recruitment and training of detention centre staff, or their sense of vocation (or that of Home Office caseworkers), were matters that I could sensibly consider in this review.[103] And, while I am not attracted by terms and conditions that in many cases are predicated upon 12-hour shifts, I have made only marginal comments on personnel matters except where (at Yarl's Wood) they are manifestly central to the welfare of detainees.

6.263 I do though welcome the introduction of body cameras to be worn by staff when required. Experience teaches that video technology is a safeguard both for the detained and for staff, and often results in an incident de-escalating.

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[103] UNHCR Detention Guideline 8 (paragraph 48 (xvi) reads: "All staff working with detainees should receive proper training including in relation to asylum, sexual and gender-based violence, the identification of the symptoms of trauma and/or stress, and refugee and human rights standards relating to detention."

6.264 There is one other matter on which I can offer views. A submission by the solicitors, Birnberg Peirce & Partners, to the Inquiry into the use of Immigration Detention in the UK by the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration argued in respect of the sexual relationships that have occurred between some staff and detainees at Yarl's Wood: "the possibility of consenting to sexual contact in a detention environment is highly questionable".

6.265 They continued:

> "Section 75 of the Sexual Offences Act 2003 sets out a number of evidential presumptions in respect of consent to sex. There are a number of circumstances in which consent can be said to be vitiated by the context, such as where the complainant feared violence or where the complainant was intoxicated. However, the list does not include the context of a complainant who is detained in immigration detention (or some other detention contexts such as prison or a mental institution) and the perpetrator is their custodian. It is our submission that there should be an amendment to this Act to add an additional factor which will vitiate consent and that is where sex takes place between a member of staff and a person who is in their custody. The power imbalance is so stark, and the detainee in such a vulnerable position, that it cannot be said that consent could be meaningful in this context. Furthermore, if any sexual contact in this context was *prima facie* a criminal act, this might act as an effective deterrent."

6.266 I agree with this analysis. For staff to engage in sexual activity with those to whom they owe a duty of care should not just be a matter for their employer. I am told by the Home Office that the number of corroborated cases is small, but even one is one too many. It is an abuse of power on which the law should speak.

6.267 This matter evidently has implications beyond the Home Office and beyond immigration detention.

Recommendation 45: I recommend that the Home Office seek the views of the Ministry of Justice and the Department of Health on extending section 75 of the Sexual Offences Act 2003 to IRCs, prisons and mental hospitals.

PART 7: HEALTHCARE

7.1 Healthcare is central to the terms of this review. It is also a critical part of the detention regime. The health, safety and wellbeing of all detainees depend on the professional, efficient and timely delivery of healthcare services.

7.2 In its evidence, the BMA expressed concerns about agency staff, the time available for consultations, training for doctors, mental health and the absence of a multi-disciplinary team as in the community, and – as noted earlier – the refusal of rule 35 reports on the basis that the GP's opinion "does not constitute independent evidence of torture". The BMA's covering letter emphasised the opportunities for healthcare professionals "to address the previously unmet health needs of a particularly vulnerable group of people". Other evidence I received suggested that this approach to healthcare may not sit easily with a Home Office objective of ensuring that detainees are 'fit to fly' and can therefore be removed from the country.

NHS commissioning

7.3 Until recently healthcare services were contracted through IRC service providers. In effect, this meant that those who ran IRCs on behalf of the Home Office were directly responsible for healthcare services and for responding to complaints made about them.

7.4 The position now is that healthcare for all IRCs except Dungavel is commissioned by NHS England, governed through a partnership agreement and various commissioning documents, including clinical needs assessments.

7.5 The exceptions to this arrangement are the facilities in Scotland and Northern Ireland, where NHS England has no jurisdiction.

7.6 The partnership agreement between NHS England, Public Health England, and Immigration Enforcement (as part of the Home Office) is a publicly available document that "... sets out the shared strategic intentions, joint corporate commitments and mutually agreed developmental priorities of NHS England and Home Office". It establishes how the respective parties will work together, share and use information, enable referrals to other organisations and further develop commissioning.

7.7 The identified priorities for all signatories are:

- better mental health assessment and treatment for detainees
- public health – the pro-active detection, surveillance and management of infectious diseases and suitable treatment paths
- to strengthen multi-agency approaches to managing detainees at serious risk of harm – better learning, process improvements, a multi agency approach to ACDT
- to align commissioning systems – including information governance.

7.8 I met with NHS England representatives to discuss their approach to the planning and provision of healthcare services, and the challenges and opportunities they have been given. While acknowledging that the process was a "journey", NHS England demonstrated a strong desire to improve services in all the facilities for which they now have responsibility. They also said that there had been significant investment of their own resources in certain areas where demand had exceeded anticipated need (such as at Harmondsworth where, for example, dentistry facilities were already being updated).

7.9 There have been some transitional issues, however, that need resolving:

- Service providers who are responsible for the running of IRCs have reported frustration with their inability to see contracts and to understand service delivery levels under the new arrangements. Day-to-day relations between relevant parties need to be improved.
- NHS understanding of demand for all services has had a difficult start, with projections being outstripped by actual demand, and with some legacy issues and new arrangements affecting the smooth running of healthcare services.

7.10 NHS England has acknowledged the absence of a standard screening assessment tool for all IRCs, creating "challenges in determining common health needs across the population".[104] I understand that NHS England's long-term delivery of services will result in comprehensive data collection to enable all concerned to evaluate and predict future demand. This is a laudable ambition. The data currently provided is not sufficiently robust and, although I have relied upon it in this report, better information is required if informed decisions are to be made.

7.11 Overall, I received no evidence to suggest that the move to NHS England commissioning is anything other than welcome. It should put IRC healthcare delivery on a more level footing with provision in the wider community, as well as providing a degree of stability that was previously impossible. However, as I am aware from separate work I have conducted within the NHS, new commissioning arrangements and a change in provider can both result in short-term problems before improved results are visible.

7.12 I am also concerned that those facilities and institutions not covered by NHS England commissioning should not suffer as a result. The Home Office needs to retain a focus on these areas to ensure that they are not neglected.

7.13 The priorities as outlined in the published partnership agreement are sensible and proper ambitions. Nonetheless, no one I spoke to doubted that there were still improvements to be made in healthcare commissioning and provision.

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[104] *Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holding Facilities: National Summary Report*, March 2015.

Consistency of services and quality of care

7.14 My inquiry has found that hours of access to healthcare, services available, and whether these services are on site, vary significantly between parts of the immigration detention estate. These differences depend on whether the facility is an IRC, STHF or other type of institution, on the nature of the known or perceived demand, and whether legacy provision has continued into immigration detention.

7.15 Understandably, the IRCs have the most comprehensive healthcare services. The range of provision typically available includes:

- initial health screening and risk assessment, including an induction to healthcare. (Written information on a variety of healthcare issues is also provided in a range of languages)
- routine treatment of disease and infection
- immunisation services
- sexual health screening if indicated by the initial assessment
- care management and support for of physical disabilities
- treatment of injuries
- management of long-term conditions, such as asthma
- dental diagnosis and treatment
- optician
- identification and management of mental health conditions
- support for substance misuse dependency
- pharmacy services.

7.16 The STHFs have more limited provision:

- Larne House has a nurse on site 24 hours a day, a triage helpline that is available 24 hours a day, and a prescription service
- Pennine House also has a nurse available 24 hours a day, with access to an on call GP 24 hours a day.

7.17 Ports rely on port medical facilities where they exist (the larger facilities mainly). Dover docks is an example of a holding room that does not have healthcare on site. Staff move detainees who appear to be in urgent need of medical assistance to the local A&E under escort. Anything deemed to be non-urgent is left until an individual is screened at reception in either NASS (National Asylum Support Service) accommodation or an IRC.

7.18 Facilities at ports and airports are dependent on the support of others. At time of writing, those at Dover dock were being tested to capacity. This demonstrates that facilities that are without healthcare provision, and that depend on quick resolution of routing issues so that detainees can be transferred to a location better able to meet their needs, are very vulnerable to peaks in demand.

Induction interviews

7.19 All IRCs operate under DSO targets for initial healthcare screening and assessment:

- to be seen by a nurse for an initial health assessment within two hours of admission
- to be seen by a GP within 24 hours of admission.

7.20 Screening normally takes place as part of the induction process.

7.21 Detention Action, while noting that anyone who arrives at a centre should be seen by a nurse and offered a GP appointment, reported that:

- health screenings were often short. They said that the initial screening should take approximately 30 minutes but in practice they were much shorter, usually around ten minutes
- detainees often arrived at an IRC after a long and exhausting journey, or in the middle of the night. A recent Medical Justice study of 20 pregnant women had found that 55 per cent of health screenings had taken place between 10:00pm and 6:00am
- the initial nurse reception screening involved the usual health questions of height, weight, and history, but very little on past trauma or mental health
- interpreters were not always used when needed, especially late at night.

7.22 Detention Action added:

> "[The] screening setting is not conducive to disclosing intimate details to a complete stranger. This raises questions about the quality of information garnered from detainees self-reporting on health issues and vulnerabilities during initial health screening."

7.23 Evidence presented to the All-Party Parliamentary Group Joint Inquiry was that screenings were rushed, often conducted without an interpreter, and were very limited in their scope.

7.24 A report by the Tavistock Institute found that: "If health screening at reception is carried out at night time, and often after a lengthy journey, detainees' answers may well not reflect the true state of their health."[105]

7.25 I take the view that no system of medical screening after a long journey or in the middle of the night is likely to be very successful. The solution lies less with the screening process itself and more with the logistics that result in such journeys and such arrival times.

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[105] *Review of Mental Health Issues in Immigration Removal Centres: A report prepared for the Home Office by Dr David Lawlor, Dr Mannie Sher and Dr Milena Stateva*, 2015.

7.26 Out of respect for patient confidentiality, no healthcare screening interview was observed during the course of my review. However, one member of my team did witness good practice when a detainee was identified at reception as having diabetes, and therefore in need of food and an urgent assessment of health needs. (He had a large bag of medications with him.) The detainee was immediately given refreshments, and had received a full GP assessment and care plan less than two hours later.

Use of interpreters

7.27 My team and I also observed a number of non-medical induction interviews, over a range of time periods including an overnight observation at Yarl's Wood. At no time was an official interpretation service actually used. Other detainees were seen interpreting at the request of those conducting an induction, and detainee custody officers were witnesed using their own language skills to converse with detainees.

7.28 It is not conducive to the sharing of confidential information for a detainee to act as an interpreter.

7.29 So far as the use of interpreters in medical screening is concerned, the BMA told me:

> "Significant numbers of the detained population do not speak English, and so the use of interpretation services in medical consultations becomes vital. Whilst telephone interpretation services can be valuable, we are concerned about overreliance on their use. The use of remote interpretation services may affect the nature of the consultation, so as to inhibit discussion and make patients less likely to disclose sensitive or emotionally distressing information. Accordingly, they should not be routinely used as a substitute for in-person interpretation. Further work should be carried out into the possibility of sourcing interpreters who are used in local hospitals, where there is, in general, less reliance on telephone interpretation."

7.30 MIND proposed:

> "In accordance with the Mental Health Act 1983 Code of Practice and the NICE Clinical Guidance, detainees should be provided with comprehensive information about the available treatment options in a language and format that they understand. Detainees' access to treatments should be timely, in accordance with the time scales adhered to in community mental health care. A person-centred approach can only be facilitated in immigration removal centres if independent interpreters are available during mental health assessments and consultations and if all information relating to mental health care is provided in a language and format that detainees can access and understand. In the past, 'major concern' has been expressed about the lack of consistent use of

professional interpreters in immigration removal centres.[106] If mental health care in detention is to be adequate, these concerns must be addressed."

7.31 The Tavistock Institute report went on to argue: "If the majority of screenings are done by LanguageLine or with no interpreter, it may lead to inaccurate assessments of detainees' mental health."

7.32 The observations that my team and I made ourselves, and the evidence of others, have convinced me that professional interpreters (whether in person or by telephone) are not used widely enough.

7.33 I have considered whether on site interpretation facilities should be recommended as an essential provision. I do not believe this would be feasible in most cases. The most practical solution is to encourage greater use of off-site services like LanguageLine and thebigword.

Recommendation 46: I recommend that the Home Office review the use of fellow detainees as interpreters for induction interviews.

Recommendation 47: I recommend that the Home Office remind service providers of the need to use professional interpreting facilities whenever language barriers are identified on reception.

The demand for healthcare services

7.34 As I have noted, the available data on the demand for healthcare services is not comprehensive. However, NHS England has published the *Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holding Facilities*, which is the best source document currently available to me.

7.35 I reproduce below some highlights from the report. The first table shows activity and demand for general medical and nursing healthcare across each of the IRCs. All figures are over a 12 month period (2013-14).

7.36 The data in the table is both incomplete and contains some flaws, not least of which is the information regarding nursing appointments at Campsfield House where the reported number is grossly disproportionate to the number of appointments that could possible have been made, and is clearly in error. It is also disappointing to see that some data is missing or not available.

7.37 Despite that, what can be observed is a very high level of activity when compared to the size of the detained population for the period in question.

[106] 'Safe in our hands? A study of suicide and self-harm in asylum seekers', *Forensic and Legal Medicine* 2008, Juliet Cohen, p.243-4.

IRC	GP Appointments		Nursing Appointments		Population for period
	Booked	**Seen**	**Booked**	**Seen**	
Haslar (5 months)	411	337	296	264	870
Morton Hall	4512	3888	5621	4345	4817
Brook House	7586	6483	-	3914	7966
Tinsley House	1837	1477	-	894	1746
Campsfield House	5284	4164	23834	477	3000
Dungavel	1976	1682	10743	10157	2109
Yarl's Wood	10400	8882	Data not available		5808
Harmondsworth	11700	9360	6552	4325	6429

7.38 During IRC visits I asked both healthcare and operational staff about levels of use of healthcare for mental health treatment and for general healthcare. Responses varied between IRCs, but underpin the figures above. As noted earlier, in Yarl's Wood it was estimated that up to 90 per cent or more of detainees visited healthcare for one reason or another every day, and there and elsewhere I was told that up to half of detainees might have a mental health issue that required some level of intervention, whether clinical or otherwise.

Access to secondary care services

7.39 Detainees are able to access secondary care hospital services e.g. Accident and Emergency and specialist clinics. The figures in the NHS England source document are as follows.

IRC	A&E	Other clinic		Total hospital	% population
	No	**No**	**%**		
Haslar	1	24	5.5%	25	2.8%
Morton Hall	21	144	3%	165	3.4%
Brook House	47	559	7%	606	7.6%
Tinsley House	21	206	9%	227	13%
Cedars	1	0	0	1	0.7%
Dover	Data not available				
Campsfield House	23	50	2%	73	2.4%
Dungavel				161	7.6%
Yarl's Wood	-	73	6%	84	1.4%
Colnbrook	Data not available				
Harmondsworth	8	244	4%	280	4.3%
Pennine House	Data not available				
Larne House	Data not available				
Total	123	1300		1662	5%

7.40 This information is if anything more incomplete and potentially misleading than in the previous table, and I do not understand all the elements, or why those

elements do not sum to the totals, or to what the first set of percentages refer. I draw no conclusions other than noting that approximately five per cent of the detained population was referred to and used secondary hospital services. This is of course an extraordinarily high proportion when compared to the population as a whole (all the more so, given the age structure of the detainee group), and is itself an indication of the degree of vulnerability and need.

Criticisms of healthcare

7.41 Much of the written evidence I received concerned healthcare, confirming my view that it is a fundamental aspect of detention.

7.42 Healthcare was also a feature of most of my discussions with detainees; indeed, many expressed a deep frustration. There were accusations of rude and dismissive behaviour by staff, and poor quality treatment (receiving the wrong medication, not being able to access medication, misdiagnosis, lack of appointments) was consistently reported.

7.43 Many detainees said that their health had deteriorated while they were in detention. A variety of reasons were cited, from the quality of healthcare provision to uncertainty about their status and case progression.

7.44 I had discussions with healthcare teams at every IRC. The staff almost without exception seemed committed to their roles, but reported being overworked, with high caseloads to manage. Some acknowledged that they felt a conflict between the provision of appropriate treatment and the imperative of ensuring that a detainee was fit for travel and therefore for removal from the UK.

7.45 Some stakeholder organisations have reported interruptions of treatment for those on drug regimes, either because of poor clinical assessment or because medications were not obtained from detainees' homes at the time of their detention. Such practices are clinically dangerous and should desist.

7.46 Asylum Welcome told me that it:

> "… regularly hears from detainees about their state of health – covering a range of conditions – for example heart conditions, diabetes, HIV, epilepsy, problems as a result of injuries, torture and abuse (including sexual abuse against men), anxiety, depression, post-traumatic stress, psychosis. Our experience is that we consistently receive more complaints about the adequacy of health care for detainees at Campsfield than about any other aspect of the management of the centre."

7.47 Asylum Welcome made further serious allegations:

- that those with pre-existing medical conditions who arrived in detention without, or with only a small amount of, their regular medication, were sometimes denied additional supplies including medication for HIV and painkillers for chronic conditions

- that some detainees with health conditions had clinical plans that were not adhered to by Campsfield medical staff: "Tests and check-ups are not carried out when required – including blood tests, ECGs, monitoring of blood pressure and insulin management. Psychiatric plans are also not followed, according to reports"
- that detainees approaching the medical centre for help reported that their issues were not dealt with: "a common report is that they are given paracetamol only"
- that it could be extremely difficult to get a hospital appointment because, while detainees were generally held at Campsfield for an average of a month, hospital waiting times were longer
- that there had been occasions when detainees had needed hospital treatment (sometimes urgently) but this had been delayed because the Campsfield authorities had been unable to provide an escort
- that there had been reports of detainees suffering toothache and not having access to dental treatment
- that it was common to hear concerns raised "that detainees are suffering from mental health conditions but not receiving adequate attention."

7.48 I have not investigated these allegations. In the interests of balance, I should note that Asylum Welcome's account contrasts with the overall findings of the most recent inspection report for Campsfield House (conducted August 2014) which recorded:

> "Health care clinical governance arrangements were good. Detainees had very good access to primary care services. There were no waiting lists for GP clinics and a good range of specialist clinics and screening services was offered. Detainees had access to a pharmacist but some aspects of medicines administration needed to be addressed. Waiting times for the dentist were not excessive but detainees did not receive enough information about dental arrangements. Detainees could be seen promptly by mental health nurses, and a psychiatrist was also available. Reasonable support was provided for the small number of detainees with alcohol problems."[107]

7.49 Freedom from Torture reported an uneven "identification of and response to mental health risks affecting survivors of torture, including self-harm and suicide". They said that this was linked to a lack of specialist expertise and to healthcare processes (they said they understood that one in four detainees is screened between midnight and 6.00am when they are tired and often in a state of shock). They criticised: **"**Non-responsiveness of healthcare services to efforts by Freedom from Torture clinicians to liaise with them about the mental and/or physical health of detained clients (who are survivors of torture)."

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[107] HMIP, *Report on an unannounced inspection of Campsfield House Immigration Removal Centre, 11-21 August 2014*, p.15.

7.50 Freedom from Torture continued:

> "Discontinuity of medication for physical and mental health conditions including those related to torture. This is often because people are detained directly from reporting centres or from their homes without a chance to find their medication. Interruptions to regular medication may cause exacerbation of the condition for which it is required."

7.51 Medical Justice reported: "Inadequate and inappropriate care: Most IRCs provide primary care, and some basic secondary care facilities, either directly or through subcontractors, on the premises. However, the range and quality of care in IRCs is not equivalent to that offered to the community or in accordance with NICE guidelines."

7.52 Medical Justice said they had observed significant shortcomings in care including:

- "Lack of access to specialist healthcare, especially psychiatric assessment. One client waited more than a year for a psychiatric assessment despite repeated references to self-harm, suicide attempts and 'difficult' behaviour in her medical records. Even after an independent psychiatric assessment was carried out it took almost six months for her to be seen by an IRC psychiatrist.
- External healthcare appointments cancelled or missed often due to lack of transportation. One client missed her scheduled week 20 foetal anomaly antenatal scan due to attending a Home Office interview.
- Incidents of denial of treatment for serious conditions, e.g. HIV medication not provided on occasion and test results withheld. One HIV+ client did not receive his ARV [antiretroviral] medication for several days due to delays in obtaining his medication from the hospital pharmacy. He developed resistance to his medication which was 'probably' due to the interruption.
- Insufficient treatment and diagnosis of communicable diseases. Many detainees come from countries where there is a higher incidence of infectious disease than in the UK yet no systematic screening is conducted."

A culture of disbelief

7.53 The Royal College of Midwives was among those referring to a culture of disbelief amongst detention centre staff, whereby detainees' symptoms or health complaints were viewed with suspicion. Women for Refugee Women said that: "In spite of the high levels of health support needs, the women we interviewed pointed to the clear inadequacies of the healthcare provided in detention … Two thirds said they did not trust the medical staff in detention; above all, women spoke about how the healthcare staff in detention appear to subscribe to a

culture of disbelief." I myself encountered such a culture on the part of at least one IRC doctor to whom I spoke.

7.54 I also note this extract from Mr Johnson's assessment of cases where a breach of Article 3 of the European Convention has been found:

> "Healthcare provision: There is criticism of the healthcare provided to detainees. Of course, individual poor clinical practice may not have any underlying systemic cause. But the nature of the findings made in these cases do not really concern individual poor clinical practice. There is little or no criticism of individual clinicians. The findings are more concerned with a lack of assessment and treatment – see in particular *HA* and *D* and *MD*. These findings have been made in respect of several different removal centres and over prolonged periods of time. In several cases detainees who were in urgent need of assessment and treatment were not seeing a specialist for months on end. The nature and pattern of findings are such that they are more likely to be a reflection of a systemic problem (i.e. insufficient medical – particularly psychiatric – provision) rather than individual failings."

Healthcare complaints

7.55 I have referred earlier to the relatively low number of formal complaints about healthcare (and other issues). The table below shows the number of recorded complaints about healthcare in the period April 2014 to March 2015 inclusive.

IRC	**2014**			**2015**	**TOTAL**
	Apr - June	**July - Sept**	**Oct - Dec**	**Jan - Mar**	
Brook House	4	2	1	7	14
Campsfield House	1	1	2	1	5
Colnbrook (incl. STHF)	8	7	21	20	56
Dover	2	5	3	5	15
Dungavel	2	0	1	3	6
Harmondsworth	12	5	12	15	44
Haslar	1	1	1	1	4
Morton Hall	4	8	2	12	26
The Verne	0	0	4	8	12
Tinsley House	0	0	1	0	1
Yarl's Wood (incl. STHF)	13	26	27	45	111
Total	47	55	75	117	294

7.56 It is clear that the dissatisfaction detainees express verbally about healthcare does not translate into written complaints. What is also apparent

from the above is that the number of complaints about healthcare in Yarl's Wood is significantly higher than for any other centre, with a rising trajectory.

Continuity of care

7.57 Continuity of care was raised as an issue by detainees and healthcare staff alike. The requirements are outlined in primary care service specifications in terms of:

- release into the community or to another healthcare establishment
- the administration of travel vaccinations and malaria prophylaxis
- support for the removal of detainees, including provision of a limited supply of medications.

7.58 Several detainees reported that they were waiting for external appointments for treatment, but that they had been moved from one IRC to another, and so had gone to the bottom of the waiting list in the new NHS catchment area. In some cases this had happened more than once. I have been told that continuity of treatment is difficult when detainees are moved between IRCs. Some clinical staff expressed frustration that instructions not to move a detainee while treatment was continuing were not always followed.

7.59 Medical Justice said:

> "Detainees often arrive in detention without medical records or their current medication as many are detained in raids or when reporting. In addition, detainees are transferred between IRCs without accompanying records. Detainees are removed from the UK despite healthcare provision in their country of origin being woefully inadequate, sometimes to the point where access to care is unlikely and death almost certain, e.g. a terminally ill Ghanaian women removed to Ghana despite being unable to afford the life-prolonging treatment she needed. Forty-four per cent of detainees are released into the community, many without ensuring adequate healthcare. One of Medical Justice's clients was left at Victoria Coach Station to make her own way home despite the fact that she was unable to walk and did not have access to a wheelchair."

Recommendation 48: Home Office staff should be reminded that, to ensure continuity of care, detainees should not be transferred when there is clinical advice to the contrary.

Inpatient care

7.60 Inpatient care is not available in all IRCs. It has been reported that detainees who need inpatient care are transferred to these IRCs rather than being released to hospital, but I have not seen an authoritative study to prove or disprove this.

7.61 I have discussed with healthcare staff whether inpatient facilities should be provided in any IRC setting. There have been mixed responses. As noted earlier, some clinicians believed inpatient care to be appropriate for isolation and treatment of minor conditions, while others said that this encouraged the continued detention of those who should be more properly treated elsewhere.

7.62 Apparently perverse detention decisions may have many causes. On balance, I do not believe that there is anything to gain by the closure of existing inpatient facilities.

Self-medication

7.63 Each IRC seems to have its own approach to the self-administration of both prescription and over-the-counter drugs. Some report that everything has to be administered by healthcare, while others allow paracetamol and like medications to be administered from wings. Other centres allow some medications to be held in the detainee's possession and taken as instructed by healthcare staff.

7.64 Where it is safe to do so, self-administration should be encouraged. It both allows those who are competent to take responsibility for their own wellbeing, and frees up healthcare staff time to concentrate on other more clinically important matters.

Recommendation 49: The Home Office and NHS England should promote the self-administration of drugs where risk assessments support that approach.

Information sharing/patient confidentiality

7.65 It is encouraging that all IRC healthcare centres in England will shortly have the same access to electronic patient records. The move to SystmOne (a health information system widely used by GPs and by the Prison Service) as a means of recording individual healthcare records and data collation is a very welcome one. I understand that it will be available in all facilities in England imminently.

7.66 This is not the case outside of England, however. Arrangements will therefore need to be made for equivalent provision to ensure that paper record transfer is replaced by something better suited to modern requirements.

7.67 Some stakeholders have expressed concerns that healthcare information provided for one purpose is then shared too widely within the Home Office. Conversely, there have been concerns that the veracity of medical opinion is questioned using information obtained as part of an asylum decision, for example.

7.68 Medical Justice told me:

> "Detainees often see no distinction between healthcare and custodial staff and fear disclosure to healthcare staff will be reported to Home Office. A

recent HMIP report found that 'In one report, a doctor had made unprofessional and pejorative comments (…). This report had been forwarded to immigration staff without the detainee's consent or knowledge.' Nurses are present during detainees' consultation with the GP and guards are often present during medical consultations outside of the IRCs which breaches the confidentiality of the clinical space."

7.69 The BMA acknowledged:

> "Doctors working in IRCs may feel pressurised to disclose confidential patient information to centre staff for non-health related reasons. Sometimes doctors may be under pressure to conduct consultations within earshot of non-clinical staff. Various pressures on consultations – including trying to overcome language and cultural barriers and manage complex conditions in a short period of time – can lead to a decrease in the quality of the consultation and ordinary processes, such as obtaining consent, can become less robust."

7.70 Ms Jean Lambert MEP reported the findings of the European Parliament delegation visit to UK immigration removal centres in 2007, in which "Concerns were raised that medical services in centres are outsourced and run by private GP clinics leading to lines of medical accountability being confused and weak due to inadequate record keeping."

7.71 Information sharing is clearly a concern for those who represent detainees, and there is some evidence to suggest that lines of responsibility and accountability have become blurred. All parties have a duty to ensure that information shared for a particular purpose is not made available for others to read and misuse.

Recommendation 50: I recommend that the Home Office, in consultation with NHS England, draw up explicit guidelines as to:

- ***What informed consent looks like***
- ***What information can be shared between all parties in the event that informed consent to the release of clinical information is granted by the detainee.***

Recommendation 51: I further recommend that an alternative to SystmOne be pursued for those detention facilities not in England.

7.72 I also observed that investment was needed in the physical fabric of many of the healthcare centres I visited. All but one IRC has an initial assessment/appointment booking/drugs collection area that is in full view and hearing of other detainees. This not only cuts across a detainee's right to medical confidentiality, it also allows detainees to observe which drugs are being collected by others, potentially encouraging bullying and theft of prescription medication.

Staffing levels

7.73 The quality of care and the range of services are inevitably affected by staffing levels. I asked the Home Office for a breakdown of healthcare staffing levels for all IRCs and STHFs, but received information only for Larne House and Pennine House, and for Harmondsworth, Colnbrook and Dungavel. All other IRCs said that, as NHS commissioning is outcome based, information on staffing numbers was not recorded.

7.74 As a consequence, informed comparison is impossible. Staffing numbers for 2013-14 are available, but they are no longer useful as they relate to service providers who are no longer involved.

7.75 In discussion with healthcare providers, I have been told almost everywhere that there are problems recruiting permanent staff. Both remoteness of location and proximity to London were cited as reasons, as were rates of pay, the nature of the job, working in a detained environment, security clearance issues, and being paid more as a temporary employee rather than as a permanent member of staff.

7.76 The BMA reported:

> "... a significant variability in how healthcare staff are engaged across the IRCs. We have particular concerns about the heavy reliance on agency staff in some areas. General practice is an already demanding area of medicine, which can be exacerbated by the particular challenges of working in the immigration detention estate. To attract the best possible doctors to work in these settings, IRC work has to be seen as an attractive option, and we believe there is much work to be done in order to encourage doctors to pursue this career choice."

7.78 Providers have been keen to reassure me that they have access to regular temporary staff, or to bank staff in the case of NHS service providers, and that this mitigates any problems. And it is true that the key issue for patients is continuity of care, and this is not necessarily endangered when the same temporary staff have a regular presence. Many NHS hospitals are themselves reliant upon agency and bank staff.

7.79 However, for reasons both of finance and patient safety, an undue dependence upon temporary staff is an undesirable feature of healthcare in the immigration estate. Permanent staffing does need to be addressed as part of the ongoing improvements that are promised.

Recommendation 52: As part of its response to future growth in the demand for healthcare, NHS England needs to ensure the filling of permanent healthcare vacancies in IRCs as a priority.

Specialist services

Dental services

7.80 I have seen the Dental Service Specifications produced by NHS England for service tender purposes. The specifics of the document are commercial in confidence, but I can report that they are designed to provide IRCs with care equivalent to that available in the community. This means provision for urgent care and pain relief, and a more comprehensive service for those detained for longer including examinations and preventative care.

7.81 Appointments should be available with no more than a four week wait, with prioritisation of more urgent cases according to dental need. Education programmes on oral health are a requirement.

7.82 NHS England has reported that provision of dentistry services varies across the detention estate with most centres sub-contracting this work to a local dentistry service. Morton Hall and Dungavel have dentistry suites, but some centres offer only emergency dental care. Where data was available it showed that demand for dental services ranged from 2 per cent to 27 per cent, and was highest where dental suites were available on site.[108]

7.83 The dental facilities I have observed have been clean and orderly. Healthcare staff have reported no difficulty in accessing a suitable level of service, and there have been no direct concerns about dental treatment raised by the detainees I have spoken to. However, some stakeholders have made reference to detainees having untreated toothache.

Opticians

7.84 Where I have been able to see primary care specifications these have been for certain IRCs only. They have required the provider to provide examinations, prescriptions, glaucoma testing, referrals to specialists, and the supply and fitting of corrective spectacles covered by the NHS voucher system.

7.85 Optician services are provided under sub-contract, with some IRCs having a visiting optician and others requiring an off-site visit to outside services under escort.

7.86 Demand is reported as being between 1 per cent and 3.5 per cent of IRC populations, with up to 3 per cent of the population attending appointments.[109]

7.87 I was pleased to find that some healthcare facilities had basic over-the-counter spectacles available for detainees (such as those available on the high street without need of a prescription). All others could usefully do the same.

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[108] *Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holding Facilities, National Summary Report, March 2015*, NHS England.
[109] Ibid.

Podiatry

7.88 Once more, I have only seen primary care specifications for IRCs. They have required assessment of foot health and function, care to high risk patients, nail cutting and referral to secondary care services. There are no reliable data on demand for these services.

Physiotherapy

7.89 Those specifications I have seen required the provider to offer clinical assessment, advice and management of musculoskeletal conditions, with services running alongside other therapies available within the centres. Disposable and consumable equipment is also to be provided (walking aids, bandages etc). I have no information on the level of demand.

Sexual health

7.90 The primary care service specifications include a requirement to record and treat those who present with a sexual health issue, to provide barrier protection and lubricants, and to provide advice and to ensure that detainees have access to public health advice. There are linked requirements to record and treat individuals with HIV and to provide them with advice and removal or transfer medication.

Substance misuse services

7.91 The service specifications lay down a number of requirements for support and detoxification treatment options. The provider is expected to achieve outcomes that prevent drug-related deaths and blood borne viruses, that improve physical and mental wellbeing, and that lead to a reduction of drug and alcohol use in detention.

7.92 As I have said earlier in this report, during visits to IRCs I was told of a worrying increase in the use of new psychoactive substances. However, there does not seem to be any central initiative or plan to address this problem. This should be remedied.

Recommendation 53: I recommend that the Home Office, in association with service providers, consider what can be done to reduce the use of new psychoactive substances and to advise detainees on the effects of their misuse.

PART 8: THE MENTAL HEALTH LITERATURE SURVEY SUB-REVIEW

8.1 No issue caused me more concern during the course of this review than mental health. That concern embraces both the detection and treatment of mental illness, and the impact that detention itself may have on mental wellbeing. I begin with the latter issue.

8.2 From the evidence submitted to me by the interest groups, and from my own observations and reading,[110] it was indeed very quickly apparent that mental health issues were to be at the core of my review. As well as finding direct evidence of mental health need, I had also encountered other many other manifestations: conditions like asthma and diabetes[111] that can be triggered by stress, gastric problems, sleep disorders, anxiety, and headaches.

8.3 Although not based on a statistically representative sample (non-English speakers were under-represented), a recent study by Professor Mary Bosworth and Ms Blerina Kellezi found very high levels of depression with four out of every five respondents meeting the criteria for depression:

> "Those who were more depressed were: women, had health problems and were taking medication, had not lived long in the UK, had not been in prison prior to detention, had applied for asylum (up to 2 times), and/or had applied for judicial review. Those who were depressed had also specific experiences in that particular IRC: they were more likely to have participated in a fluid or food refusal, to have been placed on an ACDT plan, to have used interpreters, and to have been longer in detention. They did not use activities like the gym or religious services, did not report staff or the IT room or library as positive aspects of detention, and spent less time reading. They were also more likely to report that immigration detention was unjust."[112]

8.4 The researchers also found that: "those who had stayed longer in detention had lower mean scores for (i.e. were more negative about) healthcare, dignity, safety, staff decency, immigration procedural fairness, communication and autonomy, care for the vulnerable and staff help. They were also more distressed."

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[110] For example, Mental Health in Immigration Detention Action Group, *Initial Report 2013*, published by Medical Justice; Katy Robjant et al., 'Mental health implications of detaining asylum seekers: systematic review', *British Journal of Psychiatry*, 194, 2009. I also received most helpful contributions on mental health issues from, amongst others, the Royal College of Psychiatrists Working Group on Mental Health of Asylum Seekers (they also enclosed the Royal College's position statement on detention of people with mental disorders in Immigration Removal Centres, and an editorial from the *British Medical Journal*, 11 November 2014, 'Inadequate mental healthcare in immigration removal centres'), and from MIND.

[111] I understand that diabetes is generally more common amongst South Asian and Afro-Caribbean populations.

[112] *Quality of Life in Detention: results from MQLD questionnaire data collected in IRC Campsfield House, IRC Yarl's Wood, IRC Colnbrook and IRC Dover, September 2013 – August 2014*, University of Oxford, 2015.

8.5 This evidence raised all sorts of questions. Does detention trigger a pre-existing mental health problem or is it a new presentation? Are particular types of detainee more at risk? Are mental health problems rooted in previous trauma then exacerbated by detention? Is it the fact of detention, the length of detention, or the indeterminacy of detention that is the key factor, or do all apply?

8.6 It was apparent to me that to answer these questions I needed something more than my own impressionistic findings. In other words, was there properly peer-reviewed, academically sound research, based on sufficiently large sample sizes, and from a range of jurisdictions, to allow me to conclude categorically that immigration detention is causally associated with a deterioration in mental health?

8.7 However, in asking that final question I was conscious that neither the members of my team nor I had any clinical or academic expertise, and that – to carry the most weight – I needed an authoritative analysis of peer-reviewed studies. I therefore asked Professor Bosworth, Reader in Criminology and Fellow of St Cross College, Oxford, and Professor of Criminology at Monash University, Melbourne, if she would assess the literature on my behalf.

8.8 The terms for Professor Bosworth's review were as follows:

> "To provide a literature review, within the UK and internationally, of reputable academic work, in any field including clinical studies, that may provide insight into the impact on mental health of immigration detention, identifying gender and vulnerability where possible. Could attention be drawn to any evidence of whether detainees' compliance or non-compliance is a variable in any studies.[113] It would also be helpful to distinguish between the fact of detention, the length of detention, and the indeterminacy of detention as potentially independent factors, and whether there are individual detainee characteristics (for example, age, gender, immigration history and status) associated with higher risk."

8.9 I have appended Professor Bosworth's review as Appendix 5. I regard it as a study of the greatest significance. Here I identify the key findings and, in the parentheses, the conclusions I draw therefrom:

- There is a consistent finding from all the studies carried out across the globe and from different academic viewpoints that immigration detention has a negative impact upon detainees' mental health. (This fact alone has clear ethical and practical consequences.)

- The impact on mental health increases the longer detention continues. (This finding too has evident moral and policy implications.)

- The three most consistently identified forms of mental disorder related to immigration detention are depression, anxiety and Post Traumatic Stress

[113] This clause was inserted at the request of the Home Office.

Disorder. (I should add, however, that in the course of this review I also encountered some detainees with severe psychotic illnesses.)

- In addition to length of detention, the causes of mental deterioration resulting from detention include pre-existing trauma, including torture and sexual violence. (The fact that sexual violence is associated with an increased risk of mental illness in detention has influenced the recommendation I have made in this review regarding victims of rape and other sexual attacks.)

- Asylum-seekers and children are particularly vulnerable to adverse mental health outcomes in detention, as are victims of torture. Much research also identifies women as a vulnerable group.

- There is no academic work that has considered the relationship between detainees' compliance or non-compliance on their mental health. (Intuitively, I doubt that there is such a relationship, but if this is a matter of particular concern to the Home Office it should consider commissioning its own research on the issue.)

- The impact of the negative effect of detention endures long after a person is released. (This finding is consistent with what I learned on meeting former detainees during the review.)

- There is growing evidence that staff who work in immigration detention may also suffer a negative impact on their mental health and wellbeing.

- Immigration detention has been subject to too little research, and this situation should be remedied. (I share this view, which chimes with what I say elsewhere in this report about the need for the Home Office to embrace a greater spirit of openness more generally. I note in particular Professor Bosworth's finding that no clinical research has concentrated upon women in detention.)

8.10 Professor Bosworth concludes as follows:

> "Simply put, the literature shows that immigration detention injures the mental health of a range of vulnerable populations. While there is room for more research to help improve models of care and to identify risk populations, such findings are very concerning and raise urgent policy questions …"

8.11 I need hardly say more, save to make the following recommendation.

Recommendation 54: The Home Office should draw up a research strategy for immigration detention. In particular, it should consider commissioning clinical studies on the impact of detention upon women, and research aimed at improving models of care.

PART 9: MENTAL HEALTH SERVICES

9.1 Aside from my own examination of the matter, I have now presented two very distinguished analyses that draw attention to the mental health implications of detention: one that considers international evidence on the effects of detention on mental wellbeing, and one that indicates systemic failings in the provision of care in this country.

9.2 In her literature review, Professor Bosworth "consistently finds evidence of a negative impact of detention on the mental health of detainees". In his assessment of cases where a breach of Article 3 has been found, Mr Jeremy Johnson QC concludes: "The nature and pattern of findings are such that they are more likely to be a reflection of a systemic problem (i.e. insufficient medical – particularly psychiatric – provision) rather than individual failings."

9.3 I have therefore considered if there are ways in which mental health care can be enhanced. In doing so, I am aware that some of those who submitted evidence would argue that the very conditions of detention are such that no therapeutic environment can be created in which proper treatment can be delivered. I understand and respect that view, but it leads unhappily to the conclusion that no attempt at improvement or change is worthwhile. This is not a logic that I believe best serves the interests of detainees' welfare.

9.4 That said, the starting point is very far from satisfactory. In their separate submissions to this review, Mind and the Royal College of Psychiatrists both argued that there is no equivalence between the services provided in IRCs and those available in the community.

9.5 As the Tavistock Institute study concluded:

> "Although all immigration removal centres have 24 hour healthcare cover, it is not possible to provide the full range of services to treat mental health conditions that would be available to patients in hospital or in the community."[114]

9.6 The Institute noted, amongst other things:

> "Psychological talking therapies are scarce in the IRCs."[115]

9.7 I found that the variation that applies to healthcare services generally between IRCs (hours of access to healthcare, services available, and whether

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[114] *Review of Mental Health Issues in Immigration Removal Centres*, op.cit.

[115] I note also this comment: "IRCs have two main priorities: firstly, helping to effect the speedy removal of those who are in the country illegally; and, secondly, ensuring the welfare of individuals while in detention. The needs of these two priorities and the Home Office structures in place to deliver them both can lead to internal organisational conflict which leads it being less effective and efficient at both." The Government accepted, in whole or in part, all of the Tavistock Institute's recommendations (*Home Office Response to: Tavistock Institute's Review of Mental Health Issues in Immigration Removal Centres*, February 2015).

these services are on site) applies with equal force to the provision of mental healthcare support.

9.8 The healthcare team at The Verne, for example, reported that they had on site psychiatric services (shared between the Prison Service sites that they were contracted to cover). Other IRCs reported that they had to bring in psychiatric services, which could delay decision making in the event that a detainee needed to be moved to a psychiatric hospital.

9.9 Most centres reported having RMNs as part of their healthcare team, but this was not the case everywhere.

Demand for mental health services

9.10 The sensible starting point would be an assessment of mental health need. However, the data I have been given does not command confidence.

9.11 For example, I asked the Home Office for statistics on the number of detainees who are on medication for mental health issues in each IRC and STHF, and the number of detainees who are currently receiving other mental health treatment.

9.12 The information I received is set out in the table that follows. I am told it is a collation of a number of snapshots taken on a day in June or July 2015 for those IRCs that responded to the request.

	No. on medication	No. receiving other treatment	Total
Dungavel	11	20	31
Pennine House	0	0	0
Brook House	15	35	50
Tinsley House	5	12	17
Dover	12	27	39
Harmondsworth	95	5*	100
Colnbrook	40	5*	45
Total	178	104	282

*approximations

9.13 I do not regard this information as anything more than indicative, and I am surprised that the numbers are as low as they are (it is also disappointing that there was no response from Yarl's Wood). The Health and Wellbeing Needs Assessment Programme surveyed detainees as part of their fact finding. Its report shows that more than one third of detainees reported having asked for help at the IRC because they felt unhappy, stressed or worried. Twenty per cent reported having seen a doctor at the IRC about an emotional or mental health

problem. A quarter reported having seen a nurse.[116] I had also learned on my visits to IRCs of the high levels of anti-depressant and anxiolytic medications that were being prescribed.

9.14 I was also told that Home Office statistics show that 23 people were sectioned under the Mental Health Act in the period from April 2014 to March 2015. Again, from my own observations I do not believe that this captures the degree of serious psychotic illness that exists.

Recommendation 55: The Home Office and NHS England should conduct a clinical assessment of the level and nature of mental health concerns in the immigration detention estate.

Care suites

9.15 I accept that the care of those who are most vulnerable in conditions of detention is unlikely ever to equate with best practice in the community. However, as I have emphasised, vulnerability is not a static condition, and to do nothing to remedy current gaps in provision is a counsel of despair. There is a moral imperative to ensure that IRCs are offering the best support possible pending transfer or removal. I was therefore disappointed to find that those detainees who are suffering the most acute psychotic episodes could on occasions find themselves held in segregation conditions, devoid of comfort and personal attention.

9.16 The segregation facilities I have observed are not suitable for any detainee with a serious mental health condition.

9.17 More generally, those detainees perceived as at an immediate risk of suicide or self harm can be subject to one-to-one observations: sometimes in their own room (which can present serious inconvenience for their room-mates) or sometimes in rule 40 or rule 42 (segregated) accommodation.

9.18 Nowhere did I find what in other locations are frequently termed 'care suites'; that is, specially designed, decorated and furnished rooms in which those who are undergoing the most severe stress can be offered personalised support. The absence of such facilities should be remedied as soon as possible. (I am told that a care suite opened at Yarl's Wood in June 2015. I have not seen it, and thus cannot vouch for the quality of the accommodation or the purposes to which it is put.)

Recommendation 56: I recommend that the creation of care suites across the IRC estate should be taken forward as a priority.

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[116] *Health and Wellbeing Needs Assessment Programme Immigration Removal Centres and Residential Short Term Holding Facilities National Summary Report,* August 2014.

Talking therapies

9.19 Talking therapy is a broad term, covering all the psychological treatments that involve a person talking to a therapist about their problems. Although they are normally provided through a set number of face-to-face sessions (six to twelve is the usual number), the NHS also reports using online, phone and email counselling services.

9.20 The provision of talking therapies in IRCs varies significantly, with availability seemingly determined by what has historically been provided rather than by current clinical need. I identified the following services:

- **Dungavel** – provided a part time counsellor and qualified art therapist who was on site at the time of my visit. She reported a mixed client base, with some people reporting new issues, while others were referred by the doctor with pre-existing concerns.

- **Harmondsworth** – the on site team reported that a number of specialists were available, including two psychiatrists. Talking therapies were used, especially for coping strategies to improve mental resilience. The team felt they were hampered by the limited space available, especially for group therapies, the introduction of which was planned.

- **Tinsley House** – healthcare staff reported using talking therapies rather than medication for mental health issues, with anyone who had severe symptoms being transferred to Brook House in the first instance.

- **Yarl's Wood** – at the time of my visit, staff reported decreasing availability of counselling services. However, the Home Office has since told me that G4S Medical Services is commissioned to provide a full primary mental health care service, which includes talking therapies.

9.21 There are clearly individuals for whom talking therapies in an IRC environment are not appropriate. A detainee who has been diagnosed with PTSD after suffering torture, for example, will not find the level of support they need within an IRC. However, I believe there are those who would benefit from talking therapies to create resilience and to help deal with symptoms of anxiety.

9.22 The Health and Wellbeing Needs Assessment Programme National Summary Report recommended that: "NHS England may want to establish a minimum service specification for mental health support services in IRCs and STHFs including the provision of culturally sensitive and appropriate counselling." If the Home Office is to avoid creating a system whereby an individual's mental health has to deteriorate in order to warrant treatment, then talking therapies become an important part of the bigger picture.

Recommendation 57: I recommend that talking therapies become an intrinsic part of healthcare provision in immigration detention.

A partnership approach

9.23 The issues raised in relation to mental health are not ones that redound to the Home Office alone. On the contrary. NHS commissioning of health services in IRCs may be in its infancy, but there is a need to ensure from the outset that there is a close partnership between the Home Office and NHS England and the Department for Health based on a shared agenda.

9.24 I list below four further issues that should form part of that shared endeavour.

9.25. First, my observations suggest that the ability of IRCs to arrange speedy transfers of the most ill patients to appropriate psychiatric provision in the community differs markedly from IRC to IRC. This should be the subject of continuing oversight and dialogue between the Home Office and NHS England.

9.26 Second, my visits have also shown that access to RMNs and other specialists like Occupational Therapists is far from consistent, and may not reflect clinical need. NHS England commissioning arrangements focus on outcomes not on inputs. However, access to specialist services should also be the subject of oversight and dialogue between the Home Office and the NHS, informed not least by the findings of this review and the Article 3 and mental health sub-reviews.

9.27 Third, drawing on practice in the Health Service, the Home Office should review the training available to IRC staff and to immigration caseworkers on the causes, symptoms, and care for mental illness.

9.28 Finally, I note that there is a statutory ground for maintaining detention on the basis of mental illness (paragraph 30(2), schedule 2 of the Immigration Act 1971). Doubtless this is well-intentioned, but I believe it to be entirely inappropriate and, should a suitable legislative opportunity be found and with the agreement of the Department for Health, the provision should be repealed.

9.29 I suggest that the best way of taking forward this agenda would be through the development of a joint action plan.

Recommendation 58: I recommend that the Home Office, NHS England, and the Department for Health develop a joint action plan to improve the provision of mental health services for those in immigration detention.

PART 10: CASEWORKING

Detention decision making

10.1 A European Commission study (*The use of detention and alternatives to detention in the context of immigration policies, European Migration Network: Synthesis report for the EMN Focused Study 2014*), albeit based on incomplete information for many countries, has this to say on the relative effectiveness of detention and alternatives to detention:

> "Overall, the statistics that have been gathered for the purpose of this study suggest that:
>
> - The impact of detention and alternatives to detention on the ability of (Member) States to reach and execute prompt and fair return decisions may be rather insignificant (with other factors, e.g. whether the person to be returned is in possession of the required travel document, playing a much greater role);
> - Placing persons in an alternative to detention is less costly than placing them in a detention centre, although direct evidence is limited and not available in all Member States;
> - The fundamental rights of persons in detention are at greater risk than they are for persons placed in alternatives to detention; and
> - The risk of absconding could be greater in the case of alternatives to detention, while as a whole this risk is very low or non-existent in the case of detention."

10.2 On the basis of what I have discovered during the course of this review, these judgements seem very fair. The European study noted that alternatives to detention (including reporting obligations, the surrender of travel and identity documents, release on bail, electronic monitoring, provision of a guarantor, and release to care workers or under a care plan) existed in the majority of Member States, but what it termed 'community management programmes' were available in none.

10.3 Given this background, and the importance of immigration decision making to detainees' welfare, I have considered various issues relating to casework and time in detention.

The role of immigration staff and caseworkers

10.4 The Detention Centre Rules require the Home Secretary to provide detainees, on a monthly basis, with written reasons for their continued detention. On request, the Home Secretary is also required to provide detainees with an update on the progress of their immigration claim. The Operating Standards manual provides guidance for detention centre staff on liaising between detainees and outside immigration caseworkers on these matters. Detention Service Order 07/2013 (which is concerned with the provision of welfare support) refers to welfare officers facilitating contact between detainees

and immigration staff. Paragraph 55.8 of the EIG advises Home Office staff on the management of monthly detention reviews.

10.5 What I was told about actual casework practice may have presented a very partial picture of reality, but it did not reflect well. At Yarl's Wood, managers told me that a "culture of disbelief" stemmed from the DFT process. At Dungavel, managers confirmed that inconsistency in caseworker decision making was a problem, and they had examples of decisions that had interrupted continuity of healthcare. The detainees I spoke to at Harmondsworth told me that the 'reason for refusal letters' they received from the Home Office were all the same – it felt as if the decisions had been made in advance. Some detainees claimed they were not regularly receiving reports of their monthly reviews. One told me that he had been given a notice of deportation even though his judicial review was pending. His perception was that this had been done deliberately to intimidate him.

10.6 During my visit to Tinsley House, the Gatwick Befrienders organisation suggested that caseworkers cut and pasted the information that went into monthly detention reviews. The chair of the Colnbrook IMB likewise argued that the quality of monthly review reports was very low. He said that some caseworking decisions seemed extraordinary and that, in all cases, the paperwork was poor. The same statements were made month after month. When detainees requested information they rarely received responses. The whole process led to helplessness and was dehumanising. Again, I was told that caseworkers' letters appeared to rely on standard passages that were copied from one letter to the next without regard for circumstances.

10.7 The chair of Brook House IMB said that caseworking staff were seen as absent (as indeed they are). Local immigration staff were "piggy in the middle" between detainees and caseworkers.[117] Brook House detainees alleged that immigration staff did not listen to them and treated them with disrespect and rudeness. Caseworkers were preoccupied with removal. Once more, the detainees said that letters from the Home Office showed signs of having been cut and pasted. Detainees were not confident that the Home Office properly considered individual cases, in terms of both the immigration claim and the monthly review.

10.8 The private sector providers told me they thought the decision making process lacked energy. Although the caseworking function was a quasi-judiciary one, carried out on behalf of the Secretary of State, they argued that the private sector could do much of the work. (I understand that Capita previously supplied some caseworking services to the National Removals Command, but the NRC has recently brought the services back in-house and the contract has been terminated by mutual consent.)

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[117] My impression is that local immigration management is far stronger, both in its personnel and its procedures, than was the case a decade ago. Oversight of the IRC contractors has also developed markedly in recent years.

10.9 Other witnesses said that the level at which decisions to detain were taken was too junior (and contrasted with the level of seniority required of any decision to release). There was also a disconnection between immigration caseworkers and those upon whom they made their decisions. There was insufficient engagement with detainees – if a caseworker had to look a detainee in the eye when conveying a decision, they would be more likely to see the human side of the case.

10.10 The interest groups were equally critical. Medical Justice argued that: "numerous court cases have demonstrated that 'monthly reviews' are often cursory and frequently fail to take into consideration emerging issues, such as deteriorating mental health". ILPA said that detention reviews relied "on the written submissions of the junior officials, which in our experience are often unbalanced and of poor quality".

10.11 It was thus a common theme of the evidence I received that caseworkers are detached from the detainees, that responses to questions from detainees are slow and of variable quality, and that decision letters and monthly detention review reports appear to be impersonal, and "cut and pasted" from previous letters and reports. Detainees felt that they were not given a fair hearing by someone who understood their situation, and who treated them as a real person rather than as an abstract case.

10.12 The fact that Detained Fast Track caseworkers are based on the same sites as the detainees suggests that it is accepted that there are benefits from proximity. I do not know why this connection has diminished in some places, but remains in others – for example, I understand that there is still a level of engagement with detainees in Criminal Casework units in Leeds and Liverpool. Culturally, there may be a reticence on the part of some caseworkers to engage directly with detainees – some may have signed up precisely to operate as desk-bound caseworkers rather than, as they would see it, as immigration officers. Be that as it may, my view is that the welfare of detainees would be better served by a closer engagement between them and those who determine their immigration claim and continued detention.

10.13 It is not surprising that detainees feel 'dehumanised' by the existing process and believe they are treated as a 'case' not a person. I consider that all those making decisions on an immigration claim or completing a monthly detention review should have spoken with the detainee in question at least once. In order of preference, this should either be in person, via a video link or on the telephone.

Recommendation 59: I recommend that all caseworkers should meet detainees on whom they are taking decisions or writing monthly detention reviews at least once. The meeting should be face-to-face, or by video link, or by telephone.

10.14 As noted, the Detention Centre Rules require the Home Office to respond, within a reasonable time, to requests from detainees for information about the

progress of their case. The complaints I have heard suggest that these requests are not always responded to in a timely way and that the quality of responses is variable. I cannot say whether these complaints are representative, and the Home Office caseworking function, no less than other parts of public service, must operate within resource constraints. For those reasons, I make no formal recommendation. However, if they do not operate this way already, the caseworking areas should introduce clear response times and quality standards.

10.15 The issue of the length, quality and contents of decision letters is much bigger than simply the letters received by those who are in detention. However, official letters received in IRCs have both instrumental and symbolic importance. They will be read and re-read, shared and compared with fellow detainees, and presented (as I know from personal experience) to any visitor who appears to be official or in authority. Aside from the actual decision they impart, the letters are seen by those in detention as indicative of the respect or otherwise that the Home Office affords them.

10.16 One particular letter that has been highlighted as of variable quality is the monthly update of progress, produced on a form called an IS151F.

10.17 The process of improving the Home Office's written communications with detainees is one to which I attach a good deal of importance, but I am not persuaded this will be assisted by a formal recommendation from this review.

10.18 As for monthly detention reviews, I have been told that caseworkers do spend a reasonable amount of time on them and that, if there are no substantive changes in a detainee's reports from month to month, this is usually because there have been no substantive changes in the detainee's situation. However, Mr Johnson's analysis of cases in which a breach of Article 3 had been found suggests serious failings in the way in which reviews had been carried out. In the cases reviewed by Mr Johnson, he identified the following features suggesting that there were serious problems with detention reviews, especially regarding detainees with mental illness:

- the number of cases in which the reviews were flawed
- the number of flawed reviews in each of those cases
- the time period over which the flaws were sustained
- the similarity in flaws between the different cases
- the fact that senior officers had been involved in some of the flawed reviews; and
- the Home Office's preparedness to defend the flawed reviews.

10.19 In line with Mr Johnson's suggestions, I would like the Home Office to examine its processes for carrying out these reviews, including looking at training needs, arrangements for having cases signed off by senior officers, the different levels of authority required within different case working units, and dip sampling or auditing of cases on a regular and sustained basis. I note that the NRC has an internal process for peer-reviewing detention decisions for those

who have been in detention the longest. I consider the NRC approach to be good practice, and I commend it to the other casework teams in the Home Office.

Recommendation 60: The Home Office should examine its processes for carrying out detention reviews, including looking at training requirements, arrangements for signing off cases at a senior level, and auditing arrangements.

10.20 A more radical option is for a decision making process either wholly independent of the Home Office, or including an independent element. Such a system would more closely mirror other arrangements such as parole reviews or mental health reviews. I have not sought evidence on this matter in a structured way, and I must be careful not to go further than the remit given to me for this report. However, the principle of independent involvement is one that I find attractive.

Recommendation 61: As part of the examination of its own processes that I have proposed, I recommend that the Home Office consider if and what ways an independent element can be introduced into detention decision making.

10.21 I am of course aware that, parallel with the system of Home Office case reviews, a detainee can apply for bail to an independent immigration tribunal. Some of the evidence I received from stakeholders was to the effect that the current bail process is not sufficiently robust, with immigration judges relying too heavily on Home Office evidence to make their decisions.[118] I observe that these concerns may merit close scrutiny, but I have judged that they do not come within my terms of reference.

10.22 Bail applications are restricted by statute to one every 28 days where there has not been a material change in circumstances since a previous, unsuccessful bail application (applications may still be made in such circumstances but must be decided by the Tribunal on the papers), and this does not strike me as unreasonable. However, I am also conscious that some detainees may not be able to exercise that right. In an oral hearing on July 17 2014, the director of Detention Action, Mr Jerome Phelps, told Ms Teather and her colleagues on the Joint Inquiry by the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration:

> "… for most vulnerable people, it's not a right that's accessible, if you're lying on your bed in full psychological collapse you're not in a position to even instruct a solicitor, let alone make a bail application [or] argue why you should be released."

10.23 As well as a 28 day time limit on detention, the Joint Inquiry subsequently proposed a robust system for reviewing decisions to detain: "This system might take, for example, the form of automatic bail hearings, a statutory presumption

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[118] See, for example, *Immigration Bail Hearings: A Travesty of Justice? Observations from the Public Gallery*, 2011 and *Still a Travesty: Justice in Immigration Bail Hearings*, second report from the Bail Observation Project, 2013.

that detention is to be used exceptionally and for the shortest possible time, or judicial oversight, either in person or on papers."[119]

10.24 In a long, thoughtful and very helpful submission, ILPA noted that in respect of the detention of children and families the Independent Family Returns Panel oversaw the decisions. ILPA told me that they had long advocated automatic bail hearings for immigration detainees, and that: "There should be a judicial process for deciding on the detention of the mentally ill at which the detainee has the right to be represented and heard." ILPA argued: "The impact of the lack of automatic judicial scrutiny, alongside an absence of time limits on immigration detention, is that detention in the UK does not conform to international standards."

10.25 In its further submission to this review, the Mental Health and Immigration Detention Working Group said of the cases in which a breach of Article 3 was found:

> "It is notable that in each of the six cases the detainee was so ill that they lacked mental capacity (to give instructions in a legal case) for some or all of the period during their detention. We would ask that the review considers making specific recommendations about those who lack mental capacity and are in detention …"

10.26 Like the Joint Inquiry, I observe that there are many ways (with or without a formal time limit) that the current system of detention reviews could be strengthened. For example, bail hearings could be automatic at the 28 day stage, or after three or four months. I am less concerned about the means and more about the outcome: that those who are most vulnerable should not languish in detention because they lack the capacity to make a bail application.

Recommendation 62: I recommend that the Home Office give further consideration to ways of strengthening the legal safeguards against excessive length of detention.

Alternatives to detention

10.27 Alternatives to detention are available already under existing powers. Such alternatives include:

- electronic monitoring
- residence restrictions
- reporting restrictions
- employment restrictions
- bail surety
- community-based support.

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[119] *The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom*, op.cit.

10.28 This final section of my report looks briefly at the possibility of making wider use of these alternatives.

10.29 I am influenced by this finding on behalf of the UN High Commissioner for Refugees:

> "Pragmatically, no empirical evidence is available to give credence to the assumption that the threat of being detained deters irregular migration, or more specifically, discourages persons from seeking asylum. Global migration statistics have been rising regardless of increasingly harsh governmental policies on detention. Except in specific individual cases, detention is largely an extremely blunt instrument to counter irregular migration, not least owing to the heterogeneous character of migration flows. Critically, threats to life or freedom in an individual's country of origin are likely to be a greater push factor for a refugee than any disincentive created by detention policies in countries of transit or destination. More particularly, this research found that less than 10 per cent of asylum applicants abscond when released to proper supervision and facilities (or in other words, up to 90 per cent comply with the conditions of their release). Moreover, alternatives are a significantly cheaper option than detention both in the short and longer term."[120]

10.30 The Home Office's policy on alternatives to detention is set out in chapter 56 (home leave and reporting restrictions) of the EIG, chapter 57 (bail) of the EIG, and in a separate piece of Immigration Enforcement guidance entitled 'Electronic Monitoring Policy'.

10.31 The primary available alternative to detention involves the granting of bail with conditions – which could include, for example, electronic monitoring and/or residence or reporting restrictions. At present, however, electronic monitoring and other alternatives are usually enacted only when a court orders them to be used.

10.32 It has been explained that the Home Office's position is that electronic monitoring is not an alternative to detention but "an enhanced contact mechanism for individuals who present a need for closer monitoring than can be provided through reporting alone but who may not need to be detained. Extension of electronic monitoring would not be appropriate to individuals whose risk assessment indicates that, even with enhanced contact management, their compliance with the Home Office will not be improved."[121] If I may be forgiven for saying so, this strikes me as a somewhat limited view to take. Most of those currently in detention do not represent a serious (or any) risk to the public, and many represent a very low risk of non-compliance because of their strong domestic links to the UK.

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[120] UNHCR, legal and protection policy research series, *Back to Basics: The Right to Liberty and Security of Person and 'Alternatives to Detention' of Refugees, Asylum-Seekers, Stateless Persons and Other Migrants*, April 2011. [redacted]

[121] Correspondence between James Brokenshire MP, Minister of State, and Sarah Teather MP, 26 January 2015.

10.33 This is not to say that everyone currently in detention is either suitable for, or in need of, electronic monitoring were they released back into the community. Models of intensive support and case management to help detainees and to meet the Government's concerns about reoffending and absconding are not dependent upon the use of tagging.

10.34 I do not consider that any of these to be either/or options. I am interested in the approach taken in the National Removals Command, for example, where significant effort has been put into promoting voluntary return. Ideally, voluntary returns options should be exhausted, and a community-based approach attempted, before detention is considered.

10.35 There is already an element of community monitoring in place insofar as individuals who are not detained are required to report, on a regular basis, to immigration reporting centres. A more comprehensive process would perhaps involve a combination of residence and reporting restrictions, community support, the pursuance of voluntary return options, and sureties. I see no reason why electronic monitoring could not also play a part in this approach.

10.36 I think the Home Office should demonstrate much greater energy in its consideration of alternatives to detention. I hope that this report will act as a spur to that effect.

Recommendation 63: I recommend that the Home Office investigate the development of alternatives to detention.

Recommendation 64: I recommend that the Home Office consider how far electronic monitoring can contribute to the goal of fair and efficient border control.

PART 11: CONCLUSIONS

11.1 Although I have tried to avoid being unduly prescriptive in the form of my recommendations in this report, I am aware that some of them are challenging nonetheless. I am also aware that many are not new. Most of those who have looked dispassionately at immigration detention have come to similar conclusions: there is too much detention; detention is not a particularly effective means of ensuring that those with no right to remain do in fact leave the UK; and many practices and processes associated with detention are in urgent need of reform.[122]

11.2 My brief has been to approach these matters from the perspective of the welfare of the vulnerable. I have identified shortcomings in both the identification of vulnerability and in the policies designed to maintain wellbeing. However, I have also drawn attention to some aspects of detention practice that are done well: the respect shown for religious observance, the network of 'cultural kitchens', Campsfield House's pioneering of an intelligence-led approach to searching, to give three examples.

11.3 Healthcare has proved to be central to my work. I have been pleased to see the benefits already following from the introduction of NHS commissioning, and many more will surely come through in years to come. That said, much of my report constitutes an agenda no less for the Department of Health and NHS England as for the Home Office.

11.4 Perhaps my most important contribution, therefore, will be in bringing to the attention of all parties the findings from Professor Bosworth's literature review linking detention to adverse mental health outcomes. In short, her essay demonstrates incontrovertibly that detention in and of itself undermines welfare and contributes to vulnerability. I need hardly say that a policy resulting in such outcomes will only be ethical if everything is done to mitigate the impact, and if countervailing benefits of the policy can be shown. My proposals to extend the list of those presumed unsuitable for detention on account of their vulnerability should be read in that light.

11.5 Alongside my more detailed proposals, I have concluded that the detention estate as a whole should develop a more distinct identity, and adopt policies and practices better designed for its particular needs. There will always be things to learn from colleagues in NOMS (and I have identified some in this report), since

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[122] For example, the Joint Inquiry chaired by Ms Teather also recommended, *inter alia*:

- Enabling detainees' access to social media (which they reported was successful in Sweden)
- Inter-IRC moves only when "absolutely necessary"
- Victims of rape and sexual violence to be added to the list of those who should not be detained
- Better healthcare screening "when detainees are well rested and in private"
- More training for IRC staff to identify victims of trafficking.

all closed institutions exhibit common features. But immigration detention needs to move out of the shadow cast by the Prison Service. I have suggested that there should be an overall strategic plan to address the future size of the estate, its location, and the purposes to be served. Assuming there is merit in this proposal, I hope that work can start as quickly as possible.

11.6 I have also called for greater openness as part of that distinct identity, not least so that there is a wider public understanding of the role the IRCs play. For example, I suspect there is little appreciation of the fact that roughly one-in-three detainees is an ex-prisoner, or of the difficulties the Home Office encounters in persuading foreign states to accept the return of those whose nationality is in doubt and who decline to assist in the process.

11.7 Nor do I underestimate the difficult balance facing all liberal democracies in the maintenance of firm immigration control while acknowledging international obligations and the welfare needs of vulnerable people, some of whom have escaped war and oppression elsewhere in the globe. Public opinion is itself sometimes conflicted: there is ample evidence both of a desire to reduce the overall volume of immigration and of broadly-based campaigns in support of the right of particular groups and individuals to enter or remain in this country.

11.8 In my view, a smaller, more focused, strategically planned immigration detention estate, subject to the many reforms I have outlined in this report, would both be more protective of the welfare of vulnerable people and deliver better value for the taxpayer. Immigration detention has increased, is increasing, and – whether by better screening, more effective reviews, or formal time limit – it ought to be reduced.

LIST OF RECOMMENDATIONS

Recommendation 1: I recommend that the Home Office prepare and publish a strategic plan for immigration detention.

Recommendation 2: The Home Office should consider how far it can encourage a more cohesive system through more joint training and planning, shared communications, and a recognition scheme.

Recommendation 3: Where weaknesses in particular policies have been identified in Mr Cheeseman's audit, I recommend these be remedied at their next iteration.

Recommendation 4: I recommend that work to amend the Detention Centre Rules commence following the Home Office's consideration of this review.

Recommendation 5: I recommend that the Home Office draw up plans either to close Cedars or to change its use as a matter of urgency.

Recommendation 6: Given my observations at each of the Heathrow terminals and at Cayley House, Tascor should arrange for refresher training for its staff on their duty of care, and the need for proper and meaningful engagement with detainees.

Recommendation 7: I recommend that a discussion draft of the short term holding centre rules be published as a matter of urgency.

Recommendation 8: The Home Office should review the adequacy of the numbers of immigration staff embedded in all prisons.

Recommendation 9: I recommend that there should be a presumption against detention for victims of rape and other sexual or gender-based violence. (For the avoidance of doubt, I include victims of FGM as coming within this definition.)

Recommendation 10: I recommend that the Home Office amend its guidance so that the presumptive exclusion from detention for pregnant women is replaced with an absolute exclusion.

Recommendation 11: I recommend that the words 'which cannot be satisfactorily managed in detention' are removed from the section of the EIG that covers those suffering from serious mental illness.

Recommendation 12: I recommend that those with a diagnosis of Post Traumatic Stress Disorder should be presumed unsuitable for detention.

Recommendation 13: I recommend that people with Learning Difficulties should be presumed unsuitable for detention.

Recommendation 14: I recommend that transsexual people should be presumed unsuitable for detention.

Recommendation 15: I recommend that the wording in paragraph 55.10 of the EIG in respect of elderly people be tightened to include a specific upper age limit.

Recommendation 16: I recommend that a further clause should be added to the list in paragraph 55.10 of the EIG to reflect the dynamic nature of vulnerability and thus encompass 'persons otherwise identified as being sufficiently vulnerable that their continued detention would be injurious to their welfare'.

Recommendation 17: I recommend that the Home Office consider establishing a joint policy with NOMS on provision for those held in prison under immigration powers.

Recommendation 18: I recommend that the Home Office consider what learning there is for IRCs from the Prison Service's experience of operating 'first night centres' for those initially received into custody.

Recommendation 19: The Home Office should consider the need for a separate DSO on LGBI detainees. Anti-bullying policies should include explicit reference to LGBTI detainees.

Recommendation 20: The Home Office should consider introducing a single gatekeeper for detention.

Recommendation 21: I recommend that the Home Office immediately consider an alternative to the current rule 35 mechanism. This should include whether doctors independent of the IRC system (for example, Forensic Medical Examiners) would be more appropriate to conduct the assessments as well as the training implications.

Recommendation 22: I further recommend that rule 35 (or its replacement) should apply to those detainees held in prisons as well as those in IRCs.

Recommendation 23: Once the NOMS review of ACCT is complete, there should be an urgent review of ACDT and DSO 06/2008, informed by the NOMS review and by the findings of this report.

Recommendation 24: I note that DSO 03/2013 on food and fluid refusal is currently the subject of internal review within the Home Office. I recommend that the review consider alternatives to treatment within a prison or IRC in light of my discussion of this issue.

Recommendation 25: I recommend that the Home Office commission a formal review of the quality of PERs and that any deficiencies are addressed. In the meantime, all staff should be reminded of the importance of completing PERs fully.

Recommendation 26: I recommend that the Home Office consider how rapidly it can move towards a system of electronic record keeping for the PER and IS91RA.

Recommendation27: I recommend that the Home Office conduct an annual audit (or ask for an independent audit) of the RSRA process so that it remains an effective means of ensuring detainee safety.

Recommendation 28: The Home Office should consider if the allocation criteria and processes to which DEPMU operates could be strengthened.

Recommendation 29: I recommend that the Home Office and the Department of Health work together to consider whether current arrangements for safeguarding are adequate.

Recommendation 30: The internet access policy should be reviewed with a view to increasing access to sites that enable detainees to pursue and support their immigration claim, to prepare for their return home, and which enable them to maximise contact with their families. This should include access to Skype and to social media sites like Facebook.

Recommendation 31: I recommend that the Home Office reconsider its approach to pay rates for detainees in light of my comments on the benefits of allowing contractors greater flexibility.

Recommendation 32: I recommend that all IRCs should review the range of activities offered to detainees; in particular, those that could provide skills to detainees that would be useful on their return to their home country.

Recommendation 33: I recommend that the Home Office review detainees' access to natural light and to the open air, and invite contractors to bring forward proposals to increase the time that detainees can spend outside.

Recommendation 34: The Home Office should no longer require contractors to operate an Incentives and Earned Privileges Scheme.

Recommendation 35: I recommend that the service provider at Yarl's Wood should only conduct searches of women and of women's rooms in the presence of men in the most extreme and pressing circumstances, and that there should be monitoring and reporting of these cases.

Recommendation 36: I recommend that Home Office Detention Operations carry out an audit of reception and holding environments to ensure that the policy on searching out of sight of other people is properly followed.

Recommendation 37: I recommend that the Home Office consider amalgamating and modernising rules 40 and 42.

Recommendation 38: The Home Office should review all the rule 40 and rule 42 accommodation to ensure that it is fit for purpose. All contractors should be asked for improvement plans to ensure that the name Care and Separation Unit is something more than a euphemism.

Recommendation 39: I recommend that the Home Office should routinely publish statistics on the number of transfers of detainees between IRCs and STHFs.

Recommendation 40: The Home Office should review the use made of regional airports for removals.

Recommendation 41: I recommend that the Home Office negotiate night-time closures at each IRC, the times of which should reflect local circumstances.

Recommendation 42: I recommend that the practice of overbooking charter flights should cease.

Recommendation 43: I recommend that the Home Office consider if the inspection arrangements for IRCs can ensure the involvement of the ICI.

Recommendation 44: I recommend that the Home Office liaise with the Ministry of Justice to ensure that all IMBs in IRCs have sufficient membership at all times.

Recommendation 45: I recommend that the Home Office seek the views of the Ministry of Justice and the Department of Health on extending section 75 of the Sexual Offences Act 2003 to IRCs, prisons and mental hospitals.

Recommendation 46: I recommend that the Home Office review the use of fellow detainees as interpreters for induction interviews.

Recommendation 47: I recommend that the Home Office remind service providers of the need to use professional interpreting facilities whenever language barriers are identified on reception.

Recommendation 48: Home Office staff should be reminded that, to ensure continuity of care, detainees should not be transferred when there is clinical advice to the contrary.

Recommendation 49: The Home Office and NHS England should promote the self-administration of drugs where risk assessments support that approach.

Recommendation 50: I recommend that the Home Office, in consultation with NHS England, draw up explicit guidelines as to:

- **What informed consent looks like**
- **What information can be shared between all parties in the event that informed consent to the release of clinical information is granted by the detainee.**

Recommendation 51: I further recommend that an alternative to SystmOne be pursued for those detention facilities not in England.

Recommendation 52: As part of its response to future growth in the demand for healthcare, NHS England needs to ensure the filling of permanent healthcare vacancies in IRCs as a priority.

Recommendation 53: I recommend that the Home Office, in association with service providers, consider what can be done to reduce the use of new psychoactive substances and to advise detainees on the effects of their misuse.

Recommendation 54: The Home Office should draw up a research strategy for immigration detention. In particular, it should consider commissioning clinical studies on the impact of detention upon women, and research aimed at improving models of care.

Recommendation 55: The Home Office and NHS England should conduct a clinical assessment of the level and nature of mental health concerns in the immigration detention estate.

Recommendation 56: I recommend that the creation of care suites across the IRC estate should be taken forward as a priority.

Recommendation 57: I recommend that talking therapies become an intrinsic part of healthcare provision in immigration detention.

Recommendation 58: I recommend that the Home Office, NHS England, and the Department for Health develop a joint action plan to improve the provision of mental health services for those in immigration detention.

Recommendation 59: I recommend that all caseworkers should meet detainees on whom they are taking decisions or writing monthly detention reviews at least once. The meeting should be face-to-face, or by video link, or by telephone.

Recommendation 60: The Home Office should examine its processes for carrying out detention reviews, including looking at training requirements, arrangements for signing off cases at a senior level, and auditing arrangements.

Recommendation 61: As part of the examination of its own processes that I have proposed, I recommend that the Home Office consider if and what ways an independent element can be introduced into detention decision making.

Recommendation 62: I recommend that the Home Office give further consideration to ways of strengthening the legal safeguards against excessive length of detention.

Recommendation 63: I recommend that the Home Office investigate the development of alternatives to detention.

Recommendation 64: I recommend that the Home Office consider how far electronic monitoring can contribute to the goal of fair and efficient border control.

Appendices

Appendix 1: Terms of reference

Appendix 2: Text of letter from Lord Bates to Stephen Shaw, 2 April 2015

Appendix 3: Independent review of welfare in immigration detention: Review of relevant policy, by Ian Cheeseman, Home Office

Appendix 4: Assessment of cases where a breach of Article 3 of the European Convention of Human Rights has been found in respect of vulnerable immigration detainees, by Jeremy Johnson QC, 5 Essex Court

Appendix 5: The impact of immigration detention on mental health: A literature review, by Mary Bosworth, PhD, Professor of Criminology, Centre for Criminology, University of Oxford

Appendix 6: Report of all night observation at Yarl's Wood IRC from 22.30 on 31 March 2015 to 04.30 on 1 April 2015

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Appendix 9: Glossary of abbreviations and acronyms used in the report

Appendix 1: Terms of Reference for a review into the welfare in detention of vulnerable persons

The Home Office detains migrants, including foreign national offenders, to prevent their unauthorised entry to the UK and prior to removing them from the UK. In Detained Fast Track, asylum applicants may be detained pending a quick initial decision, and where policy permits, through to final appeal and, if unsuccessful, for removal. Detention is necessary in the interests of immigration control and the principle is not in question. However, it is vital that persons in detention are safeguarded, especially those who may be particularly vulnerable.

The Home Office wishes to review the appropriateness of its policies and practices concerning the welfare of those who have been placed in detention, whether in an immigration removal centre or a short-term holding facility*, and those being escorted in the UK.

The review will consider the appropriateness of current policies and systems designed to:
(a) identify vulnerability and appropriate action;
(b) provide welfare support;
(c) prevent self-harm and self-inflicted death;
(d) manage food and fluid refusal safely without rewarding non-compliance;
(e) assess risk effectively;
(f) transmit accurate information about detainees from arrest to removal;
(g) safeguard adults and children;
(h) manage the mental and physical health of detainees;
(i) other matters the review considers appropriate.

The review may also comment on how policies are being applied as well as their appropriateness. But the review shall focus on policies applying to those in detention, not the decision to detain.

The review may make specific recommendations for change. These shall take into consideration the need to maintain a strong immigration control and also to make exceptions where issues of public protection are involved, balanced with the welfare aspects. It should decide which detainees are to be considered vulnerable. These may include but need not be limited to pregnant women, victims of trafficking and those with mental health or disability issues.

The review should aim to report within six months of its agreed start date. Ministers will publish the report by laying it before Parliament as soon as reasonably practicable, with a response to the recommendations.

Areas of external expertise

This should include consultation with additional experts and interested parties, including other Government departments, HM Chief Inspector of Prisons, Prisons and Probation Ombudsman and the President of the Independent Monitoring Boards.

* This will exclude Border Force custody suites but would include port holding rooms for immigration detainees.

Appendix 2: Text of letter from Lord Bates to Stephen Shaw, 2 April 2015

Independent Review into the welfare in detention of vulnerable persons

As the Independent Reviewer of welfare in detention, and set out in the terms of reference, you have been asked to consider Home Office policies and operating procedures that have an impact on detainee welfare.

During the debate on Thursday 26 March on the report of the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration, there was general agreement that it would be helpful if as well as looking at vulnerable persons in general, you were able to look in particular at the issues of pregnancy, disability and victims of rape or sexual violence.

The Hansard transcript of the debate can be found on the Parliament website using the following link:
www.publications.parliament.uk/pa/ld201415/ldhansrd/text/150326-0001.htm#15032625000605

With sincere thanks

Lord Bates

Appendix 3: The Home Office Policy Sub-Review

INDEPENDENT REVIEW OF WELFARE IN IMMIGRATION DETENTION: Review of relevant policy by Ian Cheeseman, Home Office

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Conclusions

Introduction

This document constitutes a review of the current (as at August 2015) Home Office policies relating to the detention of individuals for the purposes of immigration control. The purpose of this policy review is to assess how far the current suite of policy documents reflects the current policy intentions and, in making this assessment, to inform Mr Shaw's independent review of welfare in immigration detention. This review looks at Home Office policy documents only, but in the knowledge that local policies, consistent with the Home Office policies but often innovative, are sometimes put in place by local contractors. For example, I was advised that the contractors at Harmondsworth are planning to put in place an "ACDT-lite" (Assessment, Care in Detention and Teamwork) process for those who may be at risk but who do not need the full ACDT process.

Aim

The aim of the policy review is to establish whether the relevant policies are:

- up to date;
- comprehensible;
- comprehensive; and
- fit for purpose.

Methodology

The methodology I have employed is as follows:

- I obtained a list of relevant policies from Home Office colleagues;
- I brigaded the policies into relevant subject headings (see below);
- I produced a composite document containing the policies relevant to each of those subject headings;
- I drew upon evidence to the main review and other sources and analysed each composite document in line with the aims above;
- I reached a view on the policies relating to each of those subjects and on the whole suite of policies.

Policies

There is a broad hierarchy of policies relating to immigration detention. At the top is the **Immigration Act 1971**, which contains the principal powers of immigration detention. In addition, there is the **Immigration and Asylum Act 1999**, which sets the overarching legislative framework for the management and operation of detention facilities and escorting arrangements.

Subsidiary to the 1999 Act are the **Detention Centre Rules 2001**, which are a statutory instrument provided for by the Act. The Rules set out, in detail, and in statutory form, the way in which individuals should be managed and cared for in immigration detention, and their entitlements and rights. The Rules cover issues

such as the procedure for admissions and discharge, searching detainees, food, accommodation, hygiene and healthcare, as well as security and monitoring. The Rules are used by Home Office staff **and** by those running immigration removal centres (IRCs) and escorting services. Although the Rules refer to "Detention Centres", the Detention Centres were re-named as "Removal Centres" by the Nationality, Immigration and Asylum Act 2002.

The **Detention Services Operating Standards manual for Immigration Service Removal Centres**, published in 2005, builds on the Detention Centre Rules. The manual brings together in one place all of the detention services operating standards introduced between 2002 and its date of publication.

The **Operating Standards for the Detention Services Escort Process** were published in 2006. These standards build on those contained in the Detention Services Operating Standards manual for Immigration Service Removal Centres and their aim is to improve performance and compliance across the escort process.

The manual and operating standards are also used by Home Office staff **and** by those running removal centres and escorting services.

The final level of policy documents is the suite of **Detention Services Orders** (DSOs) (though some are headed "Detention Service Order"). There are twenty-one of these Orders which contain instructions and policy of relevance to the review. The earliest of these documents dates from 2003 (the one related to detainee risk assessment) whilst the most recent dates from 2014 (the one related to risk assessment guidance for contracted escort staff), though some have been reviewed and reissued during the course of 2015. The DSOs are used **principally** by those running removal centres and escorting services but may also be directed at Home Office staff working in those centres or with responsibilities in connection with the escorting services.

The documents described above represent the legislation, rules, instructions and guidance governing the way in which individuals running removal centres and escorting facilities, including external suppliers running services which have been contracted out, should operate. Separate from this hierarchy sit **Enforcement Instructions and Guidance** (EIG). This comprises around 60 chapters of guidance and information for officers dealing with the full range of immigration enforcement matters within the UK. There is a chapter devoted to detention. It is primarily aimed at Home Office staff responsible for decisions to authorise, maintain or end detention and, effectively, amounts to casework instructions. The EIGs are used **only** by the Home Office.

As such, the EIG is, primarily, resources for those making enforcement-related casework decisions in respect of individuals in the immigration process, whereas the Detention Centre Rules, the Operating Standards and the DSOs are, primarily, a resource for service provider staff carrying out day to day management of the immigration detention facilities and of the individuals detained in them.

Chapter 55 of the EIG is of particular interest to this review – and to Non-Governmental organisations – as it, amongst other things, sets out the overall principles and policy, in both general and specific terms, on immigration detention.

Part 1, Section 1 – The Detention Centre Rules 2001

Summary

The Detention Centre Rules 2001 were laid before Parliament on 6 February 2001 and came into force on 2 April 2001. The Rules are secondary legislation, provided for by the Immigration and Asylum Act 1999. The Rules make provision for the regulation and management of removal centres. They are addressed to detention policy makers and to those governing and running removal centres

The Rules are broken down into seven parts, as follows:

- **part I** sets out the title of the Rules, the commencement date and definitions of certain words and phrases;

- **part II** is entitled "DETAINED PERSONS". It explains the purpose of removal centres and sets out their general ethos, which is to provide secure, humane accommodation. It also deals with the admissions and discharge processes, management of detainees' property, searching, detention reviews, the detention of women, families and children, clothing, food, alcohol, accommodation, hygiene, activities, privilege systems, religion, communications (including correspondence and visits), access to legal advice, healthcare and request and complaints procedures;

- **part III** is entitled "MAINTENANCE OF SECURITY AND SAFETY". It sets out the general principles for maintaining security and safety as well as removal from association, use of force, temporary confinement, control and restraint, and drug and alcohol testing;

- **part IV** concerns the conduct of detainee custody officers;

- **part V** concerns security issues related to individuals having access to removal centres;

- **part VI** sets out the rules relating to visiting committees (now known as independent monitoring boards);

- **part VII** allows the delegation of a removal centre manager's powers to another individual.

Are the Rules up to date?

The Rules are a statutory document and any review or subsequent amendments would take place in Parliament and with the approval of Parliament. A minor amendment was made to the Rules in 2005 to reflect the advent of the Immigration Appeals Tribunal but, otherwise, the Rules reflect the agreed Parliamentary position on the way in which removal centres operate. I have been told by Home Office officials working in the Criminality and Enforcement

Unit of the Immigration and Border Policy Directorate that a review of the Rules will take place as soon as resources are available. The Rules are not flawed and there is no imperative for them to be reviewed with haste.

Are the Rules comprehensible?

The Rules are written in standard legal language. As such, they are precisely worded. The Rules are comprehensive and, in many places, very detailed. The Rules will be comprehensible to anyone with a rudimentary understanding of legal language, and the person on the street would probably be able to find their way around them. As the basis of policy and operational practice guidance, the Rules are perfectly sound.

Part 1, Section 2 – The Detention Services Operating Standards manual for Immigration Service Removal Centres

Summary

The **Detention Services Operating Standards manual for Immigration Service Removal Centres**, published in 2005, represents a composite of all of the detention services operating standards introduced between 2002 and its date of publication. The manual is designed to build on the Detention Centre Rules and, as such, covers many of the issues already covered in the rules, but often in more detail. The manual is set out in alphabetical sections, covering:

- access to legal services;
- accommodation;
- activities;
- admissions/discharge;
- arrangements for expenditure;
- case progress;
- catering;
- clothing;
- communications;
- complaints/requests procedure;
- detainees' cash;
- detainees' property;
- disabled detainees;
- families with children;
- female detainees;
- handling a death in detention;
- health care;
- hygiene;
- incentives schemes;
- interpreters/translations;
- personnel: staff training;
- race relations;
- religion;
- removal from association;
- safer removal centres;
- security;
- standards audit;
- suicide and self harm prevention;
- temporary confinement; and
- use of force.

Is the manual up to date?

The manual was originally written and published in 2005. It reflects the provisions of the Detention Centre Rules 2001. It has not been regularly reviewed. I have been told by Home Office officials that the manual will be

revised once the Detention Centre Rules have been revised (see above) in order to bring it in line with the revised Rules.

Is the manual comprehensible?

The manual is nicely presented and well organised, set out on an alphabetical basis for ease of reference. The manual builds on the requirements set out in the Rules and, in many cases, expands on them. The manual varies in its levels of comprehensibility and usefulness. For example, the "Access to Legal Services" section comes across as a random collection of points brigaded together. The "Activities" section is helpfully detailed and sets out the responsibilities of the removal centre very clearly. The section on "Religion" comes across as rather bureaucratic, with an emphasis on the carrying out of administrative functions at the expense of guidance on actively facilitating detainees' access to their religions. The standards are set out within the framework of "minimum auditable requirements".

Part 1, Section 3 – The Operating Standards for the Detention Services Escort Process

Summary

The **Operating Standards for the Detention Services Escort Process**, published in 2006, build on the removal centre standards and reflect the fact that escorting services are almost always carried out by external contractors. This manual is also set out in alphabetical sections, covering:

- the complaints/requests procedure;
- custody of detainees;
- detainees' property;
- families with children;
- medical care;
- personnel: staff training;
- security;
- standards audit; and
- use of force.

Are the standards up to date?

The standards were originally written and published in 2005/2006. They reflect the provisions of the Detention Centre Rules 2001. They have not been regularly reviewed. I have been told by Home Office officials that the standards will be revised once the Detention Centre Rules have been revised (see above) in order to bring them in line with the revised Rules.

Are the standards comprehensible?

The standards are in the same format as the standards manual for IRCs, with subjects brigaded alphabetically. The standards are set out clearly and comprehensibly within the framework of "minimum auditable requirements".

Part 1, Section 4 – Detention Services Orders

Summary

Twenty-one detention services orders (DSOs) are particularly relevant to a review of welfare in immigration detention. DSOs are identified by year, preceded by a chronological number (so the third DSO of 2012, say, would be numbered 03/2012). When a DSO is reviewed and amended it sometimes retains its original number – so the number of a particular DSO does not necessarily indicate whether or not it is up to date. For example, the "Accommodating and managing transsexual detainees" DSO is numbered 11/2012 but it was reviewed and revised as recently as February 2015. On the other hand, some DSOs are allocated a new number once reviewed and revised. For example, the "Service of removal directions" DSO (3/2014) replaced the previous DSO on the subject (7/2011).

The twenty-one relevant DSOs are as follows:

DSO number	Title	Review
DSO 01/2003	DETAINEE RISK ASSESSMENT	last reviewed January 2003 – currently under review
DSO 12/2005	DETAINEE TRANSFERABLE DOCUMENT	last reviewed September 2008 – currently under review
DSO 6/2008	ASSESSMENT CARE IN DETENTION AND TEAMWORK	last reviewed January 2008
DSO 06/2012	MANAGEMENT OF PROPERTY	last reviewed March 2012 – currently under review
DSO 09/2012	SEARCHING POLICY	last reviewed December 2014 – due for review December 2016
DSO 10/2012	REMOVAL OF BLADES	last reviewed May 2012 – currently under review
DSO 11/2012	CARE AND MANAGEMENT OF TRANSSEXUAL DETAINEES	last reviewed June 2015
DSO 12/2012	ROOM SHARING RISK ASSESSMENT (RSRA)	last reviewed August 2012 – currently under review
DSO 13/2012	ACCESS TO MEDICATION AND CONFIDENTIAL MEDICAL INFORMATION DURING ESCORT	last reviewed August 2012 – currently under review
DSO 14/2012	CARE AND MANAGEMENT OF AGE DISPUTE CASES IN THE DETENTION ESTATE	last reviewed March 2015 – currently under review
DSO 17/2012	APPLICATION OF DETENTION CENTRE RULE 35	last reviewed April 2014 – currently under review

DSO 18/2012	PERSON ESCORT RECORD (PER)	last reviewed October 2012 – currently under review
DSO 19/2012	SAFEGUARDING CHILDREN POLICY	last reviewed November 2012 – currently under review
DSO 01/2013	PAID WORK	Last reviewed March 2013 – currently under review
DSO 02/2013	PREGNANT WOMEN IN DETENTION	last reviewed April 2013 – currently under review
DSO 03/2013	FOOD AND FLUID REFUSAL IN IMMIGRATION REMOVAL CENTRES	last reviewed May 2013 - currently under review
DSO 06/2013	RECEPTION AND INDUCTION CHECKLIST AND SUPPLEMENTARY GUIDANCE	last reviewed November 2013
DSO 07/2013	WELFARE PROVISION IN IMMIGRATION REMOVAL CENTRES	last reviewed November 2013
DSO 03/2014	SERVICE OF REMOVAL DIRECTIONS	last reviewed April 2014
DSO 06/2014	RISK ASSESSMENT GUIDANCE FOR ESCORTED MOVES – ALL CONTRACTORS	last reviewed August 2014 - currently under review
DSO 07/2014	RISK ASSESSMENT GUIDANCE FOR CONTRACTED ESCORT STAFF	last reviewed August 2014 - currently under review

Are the Orders up to date?

As can be seen from the above table, the vast majority of the DSOs are either under review or else have been reviewed within the past two years or are less than two years old. The current arrangements are for DSOs to be reviewed every two years. In cases in which a review is not currently underway or planned, this is because it is part of a larger piece of planned work upon which the Home Office is engaged. For example, DSO 6/2008 is currently on hold pending completion of changes to equivalent guidance in respect of the prison estate. The DSOs are now being managed centrally by a specific official in Home Office Immigration Enforcement, which means that there is a system in place for ensuring regular review of all DSOs.

Are the Orders comprehensible?

The quality of the DSOs, in terms of the way in which they are written and in terms of their comprehensibility, is variable.

DSO 01/2003 – Detainee Risk Assessment – the introduction is not well written. The language is a mixture of the overly formal and the overly informal, with the use of the first person. The introduction does allow the reader to understand that a new risk assessment process is being introduced but much of what follows would be incomprehensible to the layperson. It is not made clear to whom the DSO is addressed. The "Procedure" section appears to have a sensible structure and to go through the possible scenarios in some detail.

DSO 12/2005 – Detainee Transferable Document – this DSO was intended as an interim DSO. It is well written and easy to understand, setting out its purpose and the procedure to be followed clearly. It invites the question of "what happened next?" - given that it was a short term arrangement that appears to have remained in place for nearly seven years.

DSO 6/2008 – Assessment Care in Detention and Teamwork – this is an astonishingly detailed DSO which provides an exhaustive list of actions that should be taken in ACDT cases and levels of training which staff must have received in order to manage ACDT cases. However, it is rather light on guiding members of staff on what actually constitutes an ACDT case. The list approach results in it not having been constructed in a very user-friendly way. A more narrative, contextualised, approach may have made for easier reading. There is also an over-use of jargon.[1]

DSO 06/2012 – Management of property – this DSO is fairly well written and comprehensible. It might have benefited from spending more time on the context to make it clearer why the first few paragraphs focus on the rear end of the process, but this becomes apparent after a while.

DSO 09/2012 – Searching Policy – this is a clear piece of guidance which successfully brings together in one place a policy which is spread out through other policy documents. It is detailed and helpful.

DSO 10/2012 – Removal of blades – this has recently been reviewed and revised. It is generally well written and understandable. Some clarification might be needed in the "Individuals with a history of blade use" section to make it clearer whether this applies to such individuals when they are known to be currently in possession of a blade or whenever such individuals are subject to removal whether or not they have (or are suspected to have) a blade on them.

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[1] For example: *"The UK Border Agency has a legal duty to inform other relevant agencies of the self-harm or suicide risk that a detainee presents. That duty comes from the ordinary law of negligence, and can be paraphrased as the duty of care to take reasonable steps to avoid reasonably foreseeable risks. The duty also comes from Article 2 of the European Convention on Human Rights, the duty to protect the life of those in the State's detention, which includes information sharing. (The Protection and Use of Confidential Health Information in Prisons and Inter-agency Information Sharing)."*

DSO 11/2012 – Care and management of transsexual detainees – this comes across as a very well written, well researched, comprehensive and readable DSO on a very complex and sensitive issue.

DSO 12/2012 – Room sharing risk assessment (RSRA) – this DSO is complex and detailed but it is well structured, written in plain English, and quite easy to follow. In some instances it could be slightly clearer on differentiating between individuals who are at risk themselves and those who present a risk to others. There is also a statement on risk of self harm (paragraph 24) which is quite confusing but, overall, the document appears to be a good resource.

DSO 13/2012 – Access to medication and confidential medical information during escort – this DSO is generally well written and the processes are understandable and easy to follow.

DSO 14/2012 – Care and management of age dispute cases in the detention estate – this DSO explains a difficult, complex and high risk issue very well. It occasionally lapses into using the first person but is otherwise well written.

DSO 17/2012 – Application of detention centre Rule 35 – this is a clearly written DSO which provides good quality guidance to a range of practitioners.

DSO 18/2012 – Person Escort Record (PER) – this DSO is nicely written and is totally comprehensible. It is written to an extraordinary level of detail, however – even to the extent that officers are repeatedly told to complete forms legibly – and some of this detail feels unnecessary.

DSO 18/2012 – Safeguarding children policy – a long and detailed DSO, reflecting the (rightly) risk averse approach to dealing with children in the immigration system. On occasion it comes across more as an information leaflet than a piece of guidance but it does provide some specific advice which would be useful in case management terms. Not an easy read, as it is quite dense, but it does successfully set out the policy framework and the general principles.

DSO 01/2013 – Paid work – this is a very simple and straightforward DSO which sets out clearly the rates of pay for paid work in IRCs and the circumstances which dictate whether an individual is eligible to undertake such work.

DSO 02/2013 – Pregnant women in detention – this is a very short DSO which, basically, advises on whether pregnant women are fit to fly. It is fairly straightforward, presenting the policy in a clear tabular form.

DSO 03/2013 – Food and fluid refusal in immigration removal centres[2] – the policy is written in good plain English, flows logically and is understandable to the lay-reader as well as to those operating in the field. There are perhaps a

[2] On a pedantic point, the DSO should be entitled "Food and liquid refusal", as "fluid" means liquids and gases, and this policy is not concerned with gases.

couple of areas which would warrant attention, namely: in paragraph 1 there is a reference to the Mental Capacity Act 2005 which does not appear to be borne out by the Act itself; in the same paragraph there is potential for confusion over age; and in part C, the point at which the policy kicks in is not made explicit.

DSO 06/2013 – Reception and induction checklist and supplementary guidance – the body of this DSO is short and is written in simple, understandable, terms. The bulk of the DSO consists of annexes which, effectively, consist of annotated checklists for use by staff when a new detainee arrives. They are well written and clear.

DSO 07/2013 – Welfare provision in immigration removal centres (IRCs) – this is a straightforward and prescriptive DSO which sets out clearly and concisely the framework within which welfare provision in detention settings must be made and the details of the service which must be provided. In doing so, it effectively presents a practical definition of welfare support.

DSO 03/2014 – Service of removal directions – apart from paragraph 9, which is rather confusing in terms of its level of detail[3], this DSO is well written and user-friendly and helpfully sets out timescales in tabular form.

DSO 06/2014 – Risk assessment guidance for escorted moves – all contractors – this is a detailed and well articulated DSO which sets out the circumstances in which restraints can be used and the processes which govern such use. It is easy to read and understand.

DSO 07/2014 – Risk assessment guidance for contracted escort staff – this is the sister document of DSO 06/2014. It is written in the same style and is equally easy to read and understand.

[3] *"Staff must keep clear records that removal directions have been served. Confirmation must be placed on the Casework Information Database (CID) once removal directions have been served, including the date and time of service, name of the serving officer, and any witnesses. The ISE 303 acknowledgement form must be completed and faxed back to the originator following service of the removal directions. This is also a requirement when non-Immigration Enforcement staff serve the removal directions. They will present the ISE303 to the detainee, complete as appropriate and date, sign and witness the detainee's signature of receipt. All staff to note that a detainee does not need to sign the ISE303 to render it valid. Notification of the removal direction details should be provided to the detainee reception area of the IRC and to the healthcare suite to further inform for preparation of removal."*

Part 1, Section 5 – Enforcement Instructions and Guidance

EIG is a resource for caseworkers and decision makers. It comprises around sixty "chapters" of instructions and guidance on a range of enforcement issues, including:

- immigration offences and breaches;
- deportations and criminal caseworking;
- powers and prosecutions;
- restrictions;
- operational enforcement activity;
- families and children;
- detention and removals.

The chapters most relevant to this review are chapter 45 (families and children) and chapter 55 (detention and release).

Is the EIG up to date?

Chapter 45 was subject to review and restructure in December 2013 and some minor amendments have since been made. Chapter 55 has been subject to regular review since 2008 with amendments being made on twenty-one separate occasions in that time.

Is the EIG comprehensible?

For the purposes of this exercise, only chapters 45 and 55 of the EIG have been considered.

The EIG varies in terms of the quality of the writing and in terms of its comprehensibility. For example, paragraph 3 of section (a) of chapter 45 is not clearly expressed and pre-supposes a level of knowledge that not everyone will possess – though this may not be a problem given that the EIG is for use by Home Office staff only. The confused grammar of part 1 of section (b) makes it difficult to follow. Section (b) usually uses the third person but occasionally lapses into the second.

In chapter 55, it appears odd that the section setting out the limitations on the power to detain is placed before the section which sets out the actual power. Some sections, such as the section on criminal casework cases (3.A) and the section on persons unsuitable for detention (5.10), are particularly well written and easy to understand. Other sections, such as the section on risk of harm (3.2.6 onwards), are difficult to follow.

Part 2, Section 1 – Detention

The statutory power to detain for immigration purposes is set out in Schedules 2 and 3 to the Immigration Act 1971. The use of the statutory power to detain is a matter of policy and is set out in Chapter 55 of the EIG. This states that detention is most usually appropriate:

- to effect removal;
- initially to establish a person's identity or basis of claim; or
- where there is reason to believe that the person will fail to comply with any conditions attached to the grant of temporary admission or release.

Chapter 55 also provides for cases to be managed under the Detained Fast track (DFT) procedures.

Summary

Chapter 55 of the EIG covers the issues of **detention and temporary release**.

Part 1 is the overarching **policy** section. It establishes that:

- the power to detain is necessary in order to maintain effective immigration control;
- there should be a presumption in favour of temporary admission or release;
- alternatives to detention should be used where possible;
- detention should most usually be used to effect removal, to establish identity or to manage cases in which it is believed that the individual will be non-compliant with conditions;
- straightforward asylum claims which can be determined quickly can be put through the DFT. (The DFT process has been temporarily suspended, after a successful challenge, because of identification of risks surrounding the safeguards for particularly vulnerable applicants within the system.)

This section also sets out the policy in respect of:

- criminal casework cases;
- deportation;
- the use of (including the length of) detention;
- limitations on the power to detain.

Part 2 is the **powers** section. It sets out the powers to detain contained in statute.

Part 3 is the section that deals with **decisions**. This represents the bulk of the EIG and covers:

- general detention decisions;

- detaining in criminal casework cases;
- factors influencing decisions to detain;
- risk of absconding;
- risk of harm;
- bail applications.

Part 5 sets out the **levels of authority** for making detention decisions.

Part 10 sets out the **criteria for normally excluding certain categories of person from detention** and the **criteria for detaining immigration detainees in prison**.

Are the detention policies comprehensive? Are the detention policies fit for purpose?

Non-Governmental organisations that contributed to the Review are particularly critical of paragraph 10 of chapter 55 of the EIG. This paragraph sets out the categories of individuals who are *"normally considered for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons"*. These categories are:

- *"Unaccompanied children and young persons under the age of 18 (see 55.9.3 above* [which sets out the exceptional circumstances in which children might be detained]*).*
- *The elderly, especially where significant or constant supervision is required which cannot be satisfactorily managed within detention.*
- *Pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this (but see 55.4 above for the detention of women in the early stages of pregnancy at Yarl's Wood).* [55.4 is no longer in use.]
- *Those suffering from serious medical conditions which cannot be satisfactorily managed within detention.*
- *Those suffering from serious mental illness which cannot be satisfactorily managed within detention (in criminal casework cases, please contact the specialist mentally disordered offender team). In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act.*
- *Those where there is independent evidence that they have been tortured.*
- *People with serious disabilities which cannot be satisfactorily managed within detention.*
- *Persons identified by the competent authorities as victims of trafficking (as set out in Chapter 9, which contains very specific criteria concerning detention of such persons)."*

The **Association of Visitors to Immigration Detainees (AVID)**, for example, in its submission (dated 30 May 2015) to the Review, suggests that *"EIG Chapter 55.10 is inadequate, lacks clarity and leaves many at risk"* and that *"The policy*

guidance itself lacks clarity; its current terms are ambiguous and the staff responsible are neither adequately trained nor qualified medically to identify such risk factors".

AVID suggests that changes made to paragraph 55.10 in 2010 – in particular, the requirement that individuals suffering from serious medical conditions and serious mental illness would be considered unsuitable for detention only if their conditions could not be *"satisfactorily managed within detention"* – had *"increased the numbers of vulnerable people who may now be deemed 'suitable' for detention"* and had *"resulted in a 'watch and wait' approach where detention is maintained until the individual deteriorates to the point where she/he can no longer be satisfactorily managed"*. **AVID** argues that, in respect of individuals with existing mental illnesses at point of detention, the policy is triggered by deterioration in the individual's mental health. **AVID** implies that there are cases in which it is the experience of detention that triggers that deterioration.

The **Immigration Law Practitioners' Association (ILPA)**, in its submission (dated 2 June 2015) to the Review, takes a similar approach. **ILPA** advocates *"a general exemption from detention for the mentally ill"* but, short of that, supports a formulation put forward by **Medical Justice** and **MIND**, the conclusion of which is that an individual's mental illness *"is not satisfactorily managed if detention is causing or exacerbating their mental health problem, or if the person's health could be improved or treated in the community including if it could be improved by a specific treatment which is not available in the detention but would be available in the community"*.

AVID also contends that the use of pre-determined categories of vulnerability is too static and does not allow for changes over time. It suggests that factors such as *"language, literacy, learning ability, knowledge of English language and access to familial support networks"* are all relevant in determining how well an individual will cope with detention and how vulnerable they are".

Other Non-Governmental organisations, in their submissions to the review, also suggest that the exclusion criteria are too narrow. The **Detention Forum** (submission of May 2015) implies that "*language, learning disabilities, and immigration status"* should be included in *"vulnerable categories"*. Further, the **Detention Forum** suggests that *"those identified as vulnerable should never be detained"* and that a *"vulnerability tool"* should be employed in preference to the current category based approach. The **UK Lesbian and Gay Immigration Group (UKLGIG)** (submission of 29 May 2015) does not argue for a blanket exclusion for individuals identified as lesbian, gay, bisexual, transgender or intersex (LGBTI) but it does argue that LGBTI asylum claims should not be processed in the DFT (and, by implication, that LGBTI asylum claimants should not be detained). **UKLGIG** also suggests that LGBTI individuals are subject to a disproportionately high risk of bullying, abuse and harassment in the detained setting. **René Cassin** (submission of 15 May 2015) recommends that *"men and women who are survivors of rape, and sex and gender based violence should not be detained for immigration purposes"*. The **Royal College of Psychiatrists** (submission of 8 April 2015) suggests that *"people with mental disorder should*

only be subjected to immigration detention in very exceptional circumstances". **Women for Refugee Women**, in its submission of 8 April, recommends that pregnant women and victims of rape and sexual violence be excluded from detention as interim measures, with the ultimate aim of all asylum seeking women being excluded.

AVID suggests that paragraph 55.10 is not properly implemented in that individuals who meet the exclusion criteria are nevertheless detained, and it quotes a number of examples from court cases and independent reports. **ILPA** argues that, *"in (its) experience, it is far from exceptional that the mentally ill, survivors of torture and trafficked persons, the elderly and those with physical health problems are detained"*. **ILPA** suggests that the Home Office's approach to age dispute cases is questionable and that the overarching Review should make a special study of such cases.

Commentary

The Government's policy on detention for the purposes of immigration control is set out clearly in chapter 55 of the EIG. The policy is clear on the fact that detention must be used only for certain immigration purposes – to effect removal, to establish identity or basis of claim, or when an individual is unlikely to comply with conditions – and it is also clear that detention should be used sparingly and for the shortest period necessary. The thread of limiting the use of detention runs through the guidance – *"may only continue for a period that is reasonable*" (paragraph 5.1.4.1), *"Home Office staff should be clear and careful … that the decision to detain … was proportionate to the legitimate aim pursued"* (5.1.4.2), *"All reasonable alternatives to detention must be considered before detention is authorised"* (5.3), *"[detention] must be kept under close review to ensure that it continues to be justified"* (55.3.2.3) – for example. It reflects the legal position that detention is lawful if - and only if - there is a reasonable prospect of removing the detainee within a reasonable amount of time. This is balanced against the need to promote effective immigration control and protect the public. The guidance is detailed and appears to cover the range of possible scenarios and, as such, it provides Home Office staff with the tools they need to carry out their functions with authority.

Many of the external partners clearly think that paragraph 55.10 of the EIG does not provide adequate protection in terms of excluding vulnerable individuals from detention. They are particularly concerned about the changes made in 2010 to the exclusion criteria, to the effect that those suffering from mental and physical health conditions will be excluded only if their condition cannot be satisfactorily managed in detention. They argue that cases in which the Home Office was found to have breached Article 3 of the ECHR stem directly from this change and that detention in line with the policy serves to exacerbate detainees' mental health problems. Others argue that particular groups, such as LGBTI individuals or those who have been the victims of sexual violence, should be excluded from detention. Others argue that static exclusion criteria are inappropriate and that a tool that allows for an ongoing assessment of vulnerability should be employed instead.

The current formulation of paragraph 55.10 provides a good degree of certainty in that each of the existing criteria involves some kind of measurable threshold. In policy and practical terms such an approach is likely to be far easier to use and to be held accountable against than a vulnerability tool. However, some of the thresholds are more measurable than others. For example, someone is recognised as a potential victim of trafficking by being accepted into the National Referral Mechanism. But other criteria are less clear, such as those related to medical conditions

Non-Governmental organisations argue that the policy is not properly implemented and cite examples, from the courts and from independent reports, of individuals whose detention appears to have been initiated or continued despite meeting the exclusion criteria. They also argue that the Home Office fails to operate within the spirit of the policy which, effectively, describes detention as a last resort rather than the default option. All decisions to detain are made on a case by case basis, taking into account the specifics of each case. The processes and considerations vary across the broad types of case involved – criminal cases, NRC cases and DFT cases – but they all have in place processes enabling them to identify vulnerability in line with the EIG and to comply with both the spirit and the principle of the policy. It is clear from discussions with those responsible for overseeing decisions to detain that they hold to the principle of only detaining when there is a legal requirement to do so, or, in non-criminal cases where other options, such as voluntary return, have been exhausted, and where the individuals concerned are not vulnerable and where there is a reasonable prospect of quick removal.

It may be worth noting at this point that the Home Office has suspended the operation of DFT, following legal challenge, whilst the system is reviewed to ensure that appropriate safeguards are in place to enable the fair treatment of vulnerable individuals.

Part 2, Section 2 – Detention Process

The detention process is covered in the following documents:

- the Detention Centre Rules;
- the Detention Services Operating Standards manual for Immigration Service Removal Centres;
- the Operating Standards for the Detention Escort Process;
- DSO 12/2005 (Detainee Transferable Document);
- DSO 06/2012 (Management of Property);
- DSO 11/2012 (Care and Management of Transsexual Detainees);
- DSO 06/2013 (Reception and Induction Checklist and Supplementary Guidance);
- DSO3/2014 (Service of Removal Directions).

Summary

(i) Detention Centre Rules

Paragraph 4 of the **Detention Centre Rules** sets out the arrangements that need to be made to ensure that new arrivals are informed of their rights and responsibilities.

Paragraph 5 of the **Rules** explains the processes for recording, fingerprinting and photographing new arrivals.

Paragraph 6 of the **Rules** states the arrangements for receiving and maintaining detainees' property.

(ii) Detention Services Operating Standards manual for Immigration Service Removal Centres

The "ADMISSIONS/DISCHARGE" section of the **manual** sets out the practical arrangements for receiving individuals into detention, including: ensuring proper written authority; risk assessment; identifying vulnerability; medical examinations; provision of information about the centre; provision of a hygiene pack and clothing; and access to telephones. It also sets out the processes for discharging individuals.

The "CASE PROGRESS" section of the **manual** stipulates the arrangements for detainees being kept apprised of the progress of their cases by immigration staff and for the carrying out of monthly reviews.

The "COMPLAINTS/REQUESTS PROCEDURE" section of the **manual** states the requirement for a detainee complaints procedure to be in place and the process for dealing with complaints.

The "DETAINEES CASH" section of the **manual** contains the arrangements for checking and recording detainees' cash and, where appropriate, holding it whilst they are detained.

The "DETAINEES PROPERTY" section of the **manual** sets out the arrangements for checking and recording detainees' property and, where appropriate, holding it whilst they are detained.

(iii) Operating Standards for the Detention Escort Process

The "DETAINEES PROPERTY" section of the **standards** sets out the arrangements for checking, recording and caring for detainees' property whilst they are in transit.

(iv) DSO 12/2005 (Detainee Transferable Document (DTD))

DSO 12/2005 sets out the arrangements for maintaining a file of information about the detainee, designed to follow the detainee from site to site.

(v) DSO 06/2012 (Management of Property)

DSO 06/2012 contains the arrangements for organising a detainee's property in advance of their removal.

(vi) DSO 11/2012 (Care and Management of Transsexual Detainees)

DSO 11/2012 stipulates in great detail the arrangements for the care and management of transsexual detainees.

(vii) DSO 06/2013 (Reception and Induction Checklist and Supplementary Guidance)

DSO 06/2013 provides a mandatory, detailed checklist for the reception and induction of detainees on arrival at a centre. It includes coverage of: transfer of information; risk assessment; healthcare; vulnerability; and property.

(viii) DSO 03/2014 (Service of Removal Directions)

DSO 03/2014 sets out the process for setting removal directions and effecting removals.

Are the detention process policies comprehensive? Are the detention process policies fit for purpose?

The majority of these documents are concerned with the processes involved in receiving and discharging detainees and in caring for their property. Admissions and discharge requirements are set out in broad and understandable terms in the Operating Standards Manual. This is built on in DSOs 06/2013 and 03/2014 which provide detailed guidance and checklists for, respectively, receiving and

inducting detainees and serving removal directions. The management of detainees' property is dealt with in Rule 6 of the Rules, in a dedicated section in both Operating Standards Manuals **and** in a DSO (06/2012). Separately, DSO 11/2012 provides detailed and comprehensive guidance on the care and management of transsexual detainees.

Those who submitted evidence to the Review have not been overly exercised by these particular pieces of guidance, though one issue has been raised by a member of the **Campsfield House Independent Monitoring Board** (IMB). This concerns the transfer of detainees' property from their previous place of residence (prison, police station, private accommodation, or NASS accommodation). It seems that it is not rare for such property to arrive late or even not at all, and there appears to be no formal procedure for recovering missing property. In addition, the **Red Cross**, in its submission (of 11 June) to this policy review, recommends that *"provision be made to ensure detainees are able to access their personal phones"* on the grounds that *"Phones can contain important contact numbers, family photos and be the means of maintaining links to loved ones"*.

Commentary

The documents covering reception and discharge are comprehensive and prescriptive and allow removal centre staff to take a step-by-step approach to the management and care of detainees in a structured and transparent way. On the issue of guidance related to detainees' property there does not appear to be inconsistency across the four pieces of guidance and they all serve slightly different purposes (for example, the DSO is framed in the context of preparation for removal from the UK) - but four separate pieces of guidance on the same subject does mean that there is the potential for confusion. On the issue raised by the Red Cross, the policy on mobile phones is set out in DSO 08/2012 (Mobile phones and cameras in centres). The policy is clear that mobile phones which house cameras and videos and/or from which the internet can be accessed are prohibited on security grounds. However, detainees are provided with phones without these facilities and have access to the telephone numbers on their personal phones. They also have limited access to the internet. The guidance on the management of transsexual detainees is very detailed, and this is probably exactly what is needed on a subject which is so sensitive, on which detention staff may not have a lot of personal knowledge and on which there is a great deal of potential for taking inappropriate action.

In light of the **Campsfield House IMB**'s concerns about missing property, perhaps there is a case for testing whether the issue raised is localised or more widespread and whether there should be a formal procedure for chasing lost property.

Part 2, Section 3 – Information Provision/sharing

Information provision is covered in the following documents:

- the Detention Centre Rules;
- the Detention Services Operating Standards manual for Immigration Service Removal Centres;
- DSO 12/2005 (Detainee Transferable Document);
- DSO 18/2012 (Person Escort Record (PER))
- DSO 07/2013 (Welfare Provision in IRCs);
- Enforcement Instructions and Guidance – Chapter 55.

Summary

(i) Detention Centre Rules

Rule 9 of the **Detention Centre Rules** sets out the arrangements for providing detainees with information about the reasons for their continued detention and about the progress of any immigration application they have made.

(ii) the Detention Services Operating Standards manual for Immigration Service Removal Centres

The "ADMISSIONS/DISCHARGE" section of the **manual** contains the practical arrangements for receiving individuals into detention, including: receipt of the authority for detention form IS91: receipt of a completed risk assessment (IS91 RA part B); recording and relaying of information relating to a detainee's vulnerability; and gathering core information related to date of birth, physical measurements and distinguishing features. It also sets out the requirement for the transfer of detainee records at the point of discharge.

The "CASE PROGRESS" section of the **manual** explains the arrangements for detainees being kept apprised of the progress of their cases by immigration staff and for the carrying out of monthly reviews.

(iii) DSO 12/2005 (Detainee Transferable Document)

DSO 12/2005 states the arrangements for maintaining a file of information about the detainee, designed to follow the detainee from site to site, through the DTD and IS91.

(iv) DSO 18/2012 (Person Escort Record (PER))

DSO 18/2012 stipulates the detailed arrangements for communicating information about risks or vulnerabilities in respect of all detainees on escort or transfer using the PER.

(v) DSO 07/2013 (Welfare Provision in IRCs)

DSO 07/2013 prescribes the minimum requirements for the provision of welfare services in IRCs. This includes: providing information on voluntary return schemes; providing information on accessing legal services; and providing information to detainees about the centre's regime.

(vi) Enforcement Instructions and Guidance

Paragraphs 55.6.1 – 55.6.4 of **Chapter 55 of the EIG** describe the arrangements for completing IS91 forms in relation to risk assessment, authority to detain, reasons for detention and movement notification.

Paragraph 55.8 of **Chapter 55 of the EIG** spells out the requirements in respect of monthly reviews of detention. This includes a requirement for regular information to be provided to detainees about the rationale for their initial and continuing detention.

Are the information provision policies comprehensive? Are the information provision policies fit for purpose?

There are three broad elements of the issue of information sharing. First, information that follows detainees through the immigration system and which allows those making decisions to make informed decisions about, for example, the management of a case, placement, assessment of risk (to the detainee themselves or to others) and health needs. Second, information that is provided to the detainee about the progress of their immigration claim/case and the rationale for continued detention. Third, information that is provided to the detainee about their living arrangements and about the Centre in which they are being detained.

(i) Information that follows detainees

There are a number of documents that contain key information which follows the detainees through their detained immigration career.

First are the IS91 forms. These are provided for in paragraph 55.6 of the EIG. There are four of these forms. The IS91RA is a risk assessment form and it is completed by the caseowner making the decision to detain at the point at which that decision is taken. The IS91 itself is the form that authorises the detention of the individual under immigration powers and it is completed by the initial detaining officer at the point at which the location of detention has been determined. The IS91R form is a three-part form which sets out the power under which a person is detained, the reason for detention and the basis on which the decision to detain has been made. The form is completed by the caseworker managing the case and is served on the detainee at the time of their initial detention. The IS91M form is used when an individual is detained or moved without the involvement of the Detainee Escorting and Population Management Unit (DEPMU).

Second is the DTD. The DTD arrangements are set out in DSO 12/2005. The DTD complements the IS91 but records more information about the detainee than the IS91 and, as its name suggests, travels around with the detainee on transfer. The DTD is a paper folder which contains all of the key documents related to the individual detainee including medical files, security files, Home Office files and the IS91.

Third is the PER. The PER contains information about risks and vulnerabilities on escort or transfer. The PER arrangements are set out in DSO 18/2012. This is a very detailed document which sets out precisely the sort of information that should be recorded.

The approach to ensuring that key information about detainees' levels of risk (to themselves and others and from others), health needs and safeguarding needs is passed through the system appears to be comprehensive and thorough. The exercise, in respect of all three types of form, is totally paper-based. It would be in line with the Government's policy of 'digital by default' if these paper systems were speedily replaced by electronic ones. For the time being, however, the arrangements appear to represent an approach which minimises safeguarding and health risks. One point of interest – there is no apparent cross reference between the DTD and PER. It is perhaps surprising that it is not a requirement that the PER be housed within the DTD. It appears to exist completely separately when one would imagine that there might be information within the PER that should be contained in the DTD.

(ii) information that is provided to the detainee about the progress of their immigration claim/case and the rationale for continued detention

The "Case Progress" section of the Detention Services Operating Standards manual for Immigration Service Removal Centres builds on paragraph 9 of the Detention Centre Rules and puts in place the arrangements for carrying out monthly reviews and for responding to detainees' requests for information about their immigration status. It also covers the handling of information provided by the detainee in respect of rule 35 of the Detention Centre Rules. There is not demarcation between these issues and, in this respect, the manual is not as clear as it might be.

Paragraph 55.8 of the EIG sets out very detailed arrangements for carrying out monthly reviews of the rationale for continued detention.

During the Review's visit to Harmondsworth IRC, **detainees** reported that they were not regularly receiving the reports of their monthly reviews. During the visit to Tinsley House IRC it was reported that 60-70 per cent of consultations with the centre's welfare services were in relation to getting information from the Home Office, with the implication that the information was not being received through normal channels. During the visit to Colnbrook IRC, the Chair of the **IMB** suggested that the quality of monthly review reports was poor. The same statements were repeated month after month and detainees rarely received answers to their questions, which led to a feeling of helplessness and

which was dehumanising. During the visit to Brook House, the **detainees** reported that immigration staff did not listen to them and treated them with disrespect and rudeness, and that caseworkers were pre-occupied with removal. They also reported that monthly review reports always said the same thing and that there was a perception that cases were not considered individually. At HMP Holloway there was supposed to be a full time immigration officer in post but, in actual fact, there was someone there only three days a week, with a different person turning up each time. The situation was better in HMP Wormwood Scrubs, where there was an embedded immigration team which engaged with detainees through serving decisions, relaying information to caseworkers and holding surgeries. However, even then there was still an engagement gap which was only filled when there was a detainee capable of helping, and willing to help, his fellow detainees. **Medical Justice**, in its submission (dated 19 May 2015) to the Review, suggests that *"numerous court cases have demonstrated that 'monthly reviews' are often cursory and frequently fail to take into consideration emerging issues, such as deteriorating mental health (e.g. HA (Nigeria) v SSHD and MD v SSHD)"*.

(iii) information that is provided to the detainee about their living arrangements and about the Centre in which they are being detained

As part of the induction procedures set out in the Operating Standards, detainees are given information about the centre and there is also a requirement, as part of the welfare process set out in DSO 07/2013, for detainees to be given information. This approach seems to be perfectly proportionate.

Part 2, Section 4 – Healthcare and Disability

Healthcare and disability issues in detention are covered in the following documents:

- the Detention Centre Rules;
- the Detention Services Operating Standards manual for Immigration Service Removal Centres;
- the Operating Standards for the Detention Escort Process;
- DSO 6/2008 (Assessment Care in Detention and Teamwork);
- DSO 13/2012 (Access to medication and confidential medical information during escort);
- DSO 17/2012 (Application of Detention Centre Rule 35);
- DSO 02/2013 (Pregnant women in detention);
- DSO 03/2013 (Food and Fluid Refusal in Immigration Removal Centres);
- DSO 07/2013 (Welfare Provision In Immigration Removal Centres); and
- Chapter 45 of the Enforcement Instructions and Guidance.

Summary

(i) Detention Centre Rules

Paragraph 13 of the **Detention Centre Rules** requires that food provided in detention centres shall be "wholesome (and) nutritious" and that it "shall … meet all … medical needs". It also requires that detained individuals should not receive smaller portions than usual unless the medical practitioner has recommended this.

Paragraph 16 of the **Rules** sets standards of hygiene and paragraph 18 requires that detainees be given the opportunity to spend at least one hour per day in the open air.

Paragraph 33 of the **Rules** sets out a requirement that each removal centre must have in place a medical practitioner and a health care team, and it explains their roles.

Paragraph 34 of the **Rules** requires that those admitted to a removal centre receive a medical examination within twenty-four hours of admission.

Paragraph 35 of the **Rules** sets out the arrangements for medical practitioners notifying the centre manager, and thence the Home Office, of any particular health issues related to individual detainees, including suicidal intentions or suspected torture.

Paragraph 36 of the **Rules** sets out the arrangements for notifying interested parties in cases in which a detainee dies, or is seriously ill or injured.

Paragraph 37 of the **Rules** sets out the arrangements for submitting detainees to a medical examination to establish whether they are suffering from a disease

specified by an Order pursuant to Schedule 12 of the Immigration and Asylum Act 1999.

(ii) the Detention Services Operating Standards manual for Immigration Service Removal Centres

The "CATERING" section of the **manual** requires that special dietary needs on grounds of health be met and that meals be nutritious.

The "DISABLED DETAINEES" section of the **manual** sets out the requirements in respect of meeting the physical needs of disabled detainees, ensuring that they are able to access services and preventing discrimination against them.

The "HEALTHCARE" section of the **manual** explains the requirements in respect of:

- the qualifications of the healthcare staff:
- developing needs-based services;
- communication with detainees and confidentiality;
- access to healthcare, including screening, examination on admission and standard times for appointments with doctors and nurses;
- access to specific services and secondary care;
- the management of cases in which the detainee is at risk of self-harm or suicide or may have been tortured;
- the maintenance of clinical records; and
- the management of prescription drugs.

The "HYGIENE" section of the **manual** stipulates the minimum standards in respect of the hygiene of detainees and of the removal centre.

The "SUICIDE AND SELF HARM PREVENTION" section of the **manual** describes the arrangements for assessing risk of suicide and self harm, required levels of staff training and procedures for responding to cases.

(iii) Operating Standards for the Detention Escort Process

The "MEDICAL CARE" section of the **Standards** prescribes the arrangements for ensuring that detainees under escort have access to appropriate medication and for responding to situations in which a detainee is taken ill whilst being escorted.

(iv) DSO 6/2008 (Assessment, Care in Detention and Teamwork)

DSO 6/2008 spells out the arrangements for the ACDT procedures, which replaced the former F2052SH procedure. It focuses on the prevention of suicide and self harm through better and earlier identification of indicators and management of cases. The procedures are set out in great detail in an annex to the DSO.

(v) DSO 13/2012 (Access to medication and confidential medical information during escort)

DSO 13/2012 contains the arrangements during escort for controlling access to confidential medical information, controlling access to medication, and dealing with concerns about a detainee's health.

(vi) DSO 17/2012 (Application of Detention Centre Rule 35)

DSO 17/2012 states in great detail the duties of healthcare staff, centre managers and Home Office staff in respect of managing vulnerable detainees falling within the scope of paragraph 35 of the Detention Centre Rules (see above), and in line with the EIG (see below).

(vii) DSO 02/2013 (Pregnant women in detention)

DSO 02/2013 restates the policy position on the detention of pregnant women set out in the EIG (see below) and provides guidance on determining whether a pregnant woman is fit to fly.

(viii) DSO 03/2013 (Food and Fluid Refusal in Immigration Removal Centres)

DSO 03/2013 provides detailed guidance, for healthcare professionals and for Home Office Immigration Enforcement Managers, on procedures for managing cases of food and fluid refusal.

(ix) DSO 07/2013 (Welfare Provision in Immigration Removal Centres)

DSO 07/2013 stipulates the minimum standards for the provision of detainee welfare services. It establishes that welfare services should provide support on:

- financial signposting;
- domestic issues;
- education;
- contact with family and friends;
- property;
- legal issues;
- departures (including voluntary departures);
- preparation for return;
- preparation for release;
- the centre's regime.

(x) Enforcement Instructions and Guidance

Paragraph 10.1 of **Chapter 45 of the EIG** sets out the steps that must be taken by immigration enforcement staff to identify disabilities, medical conditions and additional needs and to act on them when they are identified.

Paragraph 10.3 of **Chapter 45 of the EIG** describes the consideration that must be given in cases of removal action when a woman is pregnant.

Paragraph 10.4 of **Chapter 45 of the EIG** explains the consideration that must be given in cases of removal action when a woman is a new mother.

Paragraph 8A of **Chapter 55 of the EIG** sets out the basic principles of Rule 35 of the Detention Centre Rules, namely "to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention" and "the information contained in the report needs to be considered in deciding whether continued detention is appropriate in each case".

Paragraph 9.1 of **Chapter 55 of the EIG** establishes that pregnant women should not normally be detained, other than when removal is imminent or when they are in the fast track process and gestation has not yet reached 24 weeks.

Are the healthcare and disability policies comprehensive? Are the healthcare and disability policies fit for purpose?

The provision of adequate and appropriate healthcare in immigration removal centres is a key part of daily life – it appears that, in some centres, more than half of the detainees seek to access some form of healthcare every single day - and healthcare has a significant profile in policy and guidance. It is the subject of specific, dedicated, pieces of guidance, but it is also the subject of tangential references in other documents (for example, Detention Centre Rule 18, which requires that detainees be given access to the open air for at least an hour a day).

Basic requirements in terms of standards of healthcare are set out in the Detention Centre Rules and the operating standards. There are detailed DSOs on the subject of ACDT, access to medication and medical information during escort, application of Rule 35, pregnant women in detention and food and fluid refusal. On that basis, coverage of healthcare in policy terms appears to be comprehensive. The same applies to disability issues, which are well covered in the operating standards.

(i) quality/quantity of healthcare

During the Review's visit to Yarl's Wood IRC, the **detainees** reported that there had been examples of the wrong drugs having been administered, of the appointments process not operating properly and of a woman doctor not always being available. During the visit to Harmondsworth IRC, the **detainees** reported waiting times of two to three days to see a nurse and three to four weeks to see a doctor (this is uncorroborated but, if it were true, it would be outside the time limits set in paragraph 18 of the "Healthcare" section of the IRC operating standards). The **detainees** also reported that there was a shortage of medical staff and inadequate equipment and that the healthcare staff were rude. During the visit to Colnbrook IRC, the **detainees** reported that there were long waits for appointments and that the nurses were rude.

René Cassin, in its submission (of 15 May 2015) to the Review, suggests that *"the healthcare provided to detainees is inadequate, and treatment is frequently delayed or altogether unavailable to detainees. Further, though current policy calls for thorough medical screening upon arrival in IRCs, testimonies gathered by the APPG Inquiry into the Use of Immigration Detention in the UK raise issues of deep concern with regard to the screening process. These testimonies indicate that, in practice, these screenings are rushed, often conducted without an interpreter, and are very limited in their scope. As a result, this has a deep impact on the level of medical care afforded to detainees, which in turn raises concerns over detainees' long-term health and wellbeing"*. In respect of mental health, **René Cassin** considers that *"Proper care for mental health should be streamlined into the overall healthcare services provided to detainees"*. The **Royal College of Psychiatrists**, in its submission (of 8 April 2015) to the Review, argues that individuals with mental illness should not be detained but that, in any case, *"It is … crucial that clinical and other staff working in detention centres are given adequate training and support to identify mental disorder when it does arise or deteriorate significantly in a detention centre setting"*. **Asylum Welcome**, in its submission (of May 2015) to the review, states that *"we consistently receive more complaints about the adequacy of health care for detainees at Campsfield than about any other aspect of the management of the centre"*. Among the concerns raised by **Asylum Welcome** are: *"[detainees] are denied additional supplies including medication for HIV and painkillers for chronic conditions"*; *"Tests and check-ups are not carried out when required"*; *"[urgent] hospital treatment has been delayed because the Campsfield authorities have been unable to provide an escort."*; *"we have had reports of detainees suffering toothache and not having access to dental treatment"*. **The Bail Observation Project** and **the Campaign to Close Campsfield**, in its undated submission, echoes this. It says: *"Currently serious medical problems go untreated, ongoing medical treatment is disrupted, hospital visits delayed or denied, toothache left untreated, often with the excuse that the escort service was not available"*. In its submission (of 12 June 2015) to the Review, **Freedom from Torture** suggests that entry to detention and moving around the detention estate can result in *"Interruptions to regular medication (which) may cause exacerbation of the condition for which it is required"*. On the basis of this, **Freedom from Torture** recommends that *"Review of medication should be an urgent priority during the detention admission process"*. The **Poppy Project**, in its undated submission to the Review, expresses concerns about the lack of non-specialist care in IRCs. **Medical Justice**, in its submission (of 10 March 2015), describes mental health care in immigration detention as *"often woefully inadequate"*. In its further submission of 19 March 2015, **Medical Justice** suggests that *"Healthcare provision within detention has repeatedly been shown to fall short of NHS equivalence despite the Home Office policy stipulating that 'all detainees must have available to them the same range and quality of services as the general public receives from the National Health Service'"*.

(ii) Rule 35

At a meeting with **Her Majesty's Inspectorate of Prisons (HMIP)**, HMIP told the Review that it felt that the Rule 35 process was not fit for purpose, on the basis that there was evidence of cases in which detention had been continued despite strong evidence suggesting that the detainee had been a victim of torture. The **British Medical Association (BMA)**, at a meeting of 5 May 2015, expressed concerns about Rule 35, particularly the fact that immigration caseowners, who were not clinicians, were able, in refusal letters, to discredit Rule 35(3) torture reports produced by GPs – the **BMA** agreed, however, that the quality of Rule 35 reports was poor (though they suggested that this was the result of GPs not having the necessary time and training). **Freedom from Torture** suggests that there is poor compliance with the Rule 35 process. The **Red Cross**, in its submission (dated 11 June 2015) to this policy review, reports that *"Some detainees have informed the British Red Cross that, despite a medical report being completed to verify that they had experienced previous torture, this evidence had been disregarded by the Home Office. Similarly, some detainees have identified that, despite experiencing significant health issues and having had a Rule 35 report completed to support this, they continue to be held in detention and that, in some cases, continued detention exacerbates their condition"*. The **Red Cross** recommends *"That all detainees having a Rule 35 report completed are assessed by an independent medical expert and that due consideration is given to this evidence with regard to their continued detention"*.

(iii) ACDT

During the visit to Harmondsworth, the **members of the Care and Custody management team** reported that there was a high use of ACDTs – with as many as fifty cases being open at any one time – and that ACDT was a labour-intensive process. **Service providers**, at a meeting held on 5 April 2015, considered that ACDT was more about process than outcome and that it drove a staff culture which was more interested in carrying out the process properly than in securing a satisfactory outcome. They also suggested that, as ACDT had been derived from a Prison Service practice, it was not suitable for an immigration detention environment. The view of **National Offender Management Service (NOMS)** officials, at a meeting on 12 May 2015, was that ACDTs were overused and that, as a result, they had become devalued. Because they were triggered by comparatively minor events, there was a risk that individuals in real situations of crisis might be overlooked

(iv) food and fluid refusals

During the visit to Dungavel IRC, the **site management** expressed the view that the policy of putting an individual on constant watch after two days of refusal was excessive. **Bail for Immigration Detainees (BID)**, in its submission (of May 2015) to the Review, expresses concerns about paragraph 60 of DSO 03/2013, which provides for the transfer to a prison medical facility of individuals who are refusing food or fluids and who require inpatient treatment. **BID's** view is that *"There is no reference anywhere in this policy document of*

transfer to a hospital for assessment and medical treatment. Prison is not a suitable environment for any immigration detainee, let alone a person who is refusing food or fluids and has reached a point where they require inpatient medical care".

(v) pregnant women

The issue of pregnant women is dealt with in section 6 of part 2 below.

Commentary

In terms of the basic provision of healthcare in IRCs, there is no firm evidence to suggest that the policy requirements are not being met. All IRCs provide primary care facilities on site and have ready access to secondary care. There are, however, questions about whether some of the principles of healthcare provision in IRCs are sound and about whether, in practice, the detailed level of care provided to detainees meets the standards expected either explicitly within the policy or according to the spirit of the policy. In terms of the principles, there is a read across with the issues discussed above in section 1 of part 2 – in particular, the reference in paragraph 10 of chapter 55 of the EIG (which contains the list of categories of individuals who would not normally be detained) to *"Those suffering from serious medical conditions which cannot be satisfactorily managed in detention"*. It could be argued that the very presence of beds in healthcare settings in IRCs means that the estate is artificially creating a hospital-type environment in order to allow it to continue to detain those who need a level of healthcare which goes beyond basic care. The argument runs that, if someone needs treatment that cannot be provided in a detention setting then they should be in a setting in which the appropriate treatment can be provided. Indeed, some of the patients in the in-patient unit at Colnbrook IRC (observed on a visit on 14 May) clearly had significant mental health issues and it was difficult to see why they were still in an IRC rather than in a secure hospital, when the IRC was not necessarily in a position to even maintain the individuals. It could not offer any form of treatment or therapy. On the other hand, the argument could be made that health beds are needed for when an individual has, for example, a short term injury or a virus which would not necessitate release from detention but which require a health intervention and, perhaps, observation for a day or two.

In terms of the detail of healthcare provision, expectations are set out in the Detention Services Operating manual for IRCs. These include arrangements for providing services within certain timescales. There are no specific requirements in terms of the behaviour of healthcare staff but the standards are clear that those providing medical services must have attained certain levels of professional qualifications – with the implication, and reasonable expectation, that these practitioners would observe certain behavioural standards.

Rule 35 has been the subject of strong criticism from external bodies for some time. The principle of the Rule – to provide information about detainees whose health has deteriorated or who may have been the victim of torture and thus

allow consideration to be given to release – is sound, and it is well backed up by a clear, authoritative and helpful DSO (DSO 17/2012). However, there are major questions raised by the NGOs above about whether the policy is implemented properly. The Home Office says that work is currently underway to improve Rule 35 processes, GP templates and caseworker response templates, as well as the training that is provided to those using the process.

The ACDT process is based on a similar process used in the Prison Service. It is heavily weighted towards risk aversion and towards providing detailed and prescriptive instructions on the management of cases. The purpose is to reduce the chances of a suicide or self-harm risk manifesting into real harm or, even, death. This of course is a sound ambition but the criticism levelled at the ACDT process by the contractors running the removal centres is that it is overly prescriptive. NGOs have not voiced views on the issue but, from within the system, the criticism is that the threshold for use of ACDTs is too low, that they are consequently overused and that, in low level cases, they divert resources away from serious cases.

The main criticisms of the food and fluid refusal policy are that it does not distinguish clearly enough between the dangers of refusing, respectively, fluids and foods, and that it places undue emphasis on "catching out" individuals who are ostensibly refusers but who may be eating or drinking surreptitiously. On the first of these, there is clearly a far greater danger to individuals presented by liquid refusal than is presented by food refusal – an individual can exist healthily without food for much longer than he or she can without liquid. The Home Office has indicated to me that it is looking to make this distinction clearer.

Part 2, Section 5 – Safeguarding

Safeguarding issues in detention are covered in the following documents:

- the Detention Services Operating Standards manual for Immigration Service Removal Centres;
- the Operating Standards for the Detention Escort Process;
- DSO 01/2003 (Detainee Risk Assessment);
- DSO 12/2005 (Detainee Transferable Document);
- DSO 6/2008 (Assessment Care in Detention and Teamwork);
- DSO 10/2012 (Removal of blades);
- DSO 11/2012 (Care and management of transsexual detainees);
- DSO 12/2012 (Room Sharing Risk Assessment (RSRA));
- DSO 14/2012 (Care and management of age dispute cases in the detention state);
- DSO 17/2012 (Application of Detention Centre Rule 35);
- DSO 19/2012 (Safeguarding and promoting the welfare of children in the care of Detention Operations and Service Providers);
- DSO 03/2013 (Food and Fluid Refusal in Immigration Removal Centres);
- DSO 06/2014 (Risk assessment guidance for escorted moves);
- DSO 07/2014 (Risk assessment guidance for contracted escort staff);
- Chapter 45 of the Enforcement Instructions and Guidance; and
- Chapter 55 of the Enforcement Instructions and Guidance.

Summary

(i) the Detention Services Operating Standards manual for Immigration Service Removal Centres

The "SAFER REMOVALS CENTRES" section of the **manual** sets out the requirements for removal centres to develop policies on bullying, self-harm and drug abuse and to have procedures in case for dealing with such cases and monitoring them.

The "SUICIDE AND SELF HARM PREVENTION" section of the **manual** requires that removal centre staff be trained to recognise those at risk of suicide and self harm, that suicide and self harm prevention measures be in place, and that there be procedures for dealing with cases of suicide and self harm.

(ii) Operating Standards for the Detention Escort Process

The "SECURITY" section of the **standards** includes references to carrying out risk assessments.

(iii) DSO 01/2003 (Detainee Risk Assessment)

DSO 01/2003 puts in place a formal system for assessing the risks associated with individual detainees, based on use of the IS91 form. This process was put in place following incidents at Yarl's Wood and elsewhere.

(iv) DSO 12/2005 (Detainee Transferable Document)

DSO 12/2005 sets out the arrangements for maintaining a file of information about the detainee, designed to follow the detainee from site to site, through the DTD and IS91.

(v) DSO 6/2008 (Assessment, Care in Detention and Teamwork)

DSO 6/2008 explains the arrangements for the ACDT procedures, which replaced the F2052SH procedure. It focuses on the prevention of suicide and self harm through better and earlier identification of indicators and management of cases. The procedures are set out in great detail in an annex to the DSO.

(vi) DSO 10/2012 (Removal of blades)

DSO 10/2012 describes the arrangements for dealing with cases in which detainees conceal blades in order to disrupt their removal.

(vii) DSO 11/2012 (Care and Management of Transsexual Detainees)

DSO 11/2012 stipulates in great detail the arrangements for the management of transsexual detainees, including risk management and safeguarding.

(viii) DSO 12/2012 (Room Sharing Risk Assessment (RSRA))

DSO 12/2012 states the legal requirement to carry out a risk assessment – and carry out reviews of assessments – in order to guard against the risk of detainees injuring their roommates. The DSO provides guidance on carrying out such a risk assessment.

(ix) DSO 14/2012 (Care and management of age dispute cases in the detention estate)

DSO 14/2012 explains the arrangements for managing cases in which there is doubt about whether a detained individual is an adult or a child. The purpose is to ensure that those who might be children are removed from detention and placed in the care of social services as quickly as possible on safeguarding grounds.

(x) DSO 17/2012 (Application of Detention Centre Rule 35)

DSO 17/2012 describes the duties of healthcare staff, centre managers and Home Office staff working in removal centres in respect of managing vulnerable

detainees falling within the scope of paragraph 35 of the Detention Centre Rules (see above), and in line with the EIG (see below). It is complemented by a caseworking instruction for staff managing detained cases who may receive rule 35 reports – Detention Rule 35 Process.

(xi) DSO 19/2012 (Safeguarding and promoting the welfare of children in the care of Detention Operations and Service Providers)

DSO 19/2012 sets out in detail the duties of service providers and immigration staff in respect of safeguarding children in line with the requirements of section 55 of the Borders, Citizenship and Immigration Act 2009. Because the UK does not routinely detain children for immigration purposes, this Order applies principally to children detained with their families as part of the family removal process – though it also applies to other circumstances in which children come into contact with removal centres, such as when they are visiting relatives.

(xii) DSO 03/2013 (Food and Fluid Refusal in Immigration Removal Centres)

DSO 3/2013 provides detailed guidance, for healthcare professionals and for Home Office Immigration Enforcement Managers, on procedures for managing cases of food and fluid refusal.

(xiii) DSO 06/2014 (Risk assessment guidance for escorted moves)

DSO 06/2014 provides detailed instructions for carrying out a risk assessment in advance of using handcuffs or leg restraints on detainees being escorted.

(xiv) DSO 07/2014 (Risk assessment guidance for contracted escort staff)

DSO 06/2014 provides detailed instructions for contracted staff in respect of carrying out a risk assessment in advance of using restraints on detainees being escorted.

(xv) Enforcement Instructions and Guidance

Paragraphs 4.6.1 – 4.6.3 of **Chapter 45 of the EIG** set out the steps to be taken when undertaking the enforced removal of a family. Limitations are placed on such removals where there is an identified risk of suicide or self harm.

Paragraph 6.1 of **Chapter 55 of the EIG** sets out the arrangements for carrying out a risk assessment in respect of an accompanied child in detention. Paragraphs 9.3 and 9.3.1 establish that unaccompanied children should not normally be detained but also set out the circumstances in which such detention might occur and what steps should be taken when it does. Paragraph 9.4 sets out the arrangements for family pre-removal detention.

Are the safeguarding policies comprehensive? Are the safeguarding policies fit for purpose?

For the purposes of this policy review I have regarded the following issues to be relevant to the issue of safeguarding: bullying; self-harm and suicide; risk assessment including room sharing risk assessment; removal of blades; management of vulnerable groups (not including women, who are covered separately in section 6 of part 2, below); and protection of children. This is not necessarily an exhaustive list, and there may be other ways of defining safeguarding, but the list represents the issues that are covered, in one form or another, in policy.

Other than in contexts which are covered elsewhere in this policy review (such as in respect of health related issues such as ACDTs, the treatment of women, and the treatment of LGBTI detainees), the issue of safeguarding has not been, ostensibly, a significant concern of the NGOs which have submitted views or of groups and individuals with whom Stephen Shaw's Review has otherwise engaged. From the perspective of the Review, however, the following observations may be of some relevance.

(i) Bullying

Bullying is covered in the Detention Services Operating Standards manual for Immigration Service Removal Centres but not in a prescriptive way. Centres are required to have developed and published a policy on the prevention of bullying (and self-harm and drug abuse), to measure the problem, to change the culture, to support victims and to challenge bullying behaviour. There is also a reference in DSO 11/2012 to the fact that transsexual detainees may be at particular risk of bullying and a number of references to bullying in DSO 19/2012, which relates to children (which is of limited relevance given that children are not usually detained). There is no reason to conclude that the policy on bullying is not sufficient in its current form, especially as little or no concern has been expressed about the policy itself.

(ii) Self-harm and suicide

Self-harm is covered in the IRC Operating Standards in a similar way to bullying in terms of having policies in place, monitoring cases and providing support for victims but the Standards also contain more detailed guidance on identifying those at risk of suicide or self-harm, preventing incidents of suicide and self-harm and responding to such incidents. DSO 6/2008 (Assessment Care in Detention and Teamwork) has been discussed in the previous section. It provides in-depth guidance on managing cases (or potential cases) of suicide or self-harm. DSO 12/2012 (Room Sharing Risk Assessment) refers to the need to open an ACDT when appropriate. DSO 17/2012 (Rule 35) deals with references to suicide and self-harm in Rule 35 reports. DSO 19/2012 (children) refers to suicide and self-harm but this is of limited relevance in the current policy environment.

(iii) Risk assessment including room sharing risk assessment

Risk is a key feature of many policy documents but this section of the policy review is concerned only with the physical risks presented to detainees (risks presented to detainees by the environment, by other detainees or by themselves), rather than, for example, the risk of a detainee absconding.

The Detention Services Operating Standards manual for Immigration Service Removal Centres requires that decisions on allocations to IRCs (by DEPMU) must take into account the risks posed by individual detainees to other detainees (and staff and visitors). DSO 01/2003 is entitled "DETAINEE RISK ASSESSMENT" but it is a process driven document which gives no insight into risk factors (which are presumably covered in form IS 91 RA, to which the DSO refers). This DSO reflects the guidance provided, in more narrative form, in paragraph 6.1 of chapter 55 of the EIG. DSO 12/2005 ("DETAINEE TRANSFERABLE DOCUMENT") requires risk assessments to be made on arrival at an IRC and at intervals subsequently. DSO 6/2008 ("Assessment Care in Detention and Teamwork") is about managing risk in suicide and self-harm cases and has been discussed elsewhere in this review. DSO 10/2012 ("Removal of blades") discusses the assessment of risk when a detainee has, or may have, concealed a blade, including the risk presented to the detainee and to others. DSO 11/2012 ("Care and management of transsexual detainees") contains a section which refers to the fact that transsexual detainees may be at a higher risk of suicide and self-harm, and bullying and harassment, than some other detainees and that risk assessments should take this into account. The DSO also requires that extra care be given to considering room allocation issues in transsexual cases. DSO 12/2012 ("Room Sharing Risk Assessment (RSRA)") is a detailed and authoritative exposition of the process for assessing risk in determining room sharing arrangements. DSO 03/2013 ("Food and Fluid Refusal in Immigration Removal Centres"), discussed elsewhere, is, in large part, about minimising the risks presented to detainees by their refusing food and liquid. DSOs 06/2014 ("Risk assessment guidance for escorted moves") and 07/2014 ("Risk assessment guidance for contracted escort staff") go into detail about minimising risk in the escorting environment, particularly in respect of the use of restraint.

(iv) management of vulnerable groups

Vulnerability is not meaningfully defined in policy terms, but the overarching Review has been asked to focus on some particular groups of detainees, and some other groups are also worthy of mention in the context of this policy review.

Pregnant women (and women generally) are considered in the section below, as are victims of sexual violence. Victims of trafficking do not feature strongly in detention policy, other than in paragraph 10 of chapter 55 of the EIG, which includes trafficking victims amongst the groups of people who would not normally be detained. Mental health and disability issues are considered above in the "Healthcare and Disability" section. Elderly people are not covered in depth in policy, though they are also referred to in paragraph 10 of chapter 55 of

the EIG. Individuals who have been tortured, or may have been tortured, are also included in that part of the EIG, and Detention Centre Rule 35, and its accompanying DSO (17/2012), deal with the issue of identifying possible torture victims in detention. This has also been discussed in the healthcare section above. The safeguarding of transsexual detainees is well covered in DSO 11/2012. Finally, it could be argued that the safeguarding of LGB detainees is not adequately covered in policy, given the view of some NGOs that these detainees face a disproportionately high risk of bullying, abuse and harassment in the detained setting – though this is not corroborated.

(v) Protection of children

The policy of the Government is that children are not usually held in immigration detention. In practice, children are only detained as a short term measure at ports, pending their being taken into local authority care, or as part of a family removal, or if they are detained in the belief that they are an adult (but it subsequently emerges that they are a child). The Home Office, and those operating on its behalf, are bound by section 55 of the Borders, Citizenship and Immigration Act 2009, which requires those carrying out immigration functions to have regard to the need to safeguard and promote the welfare of children. This is fully reflected, in great detail, in DSO 19/2012 ("Safeguarding and promoting the welfare of children in the care of Detention Operations and Service Providers"). DSO 14/2012 sets out the arrangements for managing cases in which the age of the detainee is in dispute, and this is based on a premise of detaining individuals if there is evidence affirming that they are adults or, in the absence of such evidence, if they have been assessed as an adult by a local authority or, in the absence of either of these, if, on the basis of their appearance and demeanour, immigration staff consider them to be significantly over the age of eighteen. There is facility for individuals to be released immediately into the care of a local authority if new evidence emerges which suggest that they might be a child.

Part 2, Section 6 – Women

Women's issues in detention are covered in the following documents:

- the Detention Centre Rules;
- the Detention Services Operating Standards manual for Immigration Service Removal Centres;
- DSO 2/2013 (Pregnant women in detention); and
- Chapter 45 of the EIG.

Summary

(i) Detention Centre Rules

Paragraph 7 of the **Detention Centre Rules**, which relates to searches, requires that detainees are not strip-searched in the sight of other detainees or in the sight or presence of an officer (or other person) of the opposite sex.

Paragraph 33 (10) of the **Detention Centre Rules** entitles detainees to be examined by a doctor of their own gender and to be informed of that right in advance.

(ii) the Detention Services Operating Standards manual for Immigration Service Removal Centres

The "FEMALE DETAINEES" section of the **manual** sets out a number of entitlements for women, namely: the right to be examined by a female nurse or doctor; the right not to have to undress in front of another detainee or within sight of a male member of staff; the right to eat in a female dining area; the right to be escorted by a female custody officer; equal access to activities and activities suitable to their interests; single sex gym sessions; and the right to be searched by a woman.

(iii) DSO 9/2012 (Searching Policy)

DSO 9/2012 sets out the policy for carrying out searches, with particular reference to searching women and their rooms.

(iv) DSO 2/2013 (Pregnant women in detention)

DSO 2/2013 restates the policy position on the detention of pregnant women set out in the Enforcement Instructions and Guidance (see below) and provides guidance on determining whether a pregnant woman is fit to fly.

(v) Enforcement Instructions and Guidance

Paragraph 10.3 of **Chapter 45 of the EIG** sets out the consideration that must be given in cases of removal action when a woman is pregnant. [N.B. 1.3 refers to

"Section 6.10 Use of force on pregnant women" but there is no section 6.10 in chapter 45.]

Paragraph 10.4 of **Chapter 45 of the EIG** sets out the consideration that must be given in cases of removal action when a woman is a new mother.

Paragraph 9.1 of **Chapter 55 of the EIG** establishes that pregnant women should not normally be detained, other than when removal is imminent or when they are in the fast track process and gestation has not yet reached 24 weeks.

Are the policies on women comprehensive? Are the policies on women fit for purpose?

For the purposes of this policy review, issues relevant to women have been broken down into two thematic sections – pregnant women and victims of rape and sexual violence. These are followed by sections on Yarl's Wood and other detention settings. Because Yarl's Wood houses the vast majority of women detainees, any generic issues which do not fall under the other categories are dealt with in the Yarl's Wood section.

(i) Pregnant women

During the visit to Yarl's Wood IRC on 24 February 2015, the **IMB** expressed concerns about the detention of pregnant women, on the basis that they could not be removed *"because no-one will lay hands on them"*. In a meeting with **HMIP** on 26 February 2015, HMIP suggested that there was little evidence to suggest that pregnant women were being detained only in exceptional circumstances. They also suggested that, whilst the levels of physical care of pregnant detainees were acceptable, there was concern about whether their wider welfare issues were being addressed. At a meeting with **detention service providers** on 5 April 2015 it was suggested that the fact that 80 per cent of pregnant detainees in Yarl's Wood were subsequently released raised questions about whether they had been correctly detained in the first place – though this figure is not corroborated. At a meeting with **Women for Refugee Women and former Yarl's Wood detainees** on 14 April 2015, the former detainees suggested that many pregnant women miscarried in Yarl's Wood, though this suggestion has not been corroborated either. At a visit to Cedars Pre-Departure Accommodation on 8 May 2015 it was reported that there was not a midwife on site but that one could be called in when necessary. Pregnant women who were part of family groups undergoing an ensured return were detained in Cedars up until the point at which airlines refused to take them because of the advanced state of their pregnancy (though, of course, they could be detained for a maximum of seven days in Cedars). **AVID**, in its submission (dated 30 May 2015) to the Review, reports that *"During an inspection of Yarl's Wood IRC, Her Majesty's Inspectorate of Prisons (HMIP) found eight pregnant women detained. They reported 'Pregnant women had been detained without evidence of the exceptional circumstances required to justify this. One of these women had been hospitalised twice because of pregnancy related complications'."* **Women for Refugee Women**, in its submission (of 8 April 2015) to the Review, supports this point. It goes on to

state that *"One woman who spoke to us … was three months pregnant when she was detained, and went on to develop hyperemesis gravidarum, a complication of pregnancy characterised by intractable nausea and vomiting, which meant that she suffered severe weight loss because she found it so hard to keep food down"* and that *"One of the pregnant women who spoke to us for I Am Human recounted the following experience of being taken to hospital, where she stayed for three days: 'I had three men guarding me. Even when the gynaecologist was doing an examination on me there were male guards in the room watching me. When I went to the toilet they were the ones who took me. When I sat down on the toilet the male guards were there. It made me feel ashamed'"*. **René Cassin**, in its submission (of 15 May 2015) to the Review, recommends *"that the Home Office cease the practice of detaining pregnant women. Women should receive a health screening prior to detention to ensure no pregnant women are detained"*. **Medical Justice**, in its submission (of 19 May 2015) to the Review, refers to its own report *"Expecting Change – the case for ending the immigration detention of pregnant women"* which *"found that the healthcare pregnant women receive in detention is inadequate and falls short of NHS equivalence and the National Institute for Health and Care Excellence (NICE) standards. Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy. Stillbirth, miscarriage and acute psychosis are amongst the problems experienced"*. The **Royal College of Midwives**, in its submission (of June 2015) to the Review, calls for the end of detention of pregnant women. It believes that the policy on detaining pregnant women is being inappropriately implemented. It also believes that appropriate maternity care cannot be given to women whilst in detention.

(ii) Victims of rape and sexual violence

During the visit to Cedars on 8 May 2015, it was reported that Rule 35 did not explicitly cover domestic violence. There was evidence of some perverse caseworker decisions on the basis that the doctor producing the Rule 35 report had not provided independent evidence. Training on these issues was difficult to come by. Cedars had sent a nurse to Freedom from Torture and, on the basis of this, the nurse was now able to deliver in-house training. **Women for Refugee Women**, in its submission (of 8 April 2015) to the Review, states that, in its reports *"I Am Human: Refugee women's experiences of detention in the UK"* and *"Detained: Women asylum seekers locked up in the UK"*, it had found that *"the majority of the women who disclosed their experiences of persecution to us told us that they had experienced rape, sexual violence or torture in their home countries, which led them to seek asylum in the UK. In Detained, for instance, 33 of the 43 women (77 per cent) who spoke to us about their experiences of persecution told us that they had been raped, 11 of them by soldiers, police or prison guards. Forty of the 43 women (93 per cent) said they had been either raped or tortured. In I Am Human, 24 out of the 34 women (71 per cent who disclosed their experiences of persecution) said they had experienced rape or sexual violence; 8 had been raped by soldiers, police or prison guards. Twenty-six out of the 34 women (76 per cent) said they had experienced either rape or torture"*. **Women for Refugee Women** goes on to say that *"the distress of being detained is … exacerbated by the failure to recognise women's histories of victimisation and abuse in detention"*.

(iii) Yarl's Wood

HMIP suggested that there was day to day intrusive behaviour on the part of Serco staff – entering rooms, room searches by male teams etc. At the meeting with **Women for Refugee Women and former Yarl's Wood detainees** on 14 April 2015, the **former detainees** claimed that: male officers had burst into women's rooms without knocking; male officers had entered a room whilst the detainee was showering; officers never apologised for such intrusions; the roommates of detainees on suicide watch would, by default, also be under constant observation; there was embarrassment involved in having to ask officers for sanitary protection – it should be freely available without having to ask for it; officers (both male and female) had been heard laughing at having seen detainees naked or on the toilet; a young detainee had been told by an officer that he would help her with his immigration claim if she slept with him; male officers were often present when female officers carried out "pat down" searches; one woman had been forced to remove her hijab at reception whilst being taken to hospital; during random room searches, officers had handled clothing, including underwear, without respect. **Women for Refugee Women** itself, in its submission (of 8 April 2015) to the Review, states that its *"I Am Human"* report *"sets out clear evidence of the inappropriate, gender-insensitive treatment of women in Yarl's Wood by male guards. Of the 38 women we spoke to for this report, 33 – that is, more than 85 per cent - said that male guards had seen them in intimate situations, including while naked, partly naked, in the shower and on the toilet"*. **Women for Refugee Women** also reports that *"A third of the women we spoke to for I Am Human … told us that they had been searched by a male member of staff, and two-thirds said they had been searched with a male member of staff watching, both of which are breaches of Home Office policy. Two women told us that they were strip-searched by a male member of staff; one of these instances happened at Yarl's Wood, and one at Colnbrook"*. It goes on to say that *"women told us that male guards routinely searched their rooms, which is a breach of Home Office policy"*. **René Cassin**, in its submission (of 15 May 2015) to the Review, discussing the allegations of the sexual abuse of detainees by staff in Yarl's Wood, calls for *"the inclusion of a higher representation of women amongst staff in IRCs"* and for the Home Office to ensure that *"a strong system of accountability is in place to monitor the behaviour of staff in the centres"*. **René Cassin** goes on to suggest that *"Any allegations of abuse – especially sexual abuse – are of the utmost concern and indicate a serious problem in the culture that has been created amongst staff in IRCs"*. The **Poppy Project**, in its undated submission to the Review, suggests that *"Insufficient consideration is given to the risks of having a disproportionately male staff. Ratios of male to female staff remain disproportionately high at Yarl's Wood in comparison with the female prison estate"*.

(iv) Other detention settings

During the visit to Dungavel IRC on 4 March 2015, it was reported that male officers did not have access to female areas. There had been a recent incident of inappropriate behaviour by a male detainee to a female detainee. The male had

been moved to another (all male) removal centre. At the visit to Cedars Pre-Departure Accommodation on 8 May 2015, it was reported that the usual family profile was a single mother with children. Dealing with the fathers who were not present was a difficult issue and most of the mothers were suffering from anxiety or depression. During a visit to Heathrow Terminal 3 holding rooms on 13 May 2015, a female detainee was observed being searched in front of several people. A distressed woman was left alone for an hour or so without intervention. During a visit to Heathrow Terminal 4 holding rooms on the same day, a distressed woman was observed having difficulty contacting family and friends. Staff were able to help once alerted to this but little attention was paid to the needs of the woman or her child. During a visit to Heathrow Terminal 4 holding rooms on the same day, two male detainees were observed to give unwanted attention to a female detainee and the female detainee was only moved to another area when the Review Team suggested it to staff. During a visit to Colnbrook IRC on 14 May 2015, the Sahara Unit, which held 27 women, was observed. Apart from the bedrooms being rather cramped the unit was a relatively comfortable area in which to be detained.

Commentary

The general principles of all the policy and guidance which relates to detention apply to women as well as men of course, but some apply to women only. There is no generic exemption from detention for women.

Pregnant women are listed in paragraph 10 of chapter 55 of the EIG as being one of the groups who would be *"normally considered suitable for detention only in very exceptional circumstances"* but there is a caveat, in that the reference is to *"Pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this…."*. Paragraph 9.1 of chapter 55, which has recently been revised in light of the suspension of DFT, now replicates this, having previously referred, in addition, to *"pregnant women of less than 24 weeks gestation at the point of entry, as part of a fast-track asylum process"*. Paragraph 10.3 of chapter 45 of the EIG sets out the arrangements for removing pregnant women from the UK as part of enforcement action. DSO 02/2013 ("Pregnant women in detention") consists, mainly, of information on determining whether a pregnant woman is fit to fly.

There is no reason to believe that the policies in respect of pregnant women are any less comprehensive than they need to be. There are two main policy issues related to the detention of pregnant women. First, should pregnant women be totally excluded from detention, without exception? This question is also raised in section one of part two of this review above. Some Non-Governmental organisations believe that they should be excluded, and have cited cases in which detention appears to have had a deleterious effect on the health of prospective mother and child. Second, is the policy of detaining pregnant women only in exceptional circumstances adhered to? The exception effectively allows for detention reasonably late on in pregnancy as long as removal is imminent. As the policy stood before the recent changes, there is no firm evidence to suggest that that the cases cited by the Non-Governmental organisations of what they

regard as pregnant women being detained in other than exceptional circumstance are actually outside the scope of the policy.

There is no specific policy in relation to the treatment of women who may have been the victims of sexual violence, other than the arrangements under Detention Centre Rule 35, which provides for reporting to Home Office caseworkers if certain medical conditions arise or if there is evidence of torture (both of which could, conceivably, be the result of sexual violence) so that this information can be taken into account in deciding whether detention should continue. In addition, trafficking victims (who may also have suffered from sexual violence) are excluded from detention. An internal Home Office assessment of Yarl's Wood cases from early 2015 in which sexual violence was raised as part of a Rule 35 or trafficking claim suggests that responses were, on the whole, quick and appropriate.

The allegations of the Non-Governmental organisations and of ex-detainees are that female detainees are searched by male staff, that rub-down searches of female detainees are carried out in the presence of male officers and that room searches are carried out by male officers – and that all of these are breaches of policy. The policy is not quite as unequivocal as that. It is clear in the policy that all searches involving the removal of clothes must only be carried out by women and in the presence of women and with no men present. Rub down searches must only be carried out by women and, **where possible**, only female members of staff should be present. As for room searches, the centre is required to **aim** to ensure that staff members conducting the search are female and that, **wherever possible**, all other staff members present are female. The ambition, presumably, was to instil a presumption that only women officers would be involved whilst not irrationally inhibiting operational procedures. Some of the examples cited by the Non-Governmental organisations and by ex detainee women are clearly outside of the bounds of the policy and raise serious questions about whether the policy is complied with universally.

The current suite of policies has nothing explicit to say about men who have been the victims of sexual violence.

Part 2, Section 7 – General Living

General living issues in detention are covered in the following documents:

- the Detention Centre Rules;
- the Detention Services Operating Standards manual for Immigration Service Removal Centres;
- the Operating Standards for the Detention Escort Process; and
- DSO 01/2013 (Paid work).

Summary

(i) Detention Centre Rules

Paragraph 12 of the **Detention Centre Rules**, which relates to clothing, allows detainees to wear their own clothes, requires them to be provided with clothes where necessary, including for their release, and requires that laundry facilities be available.

Paragraph 13 of the **Rules**, which relates to food, sets out the arrangements for the provision of wholesome and nutritious meals, meeting religious, dietary, cultural and medical needs.

Paragraph 15 of the **Rules** requires that no room can be used as sleeping accommodation unless the Secretary of State has certified it as being of at least the minimum acceptable standard.

Paragraph 16 of the **Rules** sets standards of hygiene in terms of provision of toiletries, daily ablutions and access to hair cuts.

Paragraph 17 of the **Rules**, which relates to regime and paid activity, requires that detainees be given the opportunity to participate in paid activities, educational activities, physical and recreational activities and cultural activities.

Paragraph 18 of the **Rules** requires that detainees be given the opportunity to spend at least one hour per day in the open air.

Paragraphs 22-25 of the **Rules** provides for the appointment of a manager of religious affairs, regular visits from ministers of religion, regular religious services and access to religious books.

Paragraph 26 of the **Rules** entitles detainees to maintain contact with those outside, including family members and friends.

Paragraph 27 of the **Rules** allows detainees to send and receive as many letters as they wish and for funding to be provided for this if the detainee cannot fund it him/herself. It also requires that letters can only be opened by detention staff if there are particular security needs and, then, in the presence of the detainee.

Paragraph 28 of the **Rules** sets out the arrangements for receiving visits.

Paragraph 31 of the **Rules** provides for access to telephones, at public expense if the detainee cannot fund it him/herself.

(ii) the Detention Services Operating Standards manual for Immigration Service Removal Centres

The "ACCOMMODATION" section of the **manual** reiterates the requirements set out in the Detention Centre Rules for accommodation to be certified by the Secretary of State as meeting the required standards.

The "ACTIVITIES" section of the **manual** sets out in detail the requirements in respect of the provision of education, library facilities, physical education facilities and recreational facilities.

The "CATERING" section of the **manual** explains in detail the arrangements for providing a healthy, balanced diet, including setting parameters in respect of minimum and maximum gaps between meals.

The "CLOTHING" section of the **manual** reiterates, in detail, the clothing requirements set out in the Detention Centre Rules.

The "COMMUNICATIONS" section of the **manual** sets out in detail the arrangements for detainee correspondence, phone calls and visits provided for in the Detention Centre Rules.

The "DETAINEES CASH" section of the **manual** contains the arrangements for checking and recording detainees' cash and, where appropriate, holding it whilst they are detained.

The "DETAINEES PROPERTY" section of the **manual** stipulates the arrangements for checking and recording detainees' property and, where appropriate, holding it whilst they are detained.

The "HYGIENE" section of the **manual** describes the minimum standards in respect of the hygiene of detainees and of the removal centre, in line with the requirements set out in the Detention Centre Rules.

The "RELIGION" section of the **manual** provides for the appointment of a manager of religious affairs and visits from ministers of religion.

(iii) Operating Standards for the Detention Escort Process

The "DETAINEES' PROPERTY" section of the **standards** sets out the arrangements for checking, recording and caring for detainees' property whilst they are in transit.

(iv) DSO 01/2013 (Paid work)

This DSO sets out the rates of pay that apply to paid work schemes and the circumstances in which detainees will be eligible for paid work.

Are the general living policies comprehensive? Are the general living policies fit for purpose?

This part of the policy review looks at the day to day living issues, things like accommodation, hygiene, activities, religion and food. In the detained setting, these sorts of issues can assume an enhanced importance.

(i) Accommodation

Locking up arrangements vary from IRC to IRC. The norm, especially in new-build facilities, such as on the Heathrow estate and at Brook House, is for lock-in between 9pm and 8am (though, at Brook House, for example, detainees are also locked in their rooms for half an hour at noon and 5pm for roll call). On certain wings in certain IRCs, free association, on the wing, is available at all hours. In prisons, immigration detainees are subject to the same regime as non-immigration detainees – which means that, in some circumstances, they can be in their cells for up to 23 hours per day. **Lieutenant Colonel F Cantrell of the IMB**, in his undated submission to the review, reports that an increase in capacity in Campsfield House had been achieved by increasing the number of detainees in each room. As a result, some of the rooms were now very cramped, without space for a chair.

(ii) Food

Detainees in a number of the IRCs complained about the quality of the food, suggesting that there was not enough choice, that it was the same every day and that it was bland. During the visit to Harmondsworth on 24-25 March, **detainees** complained about the hours in which they were allowed access to the shop. These were extremely limited because access was managed on a rota basis, determined by wing. Some individuals who had morning access to the shop complained that if they did not like the canteen food they had no opportunity to supplement their food intake as those who had afternoon access to the shop did. The catering manager at Morton Hall suggested that the national Prison Service contract had limiting effects that, for example, prevented him from sourcing more authentic ingredients for African and Asian dishes.

(iii) Hygiene

During the visit to Harmondsworth on 24-25 March, **detainees** complained that there was no soap in the soap dispensers outside the "squatting" toilet, and no paper towels either. The Review Team subsequently checked this and the claim was found to be true. There did not appear to be an effective system in place for those doing the cleaning (who, in this case, were the detainees as part of the paid work scheme) to notify the detainee custody officers that the materials needed

replacing. Otherwise, the levels of hygiene across the estate did not give any major indication of not meeting the standards required by the policy.

(iv) Activities

The activities regime in IRCs differs from place to place, though all meet basic needs in terms of having, for example, libraries, educational classes, and some sports facilities. Some sites are very cramped both internally and in terms of outside spaces. At most sites there is not much paid work available. It is usually the case that there is more activity available during the week than at the weekend.

During the visit to Yarl's Wood on 24 February, the **IMB** reported that not much outdoor activity was available. Otherwise, however, it was observed on the visit that there was a high number of other activities for all age ranges, with detainees surveyed to find out what activities they would like to undertake. The number of gym instructors was due to be increased and there were educational opportunities in respect of first aid, food hygiene, ESOL and interview skills. The visit to The Verne on 17 March 2015 revealed that there were lots of open spaces with outdoor activities such as football available. A number of practical skills were taught along with the usual IRC activities like arts and crafts, maths and English. At Tinsley House (visited on 8 May 2015) there was a sports hall and outdoor cricket pitch. Educationally, English, maths, IT, food hygiene, first aid, health and safety and arts and crafts lessons were available. In Pennine House (visit on 11 May) a basketball hoop had been erected in the small caged outdoor area to which access was limited. Inside, table football, jigsaws and books were available. On the visit to Colnbrook IRC on 14 May 2015, the Review Team observed that there was very little activity available in the segregation unit. A cycling machine had been removed from the segregation area when a detainee had allegedly tried to use it as a weapon. The detainees in Colnbrook complained of a lack of books in certain languages – Urdu and Polish were cited – and, generally, that they were constantly bored. During the visit to Brook House on 22 May it was reported that the teachers were very engaged with the detainees and that the maths, English and IT teacher also performed a pastoral role. The classrooms were small, but this was indicative of the general lack of space at the IRC. The activities manager organised games in the yard. There was no sports hall but there was a well-equipped gym. There was a cultural kitchen, in which detainees were able to cook food from their own cultures (as there was in a number of IRCs). The shop was like a post office counter, covered with Perspex, and was less welcoming than shops that had been observed in other IRCs – apparently as a result of violent incidents. **Lieutenant Colonel F Cantrell of the IMB** reports that, as a result of the increased number of detainees in Campsfield House (see above) there was not now sufficient availability of facilities. There were long queues in the dining room at meal times, which caused frustration. The fitness suite could cope with only a limited number of detainees at one time and the education facilities were oversubscribed. **Dr Nick Gill and Dr Rebecca Rotter of the University of Exeter**, in their submission (dated 22 April 2015) to the Review, suggest that *"Some IRCs have better facilities including more hours of free association and better gyms, food, health facilities, libraries, internet provision*

and better relations between officers and detainees. The prospect of being moved to an IRC that is lacking provisions is distressing for many of the detainees".

(v) Paid work

On the visit to Yarl's Wood on 24 February it was reported that there were fifty paid roles available to detainees. During the meeting with the **contract managers** on 5 April 2015, it was suggested that detainees would benefit from being provided with the opportunity to undertake more purposeful, constructive and therapeutic activities in detention, such as painting and decorating, or working on a vegetable patch, with a higher pay rate than was currently available (rates are capped at £1 per hour). On the visit to Colnbrook IRC on 14 May 2015, the **IMB** reported that there was not enough paid work available. The **Poppy Project**, in its undated submission to the Review, suggests that *"Work within centres is paid at an exploitative rate"* and that *"This mirrors the exploitation that some victims of trafficking may have experienced."*

ILPA, in its submission (dated 2 June 2015) to the review, says *"Work is a particular concern. Clients in detention often want to work to relieve boredom. But the private contractor's model is dependent upon the use of their labour, for which they are paid nominal rates, far below the minimum wage. Those in immigration detention are subject to administrative detention. Not to pay the minimum wage is to allow them to be exploited. This has nothing to do with the prohibition on those subject to immigration control being allowed to work: all the reasons for that, for example to deny persons with no leave opportunities to integrate, do not apply in detention. And in any event, they are working"*. Immigration detainees undertaking paid activity are statutorily exempt from the national minimum wage.

(vi) Religion

In Colnbrook IRC (visited on 14 May 2015), the **IMB** considered that access to religious leaders was at a good level. At Brook House (visited on 22 May 2015) it was reported by the **G4S centre managers** that the mosque was not big enough to meet demand and that the visitor's hall had to be used for Friday prayers. 50 per cent of the detainee population of Brook House was Muslim. It was the case in a number of the IRCs that the space for Muslim prayer was not sufficient because of the increased numbers of Muslim detainees. This appeared to be the case in Campsfield House too.

Commentary

(i) Accommodation

There is no evidence to suggest that any of the accommodation viewed in the IRCs and other detention facilities has not been certified as fit for use in the terms of Detention Centre Rule 15, or that regular checks on the accommodation are not being carried out. The nature of the accommodation varies across the estate. Much of it is decent but some rooms are less pleasant. The locked rooms in the intake unit in Colnbrook IRC, for example, are tiny, claustrophobic, shabby and very unpleasant. Their only saving grace is the fact that detainees stay in them for only one night. The fact that they have been certified suggests that the threshold for determining their adequacy is fairly low or that the certification is not being carried out in line with the stated requirements.

(ii) Food

There is no evidence to suggest that the food provided does not, in broad terms, meet the standards set out in the policy.

(iii) Hygiene

Apart from the example mentioned above, the policy requirements in terms of hygiene appear to be being met.

(iv) Activities

In the policy, non-paid activities fall into the following categories: education; books, physical education; and other recreation (such as TV, music and games). Activity provision varies across the estate. Most of the service providers appear keen to provide detainees with as much diverting activity as possible, but this is often limited by available space and financial and staffing resources. There is no evidence to suggest that any of the IRCs are not compliant with the policy requirements in at least a basic form. Some go further with, for example, music workshops and cultural kitchens. But there is a risk of oversubscription if, as has been suggested is happening at Campsfield, an increase in detainee numbers outpaces the available activity provision.

(v) Paid work

The policy on paid activity is set out in the Detention Centre Rules and is that "Detained persons shall be entitled to undertake paid activities to the extent that the opportunity to do so is provided by the manager" and that "Detained persons undertaking activities under (these arrangements) shall be paid at rates approved by the Secretary of State, either generally or in relation to particular cases". This formulation is very weak in policy terms in that it does not give detainees a *right* to work – they can only work if opportunities are made available. The current pay rate is £1 per hour (or £1.25 for specified projects). These rates, and the arrangements which govern whether individuals are eligible

to carry out paid work, are set out in DSO 01/2013. I have been told by Home Office officials that the DSO is currently being reviewed but that the review does not include a review of the rates of pay. Some NGOs have suggested that these rates are exploitative as they are well below the minimum wage. Some detainees share this view. However, section 59 of the Immigration, Asylum and Nationality Act 2006 expressly exempts paid work in IRCs from minimum wage legislation. The detention service providers have given no indication that they regard this work as a means of cutting costs, but they are keen to use it as a way of providing meaningful activity for detainees, and enabling them to relieve boredom, enhance existing skills or develop new skills and gain qualifications, whilst giving detainees the opportunity to earn a small reward to supplement the daily allowances they receive. As far as can be established, the policy is complied with fully.

(vi) Religion

The policy sets out a requirement for each IRC to have a process in place to allow detainees access, through observance and through contact with ministers, to their religions. All of the IRCs take this issue very seriously and there is no evidence to suggest that the policy is not being complied with fully. Where there are access problems this is because of space issues. In a number of centres, Friday Muslim prayers have to take place in sports halls and other large spaces because the current Muslim prayer rooms cannot cope with the number of Muslim detainees.

Part 2, Section 8 – Security

Security issues in detention are covered in the following documents:

- The Detention Centre Rules;
- The Detention Services Operating Standards manual for IRCs;
- The Operating Standards for the Detention Escort Process;
- DSO 01/2003 (Detainee Risk Assessment);
- DSO 09/2012 (Searching Policy);
- DSO 10/2012 (Removal of blades);
- DSO 12/2012 (Room Sharing Risk Assessment (RSRA));
- DSO 06/2014 (Risk assessment guidance for escorted moves); and
- DSO 07/2014 (Risk assessment guidance for contracted escort staff).

Summary

(i) Detention Centre Rules

Paragraph 7 of the **Rules** sets out the arrangements for carrying out searches of detainees.

Paragraph 26 of the **Rules** entitles detainees to maintain contact with those outside, including family members and friends, subject to safety and security considerations.

Paragraph 27 of the **Rules** allows detainees to send and receive as many letters as they wish and for funding to be provided for this if the detainee cannot fund it him/herself. It also requires that letters can only be opened by detention staff if there are particular security needs and, then, in the presence of the detainee.

Paragraph 28 of the **Rules** sets out the arrangements for receiving visits. In the interests of safety and security, visits must take place in sight of staff but, unless there are safety and security considerations, not within earshot of staff. Visitors are not permitted to take photographs of the centre.

(ii) the Detention Services Operating Standards manual for Immigration Service Removal Centres

The "COMMUNICATIONS" section of the **manual** sets out in detail the arrangements for detainee correspondence, phone calls and visits provided for in the Detention Centre Rules.

The "SECURITY" section of the **manual** is divided into a number of sections, namely: Accounting and Control; Escorts; Keys and Locks; Tools, Equipment & Materials; and Searching.

(iii) Operating Standards for the Detention Escort Process

The "SECURITY" section of the **standards** requires that contractors' local strategies set out the procedures for planning escorting and that the strategies must include amongst other things: risk assessments; vehicle checks; policies on use of restraints; safety checks; policies on searches.

(iv) DSO 09/2012 (Searching Policy)

DSO 09/2012 sets out the policy and practice for carrying out searches of detainees and their rooms, staff, visitors, vehicles and mail.

(v) DSO 10/2012 (Removal of blades)

DSO 10/2012 sets out the arrangements for dealing with cases in which detainees conceal blades in order to disrupt their removal.

(vi) DSO 12/2012 (Room Sharing Risk Assessment (RSRA))

DSO 12/2012 sets out the legal requirement to carry out a risk assessment – and carry out reviews of assessments – in order to guard against the risk of detainees injuring their roommates. The DSO provides guidance on carrying out such a risk assessment.

(vii) DSO 06/2014 (Risk assessment guidance for escorted moves)

DSO 06/2014 provides detailed instructions for carrying out a risk assessment in advance of using handcuffs or leg restraints on detainees being escorted.

(viii) DSO 07/2014 (Risk assessment guidance for contracted escort staff)

DSO 06/2014 provides detailed instructions for contracted staff in respect of carrying out a risk assessment in advance of using restraints on detainees being escorted.

Are the security policies comprehensive? Are the security policies fit for purpose?

This section focuses on security issues, namely measures that are taken to, for example, prevent detainees from escaping or causing harm to themselves or others. Some of this has been covered in other parts of this policy review (such as in the healthcare section, which looks at the removal of blades, or in the section on women, which looks at the issue of searches). The issue of restraint is covered in the section on escorting below.

During the visit to Dungavel on 4 March 2015, it was reported by the **GEO site managers** that, up until six months previously, the reception area had had a security focus. It was now seen more as part of welfare provision. During the visit to The Verne on 17 March 2015, the **Home Office site manager** reported that verbal feedback from HMIP (which was inspecting The Verne) was to the

effect that the Inspectorate was concerned about the physical security measures in place but recognised that these were justified given the detainee population mix. During a meeting with **Women for Refugee Women and former detainees** on 14 April 2015, the former detainees reported that (some of this duplicates the issues discussed in the section on women above): it felt like searching was used as a way of intimidating detainees; male officers were involved in searches when they shouldn't be; a woman wearing the hijab had been forced to remove it in front of men; officers treated detainees' clothes – including their underwear – without respect; personal medication was examined in detail during searches, which meant that officers effectively had access to personal medical information. During the visit to Campsfield House on 30 April 2015, it was reported that there were four roll calls per day. Building fabric checks were carried out every day. Searches were now intelligence led rather than routine. There was a culture of knocking before entering rooms. Turbans were searched using an electronic wand rather than by hand. A reasonable approach was taken to searches. For example the search of a diabetic detainee had been deferred because he had needed to eat. During a visit to Heathrow holding rooms on 13 May 2015, in the Terminal 3 holding room a female was subjected to a pat-down search in front of several people. On the same day, during a visit to Cayley House, the Review Team observed that detainees were searched at airport security as well as at Cayley House when they were transferred from Tascor care. The justification supplied for these multiple searches was that sharp objects had previously been found on detainees. There was a modesty curtain in the reception at Cayley House but it appeared unused. During a visit to the holding room at Lunar House on 29 June 2015 the Review Team observed that detainees were searched in an area in which they could be seen by other detainees in the main holding room. Staff resisted the suggestion of a screen on the basis that they could be assaulted with it, but couldn't remember the last time there was a physical assault on the premises. During a visit to Eaton House on 16 July, I witnessed a female detainee being searched in the holding room in front of a male detainee and a male member of staff. I was told that there had previously been a curtain for searches in the ante-room but that this had had to make way for a cupboard containing foods and other necessary equipment. In its submission (dated 8 April 1015) to the Review, **Women for Refugee Women** reports that *"male guards enter women's rooms without knocking or waiting for a response*". It also quotes one former detainee as saying *"They don't warn you when they are going to search your room. They shout room search. We complained. They said they don't have to give you warning. They all enter and search. Men touch your knickers. This upset me. A man touches your knickers and leaves them on the bed. It made me cry"*.

Commentary

The policy on searching is set out in a number of documents but it is brought together in DSO 09/2012 and there do not appear to be any inconsistencies across the suite of guidance. The basic principles are that: men cannot be present when a woman detainee is subject to a strip search; when a woman is subject to a rub down search it can only be conducted by a woman and, where possible, only women should be present; when a woman's room is searched, the

search must be conducted by a woman and, where possible, only women should be present; women can search male detainees unless the detainee has genuine religious or cultural objections. There is some evidence, as discussed in the section on "Women" above, to suggest that the policy is not always complied with.

Part 2, Section 9 – Escorting

Escorting issues are covered in the following documents:

- The Operating Standards for the Detention Escort Process;
- DSO 18/2012 (Person Escort Record (PER));
- DSO 06/2014 (Risk assessment guidance for escorted moves – all contractors);
- DSO 07/2014 (Risk assessment guidance for contracted escort staff); and
- Chapter 45 of the Enforcement Instructions and Guidance.

Summary

(i) Operating Standards for the Detention Escort Process

The **Standards** set out minimum requirements for those with responsibility for escorting refugees (including contractors) in the following areas:

- complaints/requests procedures;
- custody of detainees;
- detainees' property;
- families with children;
- medical care;
- staff training;
- security;
- standards audit; and
- use of force.

(ii) DSO 18/2012 (Person Escort Record (PER))

DSO 18/2012 sets out the detailed arrangements for communicating information about risks or vulnerabilities in respect of all detainees on escort or transfer using the PER.

(iii) DSO 06/2014 (Risk assessment guidance for escorted moves – all contractors)

DSO 06/2014 sets out the arrangements for the carrying out of risk assessment in cases in which restraints might be used in escorting procedures.

(iv) Detention services order 07/2014 (Risk assessment guidance for contracted escort staff)

DSO 07/2014 sets out detailed arrangements in respect of the use of restraints by contractors during escort.

(v) Enforcement Instructions and Guidance

Paragraphs 4.6.1 – 4.6.3 of **Chapter 45 of the EIG** sets out the steps to be taken when undertaking the forced removal of a family. The guidance covers a range of scenarios based on levels of compliance and support needs.

Are the escorting policies comprehensive? Are the escorting policies fit for purpose?

Lord Toby Harris (Chair of the Independent Advisory Panel on Deaths in Custody), at a meeting with Stephen Shaw on 20 February 2015, suggested that the sharing of information about individual detainees at time of transfer through the PER was of variable quality. During the visit to Yarl's Wood on 24 February 2015, there were multiple reports from **detainees** of long delays in reception, especially at night, and of late night moves to the centre. The **detainees** reported being kept in vans outside the centre, multiple moves of individuals and multiple pick ups by one van. There were reports of up to ten escorts being used for one removal. During a meeting with **HM Inspectorate of Prisons**, held on 26 February 2015, it was suggested that late night transfers were not always necessary and that they seemed to be happening at night for the convenience of the Home Office. It was suggested that up to 50 per cent of transfers were happening at night. **HMIP** also suggested that the Home Office still regularly overbooked charter flights, resulting in detainees travelling to the airport as reserves (without being told that they were reserves) and then having to be taken back to the Centre. During a visit to Dungavel IRC on 4 March 2015, **detainees** reported movements with only thirty minutes notice and transfers in the middle of the night. Waiting times for reception were reported as up to three hours. There was a report of detainees having arrived at Dungavel on 15 January from another centre and being turned back because there was snow on the approach to Dungavel and because the G4S staff had refused to walk the detainees from the van to the gates of the IRC. As a result, the six detainees had been taken back to their original centre – a round trip of eleven hours. During the visit to The Verne IRC on 17 March 2015, it was reported that a third of the moves to The Verne in February had taken place between 10pm and 6am. The site received little notice of movements out and it was possible that the Tascor IT system was responsible for this. During a meeting with **senior contract directors** on 5 April 2015, it was suggested that 32 per cent of arrivals occurred during the night-time hours and that there had been some odd scenarios – for example, individuals moved from Dungavel to spend a night at one of the Gatwick or Heathrow IRCs when they could perhaps have flown from Glasgow. A number of those interviewed during the course of the Review alleged that night-time moves were carried out in order to allow Tascor to make the best use of its van stock. Crew workloads were computer generated and were updated hourly and this resulted in short notice moves, cancellations in favour of more profitable moves and detainees arriving in groups, which resulted in backlogs at reception. At a meeting with **NOMS** on 12 May 2015, it was suggested that there were basic decency issues at stake with the number of moves that individuals were required to make and, particularly, with night moves. It was suggested that Tascor should not be allowed to move people at night time, other than when it was necessary because of flight times or in order to move people to better

facilities. In its submission (dated 19 May 2015) to the Review, **Medical Justice** reports that it *"sees evidence of inappropriate force used during removal attempts; injuries sustained include fractured bones and were detailed in (its 2008) research dossier "Outsourcing Abuse".*[4] *These injuries are often not recorded or photographed by healthcare for evidence in complaints procedures. One man, the father of 5 British children, was unlawfully killed at the hands of G4S guards on a British Airways flight. It is unknown what injuries are suffered by those who have been successfully removed as there is no effective complaint mechanism in place for these individuals or effective independent oversight after they have left the UK."*.

Otherwise, the NGOs have raised no specific concerns about the escorting process.

Commentary

Policy on escorting is, essentially, set out in three documents – the Operating Standards for the Detention Services Escort Process, DSO 18/2012 and DSO 06/2014. Between them, they set the standards for assessing risk, using force, ensuring the safety and comfort of detainees, and maintaining records.

The policy does not, however, cover three key issues: the times of day at which escorted moves can take place; the standards of behaviour expected of escorting staff; and the pay and conditions of escorting staff. These may well be contractual and operational matters rather than policy ones, but they are relevant to the welfare of detainees and therefore warrant mention here.

There has been a significant amount of criticism of the fact that a number of moves between separate IRCs, and between IRCs and other venues, take place at night time. It is accepted that some night-time travel is necessary – for example, to get people to airports for early morning flights – but what is less clear is why routine moves happen at night-time. One possibility is that, on occasion, it makes logistical sense for Tascor. For example, the I witnessed an operation which ran thus: detainee A was picked up from Brook House; detainee B was picked up from Tinsley House; detainee B was dropped off at Harmondsworth; detainees C and D were picked up from Colnbrook; detainees A, C and D were taken to Luton Airport to catch their return flights. Because the flights were between 8am and 9am, detainees A, C and D could not be delivered to Luton Airport until 4am, so the first pick up did not take place until midnight. This meant that detainee B was picked up at about 12.45am and deposited at Harmondsworth at about 2am. In logistical and efficiency terms this made sense – if the van was already going to Brook House it made sense to do a pick up from Tinsley House (which is next door to Brook House), and if it was going to Colnbrook it made sense to do a drop off at Harmondsworth (which is next door to Colnbrook) – and it meant that it was not necessary to deploy another van to do the one pick-up/drop-off. But, from the perspective of the detainee, it meant travelling at anti-social hours and, after going through reception, going to bed in

[4] The claims made in this dossier were investigated by Dame (now Baroness) Nuala O'Loan, the first Police Ombudsman for Northern Ireland.

an unfamiliar place at perhaps 4am – and, possibly, disturbing his new room-mate in the process. Another factor is the fact that Tascor is a 24-hour operation, carrying out a complex range of ever-changing moves around the country. Removing night-time moves from its schedule may mean that it is not able to operate to full capacity which may have implications for Tascor's business and a knock on effect on the people who are employed by Tascor.

I understand that the obligations on contractors in terms of the expected standards of behaviour of staff are set out via a combination of contractual provisions and security clearance, and DSO 10/2014 lists examples of behaviour which would be unacceptable (to the extent of constituting serious or gross misconduct). As far as the standards of behaviour of escort staff are concerned, I have observed some escorted operations in the UK and the Tascor staff with whom I have been in direct contact have behaved in a totally acceptable fashion in terms of the way in which they have treated the detainees in their charge. They have been polite, they have treated the detainees with courtesy and respect, and they have gone out of their way to ensure, as far as possible, the comfort of the detainees. The attitude of these Tascor staff, and their commitment to their roles, has been impressive. There is one exception to this, however. By chance, I witnessed an individual being picked up at an IRC for a removal flight by a Tascor escorting team and, in my view, the approach taken by the team spilled over into pugnacity without any apparent provocation. I was (and remain) unaware of the immigration history of the individual concerned and it may be that the escorting team had been wary of him because of his previous actions. But, in my view, the team was not averse to identifying an opportunity to escalate the situation, and chose to interpret neutral comments from the detainee as non-compliance, resulting in him being cuffed and manhandled. The detainee then became violent. Most Tascor staff I have spoken to see it as their responsibility to pre-empt possible difficulties by talking to the detainee but, in this case, a more heavy-handed approach was taken. On the whole there is clearly an acceptable standard of behaviour that most Tascor staff are able to meet – and most of them take pride in meeting this.

Tascor staff do a very difficult job in very difficult circumstances. They have a high level of responsibility. They work long shifts at anti-social hours. Their lifestyles do not lend themselves to healthy eating, regular sleeping patterns and family life. Tascor staff often work overtime in order to supplement their incomes – exacerbating the anti-social nature of the job. This is a matter of choice for the individuals concerned of course, but it becomes a matter for the Review if there is a risk of the levels of stress and tiredness of the officers impacting on the comfort, wellbeing and safety of the detainees.

Conclusions

The policies which impact on the welfare of immigration have evolved over the past fifteen years. As discussed previously in this review, they come in a number of forms, some emanating from others, some existing independently of others. Because of the evolutionary nature of the policies, there is a risk of overlaps, gaps and inconsistencies. In actual fact, there are not as many of these as might have been expected.

Taken as a whole, the suite of policies and guidance represent a comprehensive tool for civil servants and contractors working in the detention field. There are isolated examples of particular pieces of policy being poorly written, with occasional lapses into jargon and overly-bureaucratic language. The majority, however, are clear and present the policy position and process requirements in an understandable and helpful way.

I have identified some areas of policy in which there are, in my view, overlaps (and the potential for confusion) and gaps.

Overlaps

(i) Detainees' property

As I have noted on page 29 of this review, there are four separate pieces of guidance on the issue of detainees' property. Although there does not appear to be inconsistency across them, it would be as well to consolidate them.

Gaps

(i) Person Escort Records (PER)/Detainee Transferable Documents (DTD)

As discussed on page 32 above, it seems strange that there is no direct link in policy between the PER and the DTD.

(ii) Lesbian, Gay and Bisexual (LGB)

There is very little mention in policy of the management of LGB cases and this is an omission, given the (albeit uncorroborated) concerns raised by the UK Lesbian and Gay Immigration Group about levels of bullying and harassment against LGB individuals in detention. (Page 47.)

Appendix 4: The Article 3 Sub-Review

Assessment of cases where a breach of Article 3 of the European Convention of Human Rights has been found in respect of vulnerable immigration detainees

Introduction

1. On 9th February 2015 the Home Secretary appointed Stephen Shaw CBE to conduct an independent review of policies and procedures affecting the welfare of those held in immigration removal centres. The purpose of the review is to seek to identify whether improvements can be made to safeguard the health and wellbeing of detainees, and those being escorted in the UK.

2. I am asked to assist Mr Shaw by providing an independent legal assessment of cases where the Courts have found a breach of Article 3 of the European Convention of Human Rights in respect of the treatment of immigration detainees since May 2010. In particular, I am asked to provide a summary of the relevant judgments in which such a breach has been found, to offer an opinion on the degree to which the Court's findings are case specific, or whether they show some kind of systemic failing either in policy or the actual conditions of detention. I am also asked to consider whether the judgments contain findings that have implications for the wider policy and care of detainees, especially those regarded as vulnerable.

3. I have discussed with Mr Shaw my professional practice which has included undertaking a number of cases where I have been instructed on behalf of the Secretary of State, including cases concerning immigration detention (but

none in which a breach of Article 3 has been found). He is satisfied (as am I) that that background does not amount to a conflict of interest and does not compromise my independence.

Legal framework

4. Legislation provides broad powers to detain individuals for the purpose of removal from the United Kingdom – see in particular paragraph 2 of Schedule 3 to the Immigration Act 1971. Those broad powers are subject to a number of implicit limitations. They include that detention should only be imposed for the statutory purpose of securing removal from the United Kingdom, and should only be imposed for a reasonable period of time[5]. Nothing in those legislative powers explicitly exempts the mentally ill from detention.

5. Rule 35 of the Detention Centre Rules 2001 requires particular steps to be taken when detention may result in ill-health. It states:

> **35 Special illnesses and conditions (including torture claims)**
>
> (1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
>
> (2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.
>
> (3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.
>
> (4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
>
> (5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to

[5] *R v Governor of Durham Prison ex parte Hardial Singh* [1984] 1 WLR 704.

> require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.

6. UK Visas and Immigration has published "Enforcement Guidance and Instructions" setting out, at a policy level, the circumstances in which it will seek to detain individuals in pursuance of its statutory powers. Chapter 55 makes specific provision in respect of the mentally ill. It stated (in the version in force between May 2010 and 26th August 2010):

> The following are normally considered suitable for detention in only very exceptional circumstances…
> …
> those suffering from serious medical conditions or the mentally ill…

7. From 26th August 2010 it stated:

> The following are normally considered suitable for detention in only very exceptional circumstances…
> …
> those suffering from serious mental illness which cannot be satisfactorily managed within detention... In exceptional cases it may be necessary for detention… to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act.

8. The following sets out the correct approach to the policy[6]:

> 51. …the existence of very exceptional circumstances demands both a quantitative and qualitative judgment. Were this provision to stand in isolation in the policy the power to detain the mentally ill could only be used infrequently, and the circumstances would have to have a quality about them which distinguished them from the circumstances where the power is frequently used. Otherwise effect would not be given to the requirement that the circumstances not simply be exceptional but very exceptional.
>
> 52. There are two points to be made. The first is that in my view mental health issues only fall to be considered under Chapter 55 where there is available objective medical evidence establishing that a detainee is, at the material time, suffering from mental health issues of sufficient seriousness as to warrant consideration of whether his circumstances are sufficiently exceptional to warrant his

[6] See *per* Cranston J in *Anam v SSHD* [2009] EWHC 2496, approved by the Court of Appeal (Maurice Kay, Longmore and Black LJJ) [2010] EWCA Civ 1140.

detention. This consideration must be given to the nature and severity of any mental health problem and to the impact of continuing detention on it.

53. Secondly, the provision that the mentally ill be detained in only very exceptional circumstances does not stand in isolation. The opening part of paragraph 55.10 provides that for Criminal Casework Directorate cases "the risk of further offending or harm to the public must be carefully weighed against the reason why the individual may be unsuitable for detention". Paragraph 55.13 indicates, as would be expected that that demands a consideration of the likelihood of the person re-offending and the seriousness of the harm if re-offending occurred. With an offence like robbery, the paragraph specifically requires substantial weight to be given to the risk of further offending and harm.

54. Absconding as a consideration is introduced by paragraph 55.3A for CCD cases. That provides that in assessing what is a reasonable period of detention necessary for removal in the individual case, case-workers must address all relevant factors, including the risks of re-offending and absconding. That paragraph specifically mentions mental illness when considering more serious offences such as robbery. The relevant passage has been quoted earlier in the judgment: case-workers must balance the risk to the public from re-offending and absconding if the detainee is mentally ill.

55. The upshot of all this is that although a person's mental illness means a strong presumption in favour of release will operate, there are other factors which go into the balance in a decision to detain under the policy. The phrase needs to be construed in the context of the policy providing guidance for the detention of all those liable to removal, not just foreign national prisoners. It seems to me that there is a general spectrum which near one end has those with mental illness who should be detained only in "very exceptional circumstances" along it – the average asylum seeker with a presumption of release – and near the other end has high risk terrorists who are detained on national security grounds. To be factored in, in individual cases, are matters such as the risk of further offending or public harm and the risk of absconding. When the person has been convicted of a serious offence substantial weight must be given to these factors. In effect paragraph 55.10 demands that, with mental illness, the balance of those factors has to be substantial indeed for detention to be justified.

9. Article 3 of the European Convention on Human Rights states:

ARTICLE 3: Prohibition of torture
No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

10. It is unlawful[7] for a public authority (such as UKVI) to subject a person to inhuman or degrading treatment. The prohibition of inhuman and degrading treatment is absolute. Such treatment is not capable of justification, although the circumstances in which the treatment is imposed are relevant to the assessment of whether it amounts to inhuman and degrading treatment.

11. Detention does not in itself raise any question of inhuman or degrading treatment. There is no general obligation to release detainees on health grounds. Conditions of detention must, however, be compatible with respect for human dignity and must not involve distress or hardship of an intensity that exceeds the unavoidable level of suffering inherent in detention. Health and well-being must be adequately secured by (amongst other things) the provision of requisite medical assistance[8].

12. Treatment must reach a minimum level of severity before it can be said to amount to inhuman or degrading treatment in breach of Article 3. That standard is highly fact sensitive, depending on all the circumstances of a particular case, including the age and state of health of the claimant, the circumstances in which the treatment took place and the effects of the treatment on the claimant[9].

Cases in which a breach of Article 3 ECHR has been found

13. There are six cases in respect of which a breach of Article 3 ECHR has been found in respect of vulnerable immigration detainees. They are (in chronological order):

[7] By reason of s.6(1) Human Rights Act 1998.
[8] *Kudla v Poland* (2002) 35 EHRR 11.
[9] See eg *Ireland v United Kingdom* (1978) 2 EHRR 25 at [162].

(a) *R (S) v Secretary of State for the Home Department* [2011] EWHC 2120 (Admin).

(b) *R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748 (Admin).

(c) *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin).

(d) *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin).

(e) *R (S) v Secretary of State for the Home Department* [2014] EWHC 50 (Admin).

(f) *R (MD) v Secretary of State for the Home Department* [2014] EWHC 2249 (Admin).

14. It is likely that this is a comprehensive list and that these represent the only 6 cases where a breach of Article 3 has been found in this context since May 2010:

(a) Cases challenging immigration detention are almost always[10] brought in the Administrative Court or the Queen's Bench Division of the High Court.

(b) All cases determined in the Administrative Court or the Queen's Bench Division of the High Court are reported on BAILII[11].

[10] But not invariably – cases are sometimes brought in the County Court – see for example some of the cases referred to by Bhatt Murphy solicitors on their website: [redacted] But it is relatively unusual for this type of claim to be brought in the County Court and I have not been able to find any reference to a claim in the County Court where a breach of Article 3 has been found in this context.

(c) I have undertaken searches of BAILII and other search engines and have not identified any additional cases.

(d) The cases identified above (and others which consider the general issues) refer to the earlier authorities in the list, but in none of those authorities (or others which consider the general issues) is reference made to any other case where a breach of Article 3 has been found in this context.

15. Of course, only those cases which are litigated to a substantive hearing can result in a positive finding (one way or the other) in respect of a breach of Article 3. It is possible that there are other cases in which claims alleging breaches of Article 3 have been settled (and the stronger cases are probably more likely to be settled). It is also possible that there are other cases in which possible breaches of Article 3 have not been litigated, whether because the individual has been removed from the United Kingdom and has not sought to bring a claim from abroad, or has not been able to secure access to legal advice, or else, for whatever reason[12] has not sought to bring a claim.

16. It has been pointed out that the 6 cases where an Article 3 breach has been found should be viewed in the context that approximately 30,000 people are detained each year under immigration powers. Compared to that number, the proportion where there has been found to be a breach of Article 3 is tiny. For the reasons given in the previous paragraph, however, I do not think that any great significance can safely be attached to that feature[13]. It does not, in itself,

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[11] British and Irish Legal Information Institute – [redacted]

[12] Baroness Hale, writing extra-judicially, has observed that those suffering from some forms of mental illness (such as depression) may be less likely than others to bring claims to assert their legal rights – see Hoggett on Mental Health Law (Sweet & Maxwell, 1996).

[13] And see paragraph 49 below for cases where no breach of Article 3 has been found but where the underlying criticisms resonate with the findings in those cases where there has been a breach of Article 3.

show that the failings identified in the individual cases are limited to those cases and are not symptomatic of underlying systemic issues. More important than the numbers are the nature of the findings in the cases and the extent to which they demonstrate similar failings at different periods of time in different removal centres and involving different decision makers. On the other hand, this is a very small number of cases. The findings in these cases can do no more than indicate the possibility of underlying systemic failings.

Summaries of the cases where a breach of Article 3 has been found

17. I summarise each case of the six cases identified in paragraph 13 above in turn.

(1) R (S) v Secretary of State for the Home Department [2011] EWHC 2120

18. S is an Indian national, born in 1976. He unlawfully entered the UK in 1995. In 2009 he was convicted of offences of violence and sentenced to 16 months imprisonment. During his imprisonment he was placed on a special regime of supervision due to incidents of self-harm and an attempt at suicide. At the conclusion of his sentence S was detained pending deportation. He was again placed on a special regime due to very low mood and threats of self-harm. He was placed on anti-psychotic medication. S's mental health problems were drawn to UKBA's attention by S's solicitors. Nevertheless, repeated detention reviews stated that S was "in good health" and authorised continued detention. S spent a period of time in custody (including pursuant to a hospital order imposed under s38 Mental Health Act 1983) as a result of an attempt at escape, but he returned to immigration detention in April 2010. By this stage there was a wealth of medical evidence[14] to the effect that S was

[14] UKBA disputed that this evidence had come to its attention, but the Court found this "difficult to accept". Even if UKBA was not in possession of the reports, it was on notice of their existence and it was incumbent on it to obtain the reports but "it is not possible to determine why or how this oversight on the part of UKBA occurred since so little assistance has been provided to the Court in the evidence on these matters."

suffering from post-traumatic stress disorder and other mental health illnesses and that continued custody would result in a deterioration of his condition. The decision to detain stated that "[S] claims to be mentally ill but we have no evidence of this." Medical examinations whilst S was in detention showed that he was at "very high risk" of self-harm. Within days of his detention S's mental health deteriorated, as had been predicted. Even after the medical evidence was undoubtedly in Harmondsworth's possession, there was no review of detention. A report was sent to UKBA under r35 of the 2001 Rules (the terms of the report do not appear from the judgment). Some 3 weeks later there was a detention review which did refer to the medical evidence and stated:

> …It has been taken into account that those with a mental illness can only be detained under immigration powers in exceptional circumstances and full consideration has been given to the presumption to release – liberty… Given the risk of harm, offending and absconding, the presumption in favour of liberty is outweighed in this case…

19. The Court was highly critical of this review for a number of reasons, including that it failed to grapple with the effect of detention on S's condition and it did not appear to treat S's mental condition as something which required significantly weighty countervailing considerations to justify detention.

20. Subsequent reviews (following the initial decision to detain there were a total of 5 subsequent reviews) suffered from the same defects. The First Tier Tribunal refused bail, but it was not clear whether it was shown any of the expert reports. S was released on bail in September 2010 when he was granted permission to claim judicial review of his detention.

21. The Court found that S's detention was unlawful because he had not been served with the deportation order. More importantly for present purposes, the Court also found that the decisions were flawed because on each occasion

the decision maker had failed to apply the policy requirement of exceptional circumstances, to recognise properly S's mental condition, and to consider properly objective evidence as to the effect of detention on S.

22. The Court found that the detention amounted to a breach of Article 3 because it was contrary to undisputed medical evidence and because the claimant's condition (as predicted) deteriorated rapidly as detention was maintained. The detention involved both a debasement and humiliation of S since it showed a serious lack of respect for his human dignity, and created a state in S's mind of real anguish and fear, which led to self-harm and humiliating behaviour.

(2) R (BA) v Secretary of State for the Home Department [2011] EWHC 2748

23. BA is a national of Nigeria. He arrived in the United Kingdom in 2005 with 644g of cocaine hidden in his body. He was sentenced to 10 years imprisonment with a recommendation for deportation at the end of his sentence. Whilst serving his sentence of imprisonment it was clear that he was suffering from a mental illness. He was admitted to hospital under s47 Mental Health Act 1983. A report indicated that if he was returned to prison "his mental state would deteriorate to dangerous levels where there are significant health risks." He was subsequently returned to prison for a short period of time but he quickly deteriorated and was returned to hospital.

24. The custodial part of his sentence came to an end in December 2011, albeit he remained detained under the 1983 Act. On 1st February 2011 he was transferred from hospital to Harmondsworth where he continued to be detained under immigration powers. The Court was critical of the standard of healthcare at Harmondsworth. The first entry in the medical records was made 2 months after his arrival and indicated that BA was relapsing

gradually. Thereafter, he was seen for an asylum interview but this was postponed because BA had appeared "disorientated and lethargic" and BA had said that his medication had run out and he was not able to see healthcare staff. The interviewer took the view that BA was clearly not fit and well and ready to be interviewed. He was seen by a GP on 12th May 2011 who reported that BA was "disoriented, lying on the floor, keeps repeating "I see demons"". He was first seen by a psychiatrist on 21st May 2011, more than 3½ months after his arrival at Harmondsworth. The psychiatrist recorded a differential diagnosis of either situational stress with malingering, or stress-induced psychosis. Thereafter, BA stopped eating and drank very little. On 3rd June he was again seen by a psychiatrist who diagnosed stress-induced psychosis and depression and said that BA should be referred to hospital for further assessment and treatment. He was twice admitted to hospital for a short period for re-hydration (and there were repeated medical assessments that BA needed "to be hospitalised").

25. On 29th June a doctor said that BA was unfit for "prolonged detention". A r35 report was sent to UKBA on 4th July 2011. On 6th July a doctor said that it was highly unlikely that BA could be successfully treated in an immigration detention centre, and "indeed that continuing to do so courts a real risk that he could die" – he needed urgent psychiatric care which must be outside detention. In a report dated 19th July 2011 a doctor concluded that BA's deterioration was directly related to his immigration issues and detention. On 28th July 2011 a medical examination indicated that there was a risk that BA's internal organs could shut down. Harmondsworth wrote to UKBA and said "Based on BA's presentation this morning and the decision to maintain detention despite two letters stating that he is unfit to be detained, I will now be [formulating] an end of life care plan for this gentleman." BA was admitted

to hospital under s49 Mental Health Act 1983 on 6th August 2011 and his condition rapidly improved.

26. During the period of BA's detention there had been 8 reviews after the initial authorisation of detention. The decision makers were aware of BA's condition. The initial decision noted BA's illness but stated that BA's clinician was "content" for BA to be detained. Subsequent reviews considered that detention was justified because of a risk of absconding and re-offending and the risk of "serious harm" posed by BA "taking into account his mental health issues." The first reference to paragraph 55.10 of the EIG was in a review in June 2011 but that review did not refer to any of the considerations relevant to paragraph 55.10. The next review, in July 2011, was word for word identical. At the end of that month the strategic director of the Criminal Casework Directorate refused to authorise release because BA was a "high risk subject who poses a risk to the public and who must also present as a reasonable risk of absconding" and his mental health problems were "self-inflicted". An assistant director expressed surprise at this decision and wrote "… we will discuss informing the RRT as there will be significant press interest if he does subsequently pass away. We have made sure that healthcare are keeping good and accurate details of his care and this record will be available to the PPO should he die." The final review took place 9 days late. It continued to authorise detention.

27. The Secretary of State argued before the Court that the phrase in the EIG "those suffering from serious mental illnesses which cannot be satisfactorily managed in detention" only applied at the point at which a detainee was currently and obviously suffering from a condition that could not be managed in detention (as opposed to applying when a detention decision was made in respect of a person suffering from a mental illness (albeit he was well at the

time of the decision) which might not be capable of satisfactory management in detention). The Judge rejected this submission:

> It seems to me that… interpretation of the policy is likely to lead to the very problems which occurred here. The laissez faire approach entailed in this construction would permit the Secretary of State to detain someone who is potentially unsuitable for detention, and to forget about him, leading to risks that the detainee's condition will not be monitored, and of deterioration to a point where the illness cannot be managed. [The correct approach, of applying the policy even to those who were well at the time of the decision] is likely to lead to a more conscious approach to the identification, and care and custody, of those with serious mental illnesses, because it requires the Secretary of State to confront this issue at the outset, to make plans for the detainee's welfare if the decision is to detain, and to be alert, in detention reviews, for signs of deterioration which may tilt the balance of factors against detention.

28. The Deputy Judge found that the initial decision to detain, and the subsequent reviews, breached paragraph 55.10 of the EIG. They did not grapple with the issues that arise under that paragraph. Mere references to BA's illnesses were insufficient to discharge the analytical duties that arose. There had been no consideration (until the later reviews) of the test in paragraph 55.10 or how it was said to be met on the facts.

29. The Judge found that there was a breach of Article 3 ECHR:

> 236. In my judgment there was a deplorable failure, from the outset, by those responsible for BA's detention to recognise the nature and extent of BA's illness. This may well have contributed to the complete absence of any monitoring of BA's condition in the early stages of his detention (from 1 February to 30 March 2011). Although he first showed signs of disturbance on the latter date, and was plainly unfit for interview on 8 April 2011, he was not seen by a psychiatrist until 21 May 2011. At the time of the proposed interview, someone had forgotten to give him his medication for about a week. All of this in turn may have contributed to his gradual relapse, and then his determined, and persistent, refusal of food and drink, with dire consequences for his physical health. Even then, his eventual transfer to hospital was significantly delayed for various reasons. …
>
> 237. I do not consider, however, that the article 3 threshold was reached until 4 July, when Valerie Anderson reported her view that he was "in such poor physical condition that he should now be considered unfit to be detained". In coming to

> this conclusion, I have taken into account the fact that, if the Secretary of State had acted lawfully, she could and would have detained BA until 21 June 2011. I have also taken into account that even if BA's refusal of food and drink was caused by his illness, rather than (as the Secretary of State's officials have at various times implied) wilfully, it is extremely difficult to deal with such behaviour in a way which both respects personal dignity and autonomy, and also safeguards health. Nor has anyone charged with his welfare deliberately set out to cause him suffering or distress. But I do consider that there has been a combination of bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare. The documents disclosed by the Secretary of State have also shown, on one occasion, a callous indifference to BA's plight. If I am wrong about this, and the article 3 threshold was not breached, I would hold that, at this point, the Secretary of State infringed BA's article 8 rights by continuing to detain him.

(3) R (HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979

30. HA is a national of Nigeria. He entered the United Kingdom on a visitor's visa, but overstayed. In July 2009 he was sentenced to 14 months imprisonment for being concerned in the supply of cannabis. During his imprisonment HA began to experience psychiatric problems. His release date was 27th August 2009 but he continued to be detained under s36(1)(a) UK Borders Act 2007.

31. In September 2009 a doctor commented "I am extremely concerned for this man and feel we need an urgent psych assessment and possible hospital transfer." HA's behaviour over the following months was "disturbed and strange". UKBA was informed in October 2009 that HA had "serious mental health problems and needs to be transferred to a more suitable establishment." In November a Registered Mental Health Nurse said that HA had "nil psychotic problems" and that his behaviour was attributable to his personality. However, shortly thereafter a doctor identified possible "paranoid psychosis" and stated that HA "may eventually need transfer to an appropriate UNIT for psy. Input." In January 2010 HA was reviewed by a psychiatrist who said "I strongly suspect that he is suffering from a psychotic illness, and this obviously must be excluded as a priority… Further

assessment is recommended in a suitable Mental Health Unit and early transfer to other secure non-custodial setting appears to be necessary. There is no ground to recommend release from detention. Transfer to a suitable secure unit under section 48 of the Mental Health Act is recommended." A report under r35 of the 2001 Rules was made the same month. He was not transferred to a Mental Health Unit. He continued to be detained and was placed in segregation for several months (and the use of force was authorised). HA was eventually transferred on 5th July 2010.

32. There had been 9 detention reviews prior to the transfer. There was very limited mention of HA's mental health, and no analysis of whether HA fell within the exceptions to detention listed in Chapter 55 of the EIG.

33. HA's solicitors sought an assurance that HA would not be transferred back to detention at an IRC. UKBA refused to grant such an assurance. UKBA was, however, informed by a doctor that HA was suffering from paranoid schizophrenia, a severe mental illness. In answer to the question whether it was "likely" that HA's mental health would deteriorate "significantly" if HA were to remain in an Immigration Removal Centre for a prolonged period of time, the doctor's response was:

> He remains vulnerable as he suffers from a severe mental disorder within the meaning of the Mental Health Act 1983… and should his mental health deteriorate, he may need enforced treatment which cannot be provided in an Immigration Removal Centre, and this may lead to considerable delays before appropriate treatment is given.

34. On 5th November 2010, HA was, without notice, transferred back to Harmondsworth. Shortly thereafter, bail was refused on the basis that the evidence did not disclose that the detention of HA had caused a deterioration in his mental health or that he could not be adequately and properly treated within a removal centre. On 6th December 2010, a consultant psychiatrist

instructed by HA's solicitors wrote that he considered that there were "serious concerns as a matter of urgency":

> In my view there is a significant risk to [HA's] mental health through the detention, the inappropriateness of this setting with a severe mental illness and the lack of adequate psychiatric care within it.
> ...
> I am of the opinion as a psychiatric expert that [HA] cannot be adequately treated in detention and without mental health workers experienced in the treatment of such a severe condition. A continuation of his detention therefore poses a severe risk to his mental health and is likely to lead to a further deterioration of his psychiatric condition.

35. In December 2010 HA was granted bail in the course of judicial review proceedings.

36. The Court found that HA's detention from 1st February 2010 until his transfer to hospital, and that his detention after being discharged from hospital, was unlawful because of a failure to have regard to the policy not to detain where that was likely to be injurious to health.

37. The Court found that HA had suffered degrading treatment in breach of Article 3 ECHR on the grounds that:

> (1) as was eventually recognised, the Claimant was suffering from a serious mental illness while he was in detention at IRCs;
> (2) his behaviour, which was described by many observers as "odd" or "bizarre", included acts which violated his own dignity in that:
> (a) he spent prolonged periods of time in isolation in segregation or temporary confinement;
> (b) he was sleeping on the floor, often naked, in a toilet area;
> (c) he drank and washed from the toilet;
> (d) he was self-neglecting by not maintaining adequate nutrition;
> (e) he did not wash or change his clothes for prolonged periods, perhaps for over one year, and was described as "grossly unkempt" on arrival at the hospital;
> (f) he suffered insomnia;
> (3) his behaviour alienated him from others in the IRCs, so that he had to be segregated;

(4) he was not given appropriate medical treatment to alleviate his mental illness for a prolonged period of more than 5 months;
(5) the use of force against the Claimant was authorised on several occasions.

38. The Judge found that the return to detention in November 2010, and the continued detention thereafter, was in breach of Article 3:

> By the time of his compulsory return to an IRC it was known that the Claimant had a severe mental illness which had not been treated for many months when he was previously in IRC detention. It was known that his mental illness had been stabilised (but not eradicated) by the use of medication, which had to be administered using force. It was known that the IRC did not have the medical facilities that the Claimant would need if he suffered a relapse. It was known that the nature of the Claimant's illness concerned in part a paranoia about IRC staff. It was also known that, when he had been in IRC detention previously, he had had to be in segregation for many months and had engaged in behaviour that was described as "odd" or "bizarre" and which included self-neglect and drinking water from the toilet. In all the circumstances of the case, in my view, to force the Claimant to return to and stay in IRC detention in November and December 2010 was at least degrading treatment and, if it were necessary to say so, inhuman treatment, contrary to Article 3: I make this last point because by this stage, unlike the first period of detention between January and July 2010, the Claimant's serious medical condition was clearly known to the Defendant. It was therefore unlawful by virtue of section 6(1) of the Human Rights Act 1998.

(4) R (D) v Secretary of State for the Home Department [2012] EWHC 2501

39. D is a national of Congo-Brazzaville. He arrived in the UK in 2002. He was first served with notice of liability to administrative removal in October 2002. Between 2005 and 2008 he was detained under immigration powers. During his detention he displayed disturbed behaviour and was described as "floridly psychotic and thought disordered." After release from immigration detention he spent a period of time admitted to hospital under s2 Mental Health Act 1983. He was abusive towards UKBA officials and he smashed a window at a reporting centre. On 21st February 2011 a decision was made that he should be detained because his removal from the UK was said to be imminent (even though the previous day it was said that there was not a high

prospect of removal before 31st March). He was detained at Brook House and over the next 5½ months he was never given any anti-psychotic drugs (despite D saying on admission that he was on medication and he wanted his prescribed mediation) and he never saw a psychiatrist. An incident of violence on D's part towards a detention centre officer triggered D's transfer to Harmondsworth for a psychiatric assessment. He was there detained for 4 months. Although he was said to be under the care of a psychiatrist, he in fact never saw any psychiatrist (save for Dr Tracy at the behest of his solicitors). The medical records record that he was suffering from schizophrenia. Dr Tracy produced a report in September 2011 stating that Harmondsworth was not conducive to optimal mental health. D's solicitors asked Harmondsworth to conduct an urgent psychiatric assessment, and asked UKBA to review D's detention at a detention centre where there was no adequate psychiatric provision (making reference to the guidance in Chapter 55.10 of the Enforcement Instructions). No such assessment took place. However, it was well documented that D was showing signs of paranoid schizophrenia. Monthly progress reports were silent about D's medical conditions. At a bail hearing on 27th September the Secretary of State gave an undertaking "to use best endeavours to ensure that the process of assessing and treating the Claimant for his mental health (including medication if appropriate) is carried out as swiftly as possible". A medical record on 28th October said that HA was hearing voices and was fleetingly suicidal and that he should be referred to the mental health team "for further assessment", but that did not take place. On 11th November a mental health nurse recorded that D was complaining of experiencing auditory hallucinations that caused him to become agitated and confused, and that he wanted to get back onto his medication. A monthly review in November recorded that there were no medical issues that precluded continued detention.

40. D was transferred to Colnbrook on 29th November 2011. He was seen by a psychiatrist promptly and was prescribed medication. However, he continued to suffer hallucinations and a further report from Dr Tracy recommended that if his condition did not improve with treatment then he should be transferred to a psychiatric unit under s48 Mental Health Act 1983. No such transfer took place. Eventually, in April 2012 he was granted bail and was released subject to reporting restrictions.

41. The Court found that detention without the availability of adequate psychiatric treatment at Brook House and Harmondsworth amounted to a breach of Article 3:

> 175. The treatment (or rather absence of proper psychiatric treatment) which was provided to D at Brook House and Harmondsworth lasted for many months and caused, or rather exacerbated, D's mental suffering. It was 'premeditated', not in the sense of any subjective intention to damage D's mental health, but rather in the sense that those with responsibility for the well-being of detainees in the two institutions knew that D had a history of mental illness and persisted in a medical regime for him which involved neglect (particularly in relation to the taking of anti-psychotic medication and denial of access to a psychiatrist) and recourse to what were in effect disciplinary sanctions under rules 40 and 42 which were unsuitable for a person with his condition.
>
> 176. What eventually I have found decisive is the fact that, on the uncontradicted evidence of Tracy 2, D's "mental state has deteriorated as a direct result of [his mental health needs not having been well met]"; and more particularly the opinion of Dr Tracy, accepted by the Official Solicitor when he took over the conduct of the present litigation, that the treatment afforded, or not afforded, to D was such as to render him legally incapable, in the sense of being unable to instruct his legal team or effectively to participate in tribunal processes. I note also the confirmation of Dr Tracy's views by Dr Larkin, who wrote: "In my view, the periods of immigration detention, in facilities with insufficient mental health input, have been a main cause of [D]'s prolonged mental health difficulties."
>
> 177. The acts and omissions at Brook House and Harmondsworth in my view intruded on D's human dignity and constituted inhuman treatment within Article 3.

42. The Court did not find that the breach of Article 3 at Colnbrook continued because there were fortnightly psychiatric reviews. However, he considered that even at Colnbrook the medical regime was "brusque and insensitive to the particular circumstances and mental state of D, and stubbornly resistant to external criticism."

(5) R (S) v Secretary of State for the Home Department [2014] EWHC 50 (Admin)

43. In this case HHJ Anthony Thornton QC found a breach of Article 3 in respect of detention at Colnbrook and Harmondsworth between December 2011 and March 2012. I do not, however, think that it is appropriate to consider the case further. That is because the Secretary of State appealed against the judgment, and S conceded that the appeal should succeed because of deficiencies in the judgment. The Court of Appeal agreed[15]. It said[16]:

> 9(c). The judge based this part of his decision on what had been said by David Elvin QC, sitting as a judge of the High Court, in *R(S) v SSHD* [2011] EWHC 2120 (Admin) . In paragraph 417 of his judgment he made various findings of fact highly critical of those who were responsible for the respondent's care and treatment, but in doing so he failed to explain why the relevant legal test was satisfied. Moreover, the respondent accepts that none of the findings in paragraph 417 are capable as they stand of justifying the conclusion that there was a breach of the respondent's rights under Art. 3 of the Convention.
>
> 10. We agree with the parties that in view of these deficiencies in the judgment the judge's decision cannot stand; it will have to be set aside and the matter re-tried. **As a result, none of his findings of fact nor any of his conclusions of law will be of any significance, either to the future conduct of this case or indeed to that of any other**. At the re-trial the parties will be free to advance whatever arguments of fact or law they think appropriate, subject to the usual constraints of the CPR. We reach this decision with some regret, because a considerable amount of time and money has been spent on these proceedings, but we accept that there is no practical alternative. [Emphasis added]

[15] Moore-Bick, Elias and McCombe LJJ – see [2015] EWCA Civ 652.
[16] *per* The Vice President of the Court of Appeal, Moore-Bick LJ (with whom the other two members of the Court agreed) at [9(c)] and [10].

(6) R (MD) v Secretary of State for the Home Department [2014] EWHC 2249 (Admin)

44. MD is a national of Guinea. She arrived in the UK on 7th April 2011. She was detained because of inconsistencies in her account. After being detained for almost 4 months she began to self-harm. She was restrained, removed from association and placed in handcuffs to prevent her from harming herself. She was examined by a trainee doctor instructed by MD's solicitors, who considered that there was an acute deterioration in her mental health provoked by her recent experiences while she was detained and that she was at risk of further deterioration in her mental health. These views were not fully addressed in the reviews of MD's detention and nor was the policy of not detaining those suffering from a serious mental illness which could not be satisfactorily managed in detention. In February 2012 an experienced consultant psychiatrist recorded that MD was suffering from Major Depression with psychotic features and Generalised Anxiety Disorder and that the treatment in the detention centre was inadequate. She concluded that MD was unfit for detention. There was no reference to this report in subsequent detention reviews. In July 2012 another experienced psychiatrist saw MD and agreed with the previous reports. She considered that MD's symptoms were unlikely to abate whilst in detention, that it was a major concern that MD had not been addressed by a psychiatrist in order to diagnose and treat her serious mental illness and that the lack of any local psychiatric assessment and a treatment plan was especially concerning and that it was clear that staff had chosen to ignore expert medical advice without seeking expert advice themselves.

45. A Chief Immigration Officer gave evidence that he would not have found that this showed that MD was suffering from a mental illness that could not be satisfactorily managed in detention.

46. MD was released after 17 months in detention.

47. The Court found that MD's initial detention was lawful, but that it became unlawful from October 2011 because it had, by then, become clear that MD could not be removed within a reasonable period of time.

48. The Court found a breach of Article 3:

> 134. The Claimant arrived in this country… in good mental health. Within 5 months of the start of detention she was experiencing episodes of acutely severe mental distress and harmed herself six times over a five week period. …the depressive illness MD suffered from during immigration detention was actually precipitated by the experience of detention …
>
> …the way she was managed was inadequate. …Even when assessed by mental health nurses, the nurses did not carry out a sufficiently thorough assessment of her psychological and social needs and her risk…
>
> …her distress, self-harm and aggressive outbursts were responded to by removing her from association and isolating her.
>
> …physical force was used quite frequently, often by a number of male officers. I have significant doubts that this was necessary in most incidents and that she could not have been calmed down in other ways. Her remaining dissociative symptom of being grabbed from behind indeed indicates that this was experienced as traumatic.
>
> …the management and treatment of MD's psychiatric condition at Yarl's Wood was inadequate in a number of ways and not appropriate to her mental state and her severe suffering. In my view it contributed to the deterioration of her mental state in detention and the prolonging of her mental suffering.
>
> …handcuffing is an unacceptable way of dealing with someone with mental illness except as a very short term measure while expert help is sought…

Summary of key features in the cases

Case	Date	Judge	Period of detention that breached art 3	Location of detention	Reasons for breach of Art 3
S [2011] EWHC 2120	5.8.11	David Evlin QC	April 2010 – September 2010	Harmondsworth Colnbrook	breakdown of communications and failure to follow a HEO direction meant that medical reports were not obtained or taken into account.
BA [2011] EWHC 2748	26.10.11	Elisabeth Lang QC	July – August 2011	Harmondsworth	…a combination of bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare…. on one occasion, a callous indifference to BA's plight.
HA (Nigeria) [2012] EWHC 979	17.4.12	Mr Justice Singh	February – July 2010 and November – December 2010	Brook House Harmondsworth	… the Claimant was suffering from a serious mental illness while he was in detention at IRCs… …he was not given appropriate medical treatment to alleviate his mental illness for a prolonged period of more than 5 months …known that the Claimant had a severe mental illness which had not been treated for many months when he was previously in IRC detention… that his mental illness had been stabilised (but not eradicated) by the use of medication, which had to be administered using force… that the IRC did not have the medical facilities that the Claimant would need if he suffered a relapse... that the nature of the Claimant's illness concerned in part a paranoia about IRC staff…. that, when he had been in IRC detention previously, he had had to be in segregation for many months and had engaged in behaviour that was described as "odd" or "bizarre" and which included

Case	Date	Judge	Period of detention that breached art 3	Location of detention	Reasons for breach of Art 3
					self-neglect and drinking water from the toilet. … to force the Claimant to return to and stay in IRC detention in November and December 2010 was at least degrading treatment and, if it were necessary to say so, inhuman treatment, contrary to Article 3…
D [2012] EWHC 2501	20.8.12	Charles George QC	February 2011 – November 2011	Brook House Harmondsworth [Colnbrook]	…absence of proper psychiatric treatment… lasted for many months and… exacerbated, D's mental suffering. ….knew that D had a history of mental illness and persisted in a medical regime for him which involved neglect (particularly in relation to the taking of anti-psychotic medication and denial of access to a psychiatrist) and recourse to [unsuitable] disciplinary sanctions D's "mental state has deteriorated as a direct result of [his mental health needs not having been well met]" …the treatment afforded, or not afforded, to D was such as to render him legally incapable, in the sense of being unable to instruct his legal team or effectively to participate in tribunal processes. …The acts and omissions at Brook House and Harmondsworth… intruded on D's human dignity and constituted inhuman treatment within Article 3.
S [2014] EWHC 50 (Admin)	28.1.14	HHJ Anthony Thornton QC	December 2011 – March 2012	Corby Police Station Colnbrook Harmondsworth	NB overturned on appeal: [2015] EWCA Civ 652

Case	Date	Judge	Period of detention that breached art 3	Location of detention	Reasons for breach of Art 3
MD [2014] EWHC 2249 (Admin)	8.7.14	Rhodri Lewis QC	October 2011 – September 2012	Yarl's Wood	...[medical reports] predicted a deterioration in the Claimant's condition. That deterioration occurred... detention... caused the onset of the mental disorder...[the medical evidence] should have brought home to [UKBA that MD] was an individual whose condition should be reviewed as a matter of urgency to determine whether continued detention was likely to exacerbate her mental state. That was not adequately done. Her behaviour was seen as an attempt to thwart her removal and dealt with in that light and not as a symptom of an underlying deteriorating mental illness. ...such treatment as was provided was inadequate leading to the deterioration of her condition and her continued suffering. ...removal from association and isolation and restraint in its various forms ...was degrading because it was such as to arouse in [MD] feelings of fear, anguish and inferiority likely to humiliate and debase [her] in showing a serious lack of respect for her human dignity. Such suffering went beyond the inevitable element connected with detention. ...did not have in place measures to ensure that [MD]'s mental health was properly examined and considered and such measures as were in place were not used effectively to diagnose and properly treat and manage her condition.

Cases where no finding of breach of article 3

49. There are large numbers of cases where the court has not found a breach of article 3 but where it has found that detention was unlawful. In a number of these cases the court's criticisms resonate with some of the findings in the cases set out above. Although no breach of article 3 was found, this may not be treated as an indication that the treatment of the individual claimant was satisfactory. In many of the cases the absence of a finding of a breach of article 3 was because the issue was not argued, or because the court considered that a claim under the Human Rights Act 1998 did not add anything of substance, or because the minimum threshold of severity for an article 3 infringement was not met. The lack of findings of article 3 violations in other cases is therefore very far from an indication that the 5 cases summarised above are outliers in terms of the substantive factual criticisms of the treatment of vulnerable detainees. Examples of these other cases (and many other examples could be given) are:

(a) *R (Mustafa) v Secretary of State for the Home Department* [2012] EWHC 126 (Admin): detention unlawful having regard to failure to carry out detention reviews in respect of mentally ill claimant.

(b) *S v Secretary of State for the Home Department* [2012] EWHC 1939 (Admin): Detention maintained notwithstanding medical evidence showing that claimant was suffering from mental illness and that appropriate treatment not available in the detention centre, and that detention was having an adverse impact on claimant's mental health. Reliance had been placed on history of failing to comply with reporting restrictions (when there was no such history). There had been a failure to have proper regard to the medical evidence and the detention was

unlawful. No claim had been brought under article 3 so that was not considered.

(c) *R (EH) v Secretary of State for the Home Department* [2012] EWHC 2569 (Admin): Detention was unlawful (as was conceded) because of failure to release in response to a r35 report and the medical evidence of mental illness which followed. Detention reviews had not taken account of mental illness and there had been no regard to the policy in paragraph 55.10 of the EIG. But the medical care was of a high standard and there was no breach of Article 3 having regard to the high threshold which must be met for such a finding.

(d) *R (Das) v Secretary of State for the Home Department* [2014] EWCA Civ 45: There had been a failure on the part of the decision makers to inform themselves as to the claimant's mental health so as to be able to determine whether the policy applied.

(e) *R (Xue) v Secretary of State for the Home Department* [2015] EWHC 825 (Admin): the claimant had only been seen by a psychiatrist once during her detention, and the recommendation for treatment had not been followed. Detention was found to be unlawful having regard to its length, its effect on the claimant, the likelihood of her mental and physical health deteriorating, and the fact that her condition was not being satisfactorily managed in detention. The medical evidence was not taken into account by those who authorised detention. No finding of breach of article 3 because the threshold was not reached.

(f) *Da Silva v Secretary of State for the Home Department* [2015] EWHC 1157 (Admin): the Court found that detention was unlawful because the

claimant's clinical condition necessitated hospital treatment which was not provided. It was not "necessary" to consider article 3.

Are the Courts' findings case specific, or do they show systemic failings?

50. All of the findings in each of the cases are case specific in the sense that the Judge was only determining the issues in the particular case. There is no indication in any of the cases that material concerning the treatment of other detainees was put before the Court[17], and it is unlikely that such material would have been put before the Court. So in each case the Judge was not in a position to make findings that went outside the ambit of the particular case.

51. Moreover, in each of these cases there was no oral evidence. As is conventional in claims for judicial review, the proceedings were dealt with on the basis of written evidence alone, with the Court generally taking the defendant's evidence, particularly the documentary material, at face value. It follows that the Courts did not have the opportunity to assess the witnesses (except on the basis of the written materials) and this limited the ability to make findings as to the underlying causes of any particular failings. This includes, in particular, findings as to whether decision-makers have acted in bad faith (see eg *HA*: "in the absence of live evidence… I am not prepared to draw [the] inference of… improper behaviour."[18])

52. However, the nature of the findings and the pattern of findings as between the different cases (taken together with some observations made in cases where no Article 3 breach has been found) do tend to suggest that these cases may be symptomatic of underlying systemic failings (as opposed to being wholly attributable to individual failings on the part of the clinicians or public servants who were involved in the particular cases).

[17] Eg by way of similar fact evidence.
[18] *Per* Singh J at [60].

53. The following themes emerge.

54. No policy criticism: None of the findings of breach of Article 3 were attributed to any problem with the legislative framework or the underlying policy. The findings were made in spite of the policy (particularly chapter 55 of the EIG) and the legislative framework (particularly r35 of the Rules) rather than because of the policy and legislative framework. None of the Judges were critical of any particular feature of the policy or the legislative framework.

55. Absence of deliberate intention to harm: In none of the case is there any finding of a deliberate intention to cause harm (although there is a finding of callous indifference in *BA*). None of the findings of breach of Article 3 are therefore based on individual officials or contractors acting in bad faith.

56. Healthcare provision: There is criticism of the healthcare provided to detainees. Of course, individual poor clinical practice may not have any underlying systemic cause. But the nature of the findings made in these cases do not really concern individual poor clinical practice. There is little or no criticism of individual clinicians. The findings are more concerned with a lack of assessment and treatment – see in particular *HA* and *D* and *MD*. These findings have been made in respect of several different removal centres and over prolonged periods of time. In several cases detainees who were in urgent need of assessment and treatment were not seeing a specialist for months on end. The nature and pattern of findings are such that they are more likely to be a reflection of a systemic problem (ie insufficient medical – particularly psychiatric – provision) rather than individual failings.

57. Bureaucratic inertia/breakdown in communications: Such findings are made, in terms, in *S* and *BA* and are arguably implicit in all of the cases. By their nature this is likely to be attributable to a failure in the systems that are in

place. The problems relate mainly to communications between the removal centre and UKBA. An important example concerns the compilation and use of rule 35 reports – eg in *S* and *BA* and *HA* and *MD*. Information in a rule 35 report is likely to be of great importance to the welfare of vulnerable detainees. It is of paramount important that it is timeously communicated to the right people and is properly addressed and taken into account. There is some suggestion from these cases that that does not always happen. There also seem to have been problems in the communications with prisons and with hospitals, so that medical evidence tending to suggest a need for assessment or treatment that has been generated during a period of imprisonment (or a period of in-patient treatment) has not been taken into account when carrying out detention reviews.

58. Detention reviews: In each of the cases the detention of the vulnerable and mentally ill claimant was unlawful. In each of the cases that was because of a failure properly to apply Chapter 55 of the policy. The failings were not simply due to the initial decision to detain or one or two detention reviews. They applied to numbers of detention reviews (sometimes involving different decision-makers) over long periods of time. There are two themes that run through the cases. The first is that the person reviewing detention does not always appear to have been aware of all of the relevant evidence (particularly medical evidence) that is relevant to the assessment of whether it is appropriate to detain (so sequential reviews are written in almost identical terms without any reference being made to important developments in the medical picture). The second is that decisions to detain are made without properly engaging with the test that has to be satisfied before a decision is made. The policy makes it clear that the mentally ill should be detained only "very exceptionally". In all but very exceptional cases temporary admission should be granted. It almost seems as if some of the decisions are made by

rote or mantra, with detention being imposed because of a risk of absconding or re-offending. Both of those features are capable of justifying detention. But they do not necessarily justify detention. Everything depends on the particular circumstances. It is necessary to quantify the level of the risk and the likely consequences if the risk materialises. It is then necessary to assess whether, in the particular circumstances of the case, including the individual's health, those factors are sufficiently weighty to displace the very strong presumption in favour of liberty. But it is difficult to identify a single detention review in any of the cases where that exercise has been undertaken with any real rigour.

59. The following features suggest that there is likely to be a general problem in respect of detention reviews for those suffering mental illness:

(a) The number of cases in which the detention reviews are found to be flawed.

(b) The number of reviews in each of those cases in which flaws were found.

(c) The time period over which detention reviews were flawed.

(d) The nature of the flaws.

(e) The similarity in the flaws between the different cases.

(f) The involvement of senior personnel in a number of the review decisions that have been found to be unlawful.

(g) UKBA's preparedness to defend each of those detention reviews (suggesting a corporate view that they were lawful).

60. It is perhaps not altogether surprising that there have been flaws in the detention reviews for mentally ill detainees. There have been a large number of changes to the general detention policy framework in recent years. The assessments that have to be made, particularly in this context (whether there is a mental illness, whether it can be accommodated in detention, whether other factors – such as the abscond/re-offend risk – are sufficiently potent to outweigh the very strong presumption in favour of liberty) are difficult and complex. They involve a high degree of analysis and judgement.

61. I do not know whether there is a particular team of staff especially responsible for carrying out reviews of mentally ill detainees, whether they have specific initial and ongoing training, whether reviews in this particularly sensitive context are checked by a supervisor, and whether there is dip-sampling of reviews for checking and quality control. But, if not, and if it is thought that (as indicated by these cases) there may be a broader problem in respect of detention reviews, it may be appropriate to consider adopting measures like these in order to maintain a high(er) standard of detention reviews. Detention should only be imposed "very exceptionally." The consequences of getting it wrong are extremely serious (as 5 findings of inhuman and degrading treatment demonstrate [19]). So the resource implications of applying a more careful approach to these cases ought not to be overly burdensome when compared to the need to protect the vulnerable from inhuman or degrading treatment.

62. Attitude/cynicism: There are cases where the Courts have found that detainees have behaved violently and abusively simply to resist removal. It

[19] And in one of the cases (BA) it was not a long way away from being a fatality. The findings of breach must also be viewed in the context of a high minimum threshold of severity before a Court is entitled to make such a finding. This means that (a) all of these cases are necessarily serious, and (b) they may possibly be just the tip of an iceberg.

might not be surprising if case-hardened decision makers developed an overly cynical attitude towards those displaying challenging or bizarre behaviour. Such behaviour might be voluntary and deliberately intended to thwart removal. Or it might be attributable to a mental illness and an indicator that continued detention is injurious to health. For a lay person it may be impossible to tell. There is an indication in the cases of a possible over-willingness simply to assume that such behaviour is intended to resist removal and not to countenance the possibility that it is due to an underlying illness[20].

Do the judgments have implications for wider policy and care of (vulnerable) detainees?

63. For the reasons given above it is likely that there are at least some wider systemic issues that are, at least in part, responsible for the findings of breach of Article 3 that have been made. But this cannot be demonstrated to any degree of certainty simply by reference to 5 case specific judgments. They are a tiny proportion of the overall numbers of immigration detainees. It would be rash to adopt policy changes as a result of these judgments without first undertaking a review of the existing policies and procedures and how these are applied more broadly in practice (not just as appears from a selection of 5 cases). That is precisely what the Secretary of State has appointed Mr Shaw to do. If I am right in my view that there are likely to be wider systemic issues then these should be capable of detection (or the absence of such issues should be capable of confirmation) by that review. Accordingly, account should be taken of the 5 cases as having potential implications for policy in relation to the care and treatment of vulnerable detainees, but it is necessary to cross-check those potential implications against the review's conclusions drawn from a broader evidence base.

[20] eg S: "S claims to be mentally ill but we have no evidence of this" and BA (very senior official saying that BA's mental health problems "self inflicted").

64. The areas in which the 5 cases tend to suggest there is a particular need for focus are healthcare provision, communication between the different agencies responsible for detainees (particularly in relation to r35 reports), detention reviews and, possibly, attitude and cynicism. I have suggested at paragraph 61 above some things that could be considered (if they are not already in place) in respect of detention reviews. Similar steps could be taken in relation to r35 reports.

Summary

65. There have been 5 cases where the Courts have found that vulnerable immigration detainees have been subjected to inhuman or degrading treatment, contrary to the Human Rights Act 1998 read with Article 3 of the European Convention on Human Rights. The findings were made on the facts of the individual cases. To that extent they are fact specific. The nature and pattern of the findings, however, tend to indicate that there are underlying problems with the systems that were (and may still be) in place. The findings also resonate with other cases where a breach of article 3 was not found, either because article 3 was not argued, or because it was not necessary to make a finding, or because the minimum threshold of severity for a finding of a breach of article 3 was not met.

3rd August 2015

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Appendix 5: The Mental Health Literature Survey Sub-Review

The impact of immigration detention on mental health: A literature review

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Executive Summary

Definition of terms

Introduction: Overview of immigration detention

Methodology: Search terms, inclusion and exclusion criteria and years of review

The impact of detention on mental health: What does the literature say?

Key causes of mental distress in detention

Vulnerable groups

Conclusion

References

EXECUTIVE SUMMARY

Background

This literature review was commissioned as part of the independent review of policies and procedures affecting the welfare of those held in immigration removal centres, which was announced by the Home Secretary, Rt Hon Theresa May MP, in February 2015 (Home Office, 2015a). The wider review, conducted by Stephen Shaw, seeks to identify whether improvements can be made to safeguard the health and wellbeing of detainees, and those being escorted in the UK. This literature review examines relevant academic literature on immigration detention according to the following terms of reference:

Summary

To provide a literature review, within the UK and internationally, of reputable academic work, in any field, including clinical studies that may provide insight into the impact on mental health of immigration detention, identifying gender and vulnerability where possible.

Detail

- To consider evidence of whether detainees' compliance or non-compliance is a variable in any studies.
- If possible to distinguish between the fact of detention, the length of detention, and the indeterminacy of detention as potentially independent factors.
- To consider whether there are individual detainee characteristics (for example, age, gender, immigration history and status) associated with higher risk.

Methods and Summary of Evidence

Relevant qualitative and quantitative academic literature from the UK, USA, Australia, France and Canada was identified and consulted through a variety of mechanisms. Initial research informed later searches. In compiling the material I conducted an extensive online search using the main academic databases, e.g. PubMed, ProQuest, PsycINFO, and Thomson Web of Science, as well as www.ssrn.com to locate working papers. I also approached medical and legal experts in each country to ensure that material was as up to date as possible.

Studies based solely on media analysis were excluded, as were those whose methodology was unclear or not robust. Other than systematic reviews, accounts based purely on secondary source material were also excluded. While the majority of literature cited was produced by academic researchers, in light of the limited amount of original empirical research produced about immigration detention, including that in the UK, some relevant reports produced by Governments, NGOs and the voluntary sector that included empirical data have been included.

These searches yielded over 30 clinical studies from Australia, the UK, and Canada, as well as the USA, France and Japan plus additional accounts by criminologists, legal scholars, sociologists, geographers and other social scientists. Studies date from 1991 – 2015.

Studies ranged in sample size from 10 to over 700, with the most recent account from the UK drawing on surveys administered to 219 detained respondents. A variety of methods were used from interviews with current and former detainees to retrospective analysis of hospital records or other medical and statistical records such as incident reports. Reflecting the high proportion of Australian studies in the literature, most of the participants were asylum seekers or refugees who had previously been detained. However the studies conducted in Britain included a wider range of immigration status. All works cited appear in the reference section at the end of the review.

Main Findings

1. Literature from across all the different bodies of work and jurisdictions consistently finds evidence of a negative impact of detention on the mental health of detainees.

2. Literature from across all the different bodies of work and jurisdictions consistently finds that the negative impact of detention on the mental health of detainees increases the longer detention persists.

3. Literature from across all the different bodies of work and jurisdictions consistently identifies three predominant forms of mental disorder related to immigration detention: depression, anxiety and post-traumatic stress disorder (PTSD).

4. Literature from across all the different bodies of work and jurisdictions identifies a number of causes of the negative impact of detention on mental health including: the length of detention; pre-existing trauma, including torture and sexual violence; pre-existing mental and physical health problems and poor healthcare and mental health care services in detention. Other factors that appear less frequently in the literature include: the uncertain duration of detention; communication problems both in detention and concerning their immigration/asylum case; and the limited range of activities in detention. There is considerable overlap among many of these issues.

5. Literature from across all the different bodies of work and jurisdictions consistently identifies children and asylum seekers as particularly vulnerable to negative mental health outcomes in detention. Literature also documents worse mental health outcomes for those who have been tortured and identifies women as a vulnerable group.

6. There is no academic scholarship on the impact of detainee compliance or non-compliance on their mental health.

7. Literature from across all the different bodies of work and jurisdictions consistently finds that negative effects of detention endure long after a person is released from confinement.

8. A growing body of literature from across all the different bodies of work and jurisdictions identifies the negative impact on the mental health and wellbeing of staff in detention centres.

9. Literature from across all the different bodies of work and jurisdictions consistently calls for more research access to understand these sites and the mental health needs of those within them better.

Conclusion

This review reports on the literature relating to the effect of immigration detention on mental health. Studies include a range of sample sizes and use a variety of research methods. They also reflect the disciplinary basis in which they are founded. In addition to clinical accounts of depression, anxiety, and PTSD, psychological, social policy, legal and criminological studies refer to 'quality of life', 'wellbeing', 'coping', 'distress' and 'trauma'. Together, the literature, which spans a 25-year period and a number of legal systems, tells a consistent story of the harmful effects of detention on mental health.

Definition of Terms

Anxiety - Whereas experiencing occasional anxiety is a normal part of life, an anxiety disorder refers to a mental disorder characterised by intense, excessive and persistent worry and fear about everyday situations. Feelings of anxiety and panic interfere with daily life, are difficult to control and are out of proportion to the actual danger.

Asylum Seeker - An asylum seeker is someone who has applied for asylum and is waiting for a legal decision on refugee status.

Depression - Depression is a mental disorder characterised by low mood, low self-esteem, diminished cognitive abilities, problems with sleep and appetite, and loss of interest in activities individuals used to enjoy before feeling depressed.

Distress - Distress refers to unpleasant emotions and feelings that negatively affect people's level of functioning.

HSCL - Hopkins Symptoms Checklist - This measure is a self report checklist that aims to detect symptoms of anxiety and depression in a 4 point Likert-type scale ranging from 1='not at all' to 4='extremely'. The items include 'Crying easily' and 'Blaming yourself for things'. The original checklist has 25 items measuring anxiety and depression. Some studies use all 25 questions, others use a more limited selection. The original scale was developed in the early 1950s by a group of researchers at Johns Hopkins University in the USA. Since then the measure

has been translated into many languages and used with a varied range of population including individuals undergoing difficult live events (including war and torture), prisoners, detainees, and immigrants.

HTQ - Harvard Trauma Questionnaire - The Harvard Trauma Questionnaire (HTQ) is a checklist similar in design to the HSCL-25 that inquires about a variety of trauma events, as well as the emotional symptoms considered to be uniquely associated with trauma. Written by the Harvard Program in Refugee Trauma (HPRT) it should be administered by health care workers under the supervision and support of a psychiatrist, medical doctor, and/or psychiatric nurse. It is not designed to be used as a self-reporting tool.

PTSD - Post Traumatic Stress Disorder - PTSD is an anxiety disorder caused by very stressful, frightening or distressing events that may develop immediately after someone experiences a disturbing event or weeks, months and even years later.

Qualitative Research - Qualitative research is often more exploratory than quantitative research. It typically includes observations and interviews, which may be semi-structured or unstructured, drawing together testimonies from participants to better understand the object of study.

Quality of Life - The 'quality of life' refers to the general physical, mental and social wellbeing of a person, the sense of satisfaction or dissatisfaction with the conditions in which a person is living relative to the goals, expectations, standards and concerns a person has. It is a broad ranging concept that connects health, relationships, autonomy, personal beliefs and legitimacy, to salient features of their environment.

Refugee - A refugee is a person who, 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country,' as defined in Article 1 of the 1951 Convention relating to the state of refugees.

Wellbeing - Wellbeing refers to the extent to which people live a 'good life.' It includes subjective qualities, such as self-esteem, satisfaction with life, relationships with others and optimism about the future as well as objective qualities including health, housing, employment, safety, nutrition.

Vulnerability - In psychological terms vulnerability refers to the susceptibility of people to mental disorders and distress. Certain characteristics and populations are associated with higher levels of mental distress.

Introduction: Overview of Immigration Detention

Around 3,500 foreign national citizens are detained under Immigration Act powers in the UK on any given day in one of ten Immigration Removal Centres (IRCs) scattered throughout the country. In addition to nominated places of immigration detention an uncertain number of men, women and children are held for periods of time in police cells, immigration reporting centres, or in hospital. Since May 2013, the Government has made available up to 1,000 bed spaces in prison, most of which have been set aside for prisoners who have finished their sentence and are awaiting deportation.[21] Around 100 other foreign nationals are held for up to five days in short-term holding facilities at ports and airports. Finally, the Home Office operates a 'pre-departure accommodation facility' for up to nine families in Cedars near Gatwick (HMIP, 2012). Families may be held there, or in nearby IRC Tinsley House, for short periods of time. While the UK has had the power to detain foreign nationals for many years, the shape and nature of the current system dates, in large part, to the past 15 years (Bosworth, 2014; Wisher, 2011).

Britain is not alone in its use of purpose built detention centres for immigration matters (see, for more information, the Global Detention Project (http://www.globaldetentionproject.org). From the US to Australia, throughout Europe and across the developing world, states apply forms of administrative detention to a proportion of foreigners upon their territory (see, for example, on France, Fischer, 2013; on Holland, Cornelisse, 2010; on Greece, Fili, 2013; on Canada, Pratt, 2005, Cleveland and Rousseau, 2013; on Australia, Grewcock, 2010; Thwaites, 2014; on the USA, the US Conference of Catholic Bishops, 2015; Ochoa et al, 2010). The make-up of the population subject to administrative detention in most countries varies, but typically includes those without documents, asylum seekers, visa overstayers, and foreign former offenders.

Australia operates a mandatory detention system for all arrivals without valid entry documents, in a system applied particularly to those who travel by boat, usually coming down from Indonesia. The UK, in contrast, places people into immigration removal centres (IRCs), usually only after their immigration and/or asylum case has been determined. Detention, in Britain, may follow many years of residence, whereas in Australia, it is increasingly used to prevent asylum seekers from reaching the mainland. In France, detainees are primarily those with irregular migration status, the vast majority of whom have been subject to a deportation order. In the US, detention is used both for people caught crossing the border without documents and for long-term US residents without immigration status. The US also incarcerates a sizable number of foreign nationals who have served a prison sentence and are awaiting deportation. Whatever their route to detention, many detainees in the US are held in local and county jails as well as in state and federal prisons.

[21] According to the most recent figures, on 30 March 2015 there were 374 detainee held in prison establishments in England and Wales held under immigration Act powers (Home Office, 2015b).

The duration of detention varies. The UK operates with no statutory upper time limit in contrast to most of the other EU member states who signed the EU Returns Directive, which imposes an 18 month limit. Australia, too, can keep foreigners locked up under immigration powers indefinitely, and tends to hold people for many years while processing their refugee claims. In the US, immigration authorities can continually extend the period of confinement, so long as they bring it back to court (Thwaites, 2014; Wilsher, 2011). For those who were detained in the UK during the year ending March 2015, "almost two-thirds (63 per cent) had been in detention for less than 29 days, 18 per cent for between 29 days and two months and 12 per cent for between two and four months. Of the 2,043 (7 per cent) remaining, 152 had been in detention for between one and two years and 26 for two years or longer." (Home Office, 2015b).

Within Europe, France operates with a strict 45-day limit. Whereas an initial period of detention in a Centre de Rétention Administrative (CRA) of just 5 days, is ordered on administrative grounds by the préfet, any further time behind bars, must be authorised by a judge, (un juge des libertés et de la detention). In 2014, Italy reduced their upper limit from 18 months to 90 days, significantly reducing the total number in their detention centres (CIEs) in the process.[22] In Norway too, detention, for most, is very brief, with recent statistics obtained during a visit to Trandum detention centre, the country's sole closed detention site, indicating that over 80 per cent of residents stay for less than one week, and 63 per cent for only one to three days.

As with time, conditions in detention are also not the same. Within Britain, there are a number of kinds of institutions, including IRC Colnbrook, IRC Brook House and Phase Two of IRC Harmondsworth all built to Category B prison security design, the re-roled Victorian prison at IRC The Verne and the more open plan system of IRC Campsfield House. Many countries use prison architecture or actual prisons. Some states, however, rely on more temporary measures. Australia's offshore detention centres on Nauru and in Papua New Guinea (Manus Island) house people in tents. Greece has used metal transport containers.

Other differences exist at the level of governance and management. The UK, Australia and the USA have outsourced the management of detention facilities to private contractors to run many of their centres. Elsewhere in Europe detention centres are the responsibility of the police. Again, within the UK, there is some internal variation, as, alongside the private contractors (Mitie, Serco and G4S), HM Prison Service currently operates three establishments, IRCs The Verne, Morton Hall, and Dover. Cedars, the pre-departure unit for families in Britain, uses a unique combination of private sector officers and employees of the children's charity Barnardo's (HMIP, 2012). While academic research and regular HMIP reports suggest there are differences among the centres, it is not possible to identify consistent outcomes for the mental health of detainees

[22] The maximum period in detention is even less, only 30 days, if the individual has spent three months or more in prison.

relating to the service provider (see, for example, HMIP, 2012; 2013; Bosworth and Slade, 2014; Bosworth and Kellezi, 2012; Bosworth, Kellezi and Slade, 2012).

Finally, detention systems vary in the population they house. Sometimes, this variation is a result of the mode of deployment. In Australia, for example, nearly all detainees are new arrivals with active refugee claims. Australia, Norway, the USA, Greece, France and Canada detain (some) unaccompanied minors. The UK does not. Since 2010, families facing deportation or removal in Britain have been handled differently to single adults. Elsewhere they remain part of the general population. Women, in all states, usually constitute a small minority, around 10 per cent. Most detainees are young men.

Studies indicate that these differences shape people's experience of detention (Bosworth, 2014; Fili, 2013; Fischer, 2015). It is reasonable, therefore, to expect them to relate to the impact of detention on mental health. However, there is not always sufficient evidence to tease out the effect of specific issues, nor how they relate to one another. In particular, while a number of studies have found that the mental health of asylum seekers, particularly those with pre-existing psychiatric conditions, and that of children, worsens in detention, there is less available academic research on the impact of detention on the mental health of other groups. There is also no explicit comparative research to guide how to interpret results from other systems.

While such gaps in the literature must be acknowledged, and need to be filled, it remains true that the body of academic scholarship converges across time and space. In contrast to scholarship on the prison, for example, where evidence exists that incarceration can offer people a means of positive transformation (Liebling, 2012) – by giving up drugs, by acquiring an education or an employable skill, by removing people from a life of violence, by providing health care or even just a period of time to reflect – there is no published account of improvements in mental health or wellbeing resulting from a period of immigration detention. At best, there are examples of good practice, from the positive effect of making music in detention on psychological health (Underhill, 2011) to the impact that instances of care and compassion from officers can have on particular detainees (Bosworth, 2014).[23] The question, which the wider review into the welfare of this population seeks to answer, then, is what is to be done. This review seeks to contribute to that discussion by presenting the current body of knowledge on these issues.

[23] HMIP reports also regularly mention positive initiatives as do IMB reports while charities like Music In Detention and visitor groups also produce evaluations of their work with detainees which reveal positive outcomes (see, for example, Bruce, 2015).

Methodology: Search terms, inclusion and exclusion criteria and years of review

Just as the modern history of immigration detention in the UK is fairly recent, so, too, the body of work on this method of confinement is both relatively new and somewhat sparse. Unlike prisons, about which we have a longstanding and robust tradition in Britain of academic scholarship particularly in criminology (Cohen and Taylor, 1972; Liebling, 2004; Carlen, 1983; Sparks, Bottoms and Hay, 1996), sociology (Piacentini, 2004), psychology (Towl, 2006) and psychiatry (Hawkins et al, 2014), but also in history (Morris, and Rothman, 1997), geography (Pallot and Piacentini, 2012) and law (Lazarus, 2004), in IRCs, the British literature is more limited and more recent. As in the prisons literature, criminologists (Bosworth, 2014), psychologists (Fazel et al, 2011) and psychiatrists (Robjant, Robbins and Senior, 2009) have written the most, with related studies produced in geography, sociology, history, migration studies and law (see, for example, Moran et al, 2013; Wilsher, 2012; Thwaites, 2014).

In part to bridge the gap, and also to expand the understanding of the mental health of populations subject to detention, it is useful and important to draw on studies produced elsewhere. While care must be taken to acknowledge distinct national practices, immigration detention is an arena, like criminal justice, that has experienced considerable policy transfer. Consequently, even within different systems, important similarities exist. Thus, while Australia pursues policies that the UK does not – in terms of offshore sites and the routine, lengthy, detention of families – they share other aspects, like the immigration points system, and the role of private companies. In both countries, detention for some can last for a very long time. In addition, academic scholarship on detention is highly international, meaning that research design is influenced by studies conducted elsewhere. For all these reasons, this report draws on literature from a variety of countries, to understand better the impact of detention on mental health.

Search terms and types of literature

In compiling this review, I identified and consulted relevant qualitative and quantitative academic literature from the UK, USA, Australia, France and Canada. Initial research informed later searches. I conducted an extensive online search using the main academic databases, e.g. PubMed, ProQuest, PsycINFO, and Thomson Web of Science, as well as www.ssrn.com to locate working papers. Search terms included 'immigration detention', 'mental health and detention', 'coping and detention', 'quality of life and detention', 'wellbeing and detention', 'mental health and asylum seeker'. I also approached medical and legal experts in each country to ensure that material was as up to date as possible. Publications fell into three main groups: academic literature, Government reports, NGO and voluntary sector reports. Within the academic literature I included qualitative and quantitative studies from the medical and social sciences. These were supplemented by some relevant reports produced by Governments, NGOs and the voluntary sector, many of which were written by

academics (see, for example, Lawlor et al, 2015; Katz et al, 2013). All works cited appear in the reference section at the end of the review.

Inclusion and exclusion criteria

Research that examines the impact of detention on the mental health of detainees varies in quality, quantity and scope. While some is produced by medical academics (Steel et al, 2006), or even by clinicians working in detention sites (Koopowitz and Abhary, 2004; Dudley et al, 2012; Sultan and O'Sullivan, 2001), questions of mental health also appear in more qualitative studies alongside other aspects of daily life in detention (Bosworth, 2014). While this study prioritises statistical accounts produced by clinical researchers, it also draws on some more descriptive studies.

Unlike the forthcoming Campbell report on the impact of detention on the health of asylum seekers (Filges et al, forthcoming), this review does not limit itself to detained asylum seekers, but considers research also undertaken with other populations subject to detention. Likewise, it does not adopt the restrictive selection criteria of a Cochrane study, (Filges at al, 2014), but takes a more expansive view of the scholarship, including qualitative as well as quantitative studies from a number of disciplines and jurisdictions, in order to build a comparative sense of the state of knowledge on this topic.

By taking a wider perspective, I am able to synthesise a large body of empirical research from over thirty clinical studies from Australia, the UK, and Canada, the USA, France and Japan plus additional qualitative accounts from across the social sciences. Certain studies however have been excluded from the current review including those based solely on media analysis and those whose methodology was unclear or not robust. Other than systematic reviews, accounts based purely on secondary source material were also excluded.

The sample size of the studies examined ranged from 10 (Bracken and Gorst-Unsworth, 1991) to over 700 (Green et al, 2010). Most participants were asylum seekers (Keller et al, 2003; Cleveland and Rousseau, 2013) or refugees who had previously been detained (Steel et al, 2006). However, the British studies included a wider range of immigration status, such as former foreign offenders and irregular migrants (Robjant, Robbins and Senior, 2009; Underhill, 2011; Bosworth and Kellezi, 2012; 2015).

Some of the clinical studies were based on interviews in detention (Katz et al, 2013; Lorek et al, 2009; Robjant, Robbins and Senior, 2009) or with former detainees in the community (Coffey et al, 2010). Others drew on retrospective analyses of hospital records (Deans et al, 2013), statistical records (Cohen, 2008) and incident reports (Dudley et al, 2003). Some scholars administered surveys to a convenience sample of participants (Bosworth and Kellezi, 2012; 2015), while others used a case study approach, drawing on clinical work with clients in detention (Sultan and O'Sullivan, 2001).

Finally, the age, gender and ethnicity of the samples varied. Some studies were conducted just with children (Lorek et al, 2009), although most concentrated on adults. Only qualitative accounts focused solely on women (Bosworth and Kellezi, 2014; Baillot et al, 2013), although women make up part of nearly all samples. Ethnicity and nationality reflect the wide range of people who are detained, although some studies focused on particular national groups. For example, Ichikawa et al, 2006, compared the mental health outcomes for 18 detained and 37 non-detained Afghan male asylum seekers in Japan, while Sobhanian et al 2006 examined the mental health of 150 previously detained asylum seekers from Iraq and Afghanistan living in Australia. In both cases, those in the community reported better mental health than in detention.

Years of the review

The research for this literature review was conducted in June and July 2015. All relevant studies dating from 1990 were included, nonetheless most date from the past decade.

The Impact of Detention on Mental Health: What does the literature say?

Literature on the impact of detention on mental health dates back to the 1990s when a number of states around the world witnessed an upsurge in asylum applicants and brought in new, restrictive, legal sanctions for irregular arrivals (eg Becker and Silove, 1993; Pourgourides et al, 1996; Pourgourides, 1997; Thompson and McGorry, 1998).[24] These early studies found a link between pre-migration trauma and the negative effect of immigration detention on mental health. Simply put, people were arriving who had experienced great hardship in their country of origin and detention made matters worse. Thus, in their comparison of Tamil detainees, asylum seekers, refugees and immigrants, Thompson and McGorry (1998) found higher levels of trauma, depression, PTSD, anxiety and suicidal ideation among those held in Melbourne's Maribyrnong Detention Centre that were attributable not just to the trauma symptoms relating to their asylum claim. In Birmingham, Pourgourides and associates (1996) likewise reported that survivors of torture were extremely distressed by aspects of their confinement, terrified of the closed rooms flanking the corridors and the uniform wearing staff. Such matters exacerbated their PTSD and other mental health symptoms.

Much of the clinical literature on mental health and immigration detention has been conducted in Australia. There, medical researchers have administered surveys and interviewed people either over the phone while in detention, face to face in the detention centres, or spoken to former detainees in the community (see, for example, Silove, Steel & Mollica, 2001; Momartin et al 2006; Steel et al, 2006; 2004; Sobhanian et al, 2006; Coffey et al, 2010). Until recent changes made it illegal to report on any aspect of life inside the detention centres, some of the medical staff employed in them contributed evidence about those in their care (Koopowitz and Abhary, 2004; Sultan and O'Sullivan, 2001). Australia has also witnessed a series of inquiries into conditions in detention, particularly concerning the treatment of children in Australia all of which address mental health (HREOC, 2004; Australian Human Rights Commission, 2014).

Conditions in many Australian detention sites are undeniably harsher than in the UK, particularly at the moment. Also, their institutions include a much higher proportion of asylum seekers. Nonetheless, important similarities in the use of the private sector and in the lack of a statutory upper time limit mean that some of the findings will also apply to those in detention in Britain.

A recent report, commissioned by the Department of Immigration and Border Protection (DIBP) into the 'experiences of irregular maritime arrivals detained in immigration detention facilities.' (Katz et al, 2013) lists a number of issues that have also arisen in recent British research into the quality of life (Bosworth and

[24] From 1992, for instance, Australia instituted mandatory detention of asylum seekers and other irregular migrants, a decision whose effects continue to be felt today. In Britain, this decade also witnessed the emergence of the contemporary detention system, initially for asylum seekers coming from the former Yugoslavia and further afield. Matters of this nature had become so widespread that, by the end of that decade, the UNHCR published a series of documents on the treatment of detained asylum seekers (see, for example, UNHRC, 1999a; 1999b).

Kellezi, 2015; 2013; 2012). Rather than mental health, this report examined the effect of detention on detainees' 'wellbeing', a psychological term that refers to subjective qualities, such as self esteem, satisfaction with life, relationships with others and optimism about the future as well as objective matters like health, housing, employment, safety, nutrition. Running to 171 pages, the lengthy report drew on interviews with nearly 350 people including 153 detainees, 168 staff and management from DIBP and the detention contractor, and 25 other stakeholders including visitors, detainee advocates and community service providers. The interviews were conducted in 11 different detention sites across Australia between February and June 2012. It should be noted that the research was undertaken at a time when the Australian Government was working with the Non-Government sector to implement humane detention protocols and maintained a high level of transparency in detention centre operations. The detention centres included in the project were: Northern IDC and Wickham Point IDC both in or near Darwin, NT; Northwest Point IDC on Christmas Island; Curtin IDC, in Western Australia; and Villawood IDC in Sydney. All at the time were managed by Serco on behalf of the Australian Government.

While the researchers found that detainees were provided with adequate basic care in terms of food and housing, they identified a series of issues that adversely affected their wellbeing including the period of time in detention, the lack of consistent and transparent information and communication during their immigration process, and what the report refers to as "limited opportunities for self-agency". The report also lists a series of other institutional factors that negatively impacted detainees, including the emphasis on security and risk management within the centres, the sometime combative communication and collaboration between service providers who did not always get along, and inadequate staffing (Katz et al, 2013).

Length of detention emerges in this report, just as it had in the earlier accounts on asylum seekers, as a key factor shaping detainee wellbeing. "Those who spent more than six months in detention," the authors noted, "were much more likely to have low levels of wellbeing and to suffer from mental illnesses." (Katz et al, 2013: ix). The report also emphasises the importance of communication. When modes of communication from the immigration services and the custodial company (Serco) were clear and consistent, they found, detainees were more likely to trust the authorities. Otherwise detainees relied on informal sources of information, which often contradicted what they were being told by their caseworker, generating stress, anxiety and confusion. Finally, the researchers found that, over time detainees became despondent and withdrawn when they had "no opportunity to exercise agency over their lives" (Katz et al, 2013: ix). Conversely, "where genuine opportunities were provided to exercise agency, at least over some aspects of their lives, IMAs [illegal maritime arrivals] who had been in detention for long periods were more positive about the facilities and their effect on wellbeing." (Katz, 2013: ix).

While Australia continues to produce much of the research on mental health and detention, a growing body of work on the psychological impact of detention is emerging from Canada (Cleveland et al, 2012; Cleveland and Rousseau, 2013;

Kronick et al, 2011; 2015). Reflecting an increased use of immigration detention, much of this literature focuses on children and on asylum seekers. Legal scholarship and sociological work, in this jurisdiction can also be found (Pratt, 2005; Costello and Kayatz, 2013).

In their 2013 publication, Cleveland and Rousseau (2013) compared the mental health of 122 detained asylum seekers with 66 non-detained asylum seekers. A greater proportion of those in detention scored above the clinical cutoff for PTSD, depression and anxiety than those in the community. The median time respondents had been in detention when they answered the questionnaire was 18 days, with 94 per cent of the sample held for less than two months. In other words, the study indicated that even a brief period of detention adversely affected mental health outcomes (see also Cleveland et al, 2012).

Finally, there have been a handful of studies produced in France (Fischer, 2013; Enjolras, 2014; 2010) and the USA (Keller et al, 2003; Venters and Keller, 2012), although given the size of the detained population in the United States, rather less material is available about it than we might expect.[25] In France, much of the literature has concentrated on issues of suicide and self-harm, exploring the sometimes contradictory pressures that onsite medical staff and charities face in their work with the detained population (Enrolas, 2015; Fischer, 2015). In the United States, few academics other than lawyers, have obtained access to sites of detention. As a consequence, much of the scholarship relies on statistics published by ICE (Immigration & Customs Enforcement) or reported in legal cases (see, for example, Ochoa et al, 2010; Nadeau, Nicholas and Stevens, 2015)

In Britain, clinical studies of the impact of immigration detention on mental health are also limited in number. Indeed, notwithstanding growing academic interest in detention more generally, restrictions on research access have meant that little empirical research has been conducted within IRCs. There have been some clinical studies measuring mental health effects of those detained (see for example, Lawlor, Sher and Stateva, 2015; Robjant, Robbins and Senior, 2009; Underhill, 2011), or recently released (Arnold et al, 2006), while earlier work examined the impact of detention on children who had been released (Lorek et al, 2009; Fazel et al, 2011) and one article examined the incidence of suicide and self-harm among detained asylum seekers (Cohen, 2008). A small body of applied criminological research includes a measure of depression in accounts of the 'quality of life' in detention (see, for example, Bosworth, 2014; Bosworth and Kellezi, 2012; 2013; 2014; 2015; Bosworth, Kellezi and Slade, 2012), while other qualitative research with former detainees offers descriptive accounts of detention and some of its effects (Klein and Williams, 2012). Finally, systematic reviews by clinical researchers offer a useful overview of mental health issues (Robjant, Hassan and Katona, 2009), and a host of reports by Government and Non-Government agencies touch on issues to do with mental health in a variety of ways (see, inter alia, APPG, 2015; HMIP, 2013; IMB, 2014; Medical Justice, 2014; Medical Foundation for the Care of Victims of Torture, 2009).

[25] A useful overview of recent work in the US on mental health issues in detention, with a particular focus on asylum seekers, can be found in Nadeau, Nicholas and Stevens, 2015.

In 2009, Katy Robjant published the results of a pilot study with 67 adult detainees, 30 other detainees and 49 asylum seekers in the community (Robjant, Robbins and Senior, 2009). Across the group, individuals exhibited high levels of anxiety, depression and PTSD, with those who had been in detention over 30 days and had a history of trauma more depressed than the rest. Reports produced by the research group at the Centre for Criminology at the University of Oxford have also documented evidence of high levels of depression at around 80 per cent among the detained community, using an abbreviated form of the HSCL-D (Bosworth and Kellezi, 2012; 2013; 2015). First administered in 2010-2011, to a sample of 158 women and men in IRCs Brook House, Tinsley House and Yarl's Wood, and again in 2014 to 219 women and in men in Campsfield, Colnbrook, Yarl's Wood and Dover, this survey found that those who were more depressed were more likely to have been in detention longer, to have applied for asylum and to report health problems (see also Bosworth and Kellezi, 2013).

Finally, a study commissioned from the Tavistock Institute by the Home Office that was published in 2015 reviewed how mental health issues were handled in detention (Lawlor, Sher and Stateva, 2015).[26] While not concerned with the causes of mental health problems, this report identifies some institutional factors that may exacerbate matters, including what they refer to as 'detainees' sense of powerlessness, hopelessness and fears for the future,' the lack of 'psychological talking therapies,' and generalised uncertainty and stress.

Wherever it is produced, much of the psychological and psychiatric literature continues to focus on asylum seekers. Over the past two decades numerous studies from around the world have found higher rates of depression, anxiety and PTSD in this population. While such problems ease somewhat upon release, their effects can linger for many years, with those who were incarcerated the longest, affected the worst (see for example, Keller et al, 2003; Nickerson et al, 2011; Filges et al, 2014; Cleveland and Rousseau, 2013; Kronick et al, 2011).

Criminological scholarship offers an exception to this narrow focus. In Britain, for example, scholars have examined the experiences of ex-prisoners held post sentence in prison under Immigration Act powers (Kaufman, 2015) as well as detainees more generally (Bosworth, 2014). In the US, criminologists have documented the lives of former offenders who have been deported (Brotherton and Barrios, 2013). In both cases, prisoners held in detention after the completion of their sentences report high levels of frustration and uncertainty. Those who have been deported find it hard to re-integrate to their country of birth. Within the detention setting, the outcomes for former prisoners are mixed. Whereas initially some are more resilient, due to their prior experience of incarceration, those who linger in detention, report lower levels of satisfaction with the 'quality of life', difficulties in communicating and understanding their immigration case (Bosworth and Kellezi, 2015).

[26] For a similar account of health provision in French detention centres see Enjolras, 2009.

Key causes of mental distress in detention

Throughout the literature, a series of factors emerge as key contributors to mental distress most notably: duration, pre-existing trauma, and pre-existing health and mental health problems. Other subsidiary issues include uncertainty, communication, provision of healthcare and mental health care services, and activity in detention. Age, immigration status and gender also mark out vulnerable groups. Literature on each of these matters will be addressed in turn below.

Duration

Evidence from all sources suggests that the duration of detention is closely related to mental health outcomes (Sultan and O'Sullivan, 2001; Steel et al 2006; Green and Eager, 2010; Steel et al, 2004). Studies differ only on the time frame. Whereas Green and Eager (2010) found that those who had been detained in Australia for 24 months or longer displayed the highest incidence of mental health disorder, most studies find the tipping point occurs far sooner. For Katz and his colleagues, those detained in Australia 'who spent more than six months in detention were much more likely to have low levels of wellbeing and to suffer from mental illnesses' (Katz et al, 2013), an empirical finding supported by the Steel et al 2006 and Sultan and O'Sullivan, 2001 studies. In the USA, psychiatrist Keller et al (2003) reported that mental health decreased after two months. In Britain, Katy Robjant and her colleagues found mental health deteriorated after merely 30 days (Robjant, Robbins and Senior, 2009), while for children, Lorek et al (2009) argued that any time at all in detention was harmful. In Canada, in their submission to the House of Commons Committee on Bill C-4, Cleveland, Rousseau and Kronick (2012) reported that after just 18 days in a detention centre, nearly 75 per cent of their sample met the clinical criteria for depression, while 67 per cent had symptoms of anxiety and 33 per cent PTSD. In all but the British studies, the population surveyed were asylum seekers.

Pre-existing trauma

As with the work on duration, so, too, most of the literature which identifies pre-existing trauma as an explanatory factor in mental health problems in detention is based on research with asylum seekers (Kronick et al, 2011). The pre-existing trauma, thus relates to the original reason for flight, and may include torture (Arnold et al, 2006). Some of it refers to violence experienced during travel (Picowarwcyzk, 2007). In this body of work, some attention is given to women's experience of sexual victimisation, either at the hands of human smugglers, traffickers or their partners (Chantler, 2012; Human Rights Watch, 2009; Baillot et al, 2013).

Pre-existing mental health and physical health problems

Many of the groups in detention are likely to have more extensive mental health care and physical health care problems than the general population. While methodological differences (Keller et al, 2006) and differences in the population

sampled (and its size) affect the rates of mental illnesses reported, asylum seekers and refugees in particular (Heeren et al, 2014; Robjant, Hassan and Katona, 2009, 2009; Vostansis, 2014; Porter and Haslam, 2005; Bernardes et al, 2011), but also low income migrants (Marmot et al, 2010) and prisoners (Plugge and Fitzpatrick, 2005; Horton et al, 2013), all usually perform far worse on measures for physical and mental health than other sections of the population subject to immigration detention.

In terms of the current detained population in Britain, a recent NHS health needs assessment report on the immigration detention estate in the UK found, on the whole, that the population reported being in good physical health. At the same time, however, the report noted that detainees were 'highly stressed' and exhibited raised prevalence of certain forms of disease and chronic ill health such as diabetes and tuberculosis (NHS, 2015). If prior studies are correct, such factors may, in turn, become risk factors for mental health as pre-existing medical conditions tend to deepen in detention and are a key cause of mental distress (Coffey et al, 2010). It would be useful, the next time the NHS surveys the population, to build in a longitudinal framework of analysis.

Health care and mental health care services in detention

In 2015, members of the Tavistock Institute in London published a report on the provision of mental health care in Britain's immigration removal centres, in which they called for more training in basic medical and mental healthcare for custody officers and a greater emphasis on mental health provision throughout the estate (Lawlor et al, 2015). Such findings resonate with other reports from the Yarl's Wood Independent Monitoring Board (IMB), for instance, that detail problems in medical provision (IMB, 2014). Matters are worse elsewhere, with a recent review of the US finding inadequate provision of health care in most centres, many of which, US Department of Homeland Security statistics show, operate without any psychiatric or nursing staff. Quite basic information about the mental health of detainees in the United States is particularly poorly documented, as screening tools simply do not include questions about it (Nadeau, Nicholas and Stevens, 2015).

In the Australian context, poor primary care in detention is found to relate to mental health distress (Katz et al, 2013). So, too, in Britain, the 2015 MQLD, found in its sample of 219 respondents that those who reported being under medical treatment in detention were more likely to report being depressed (Bosworth and Kellezi, 2015). In the UK, provision of health care has recently been handed over to the NHS and has not yet been evaluated. Further evidence on this matter needs to be gathered.

Uncertainty

In those jurisdictions like the UK, that do not have an statutory upper limit to the period of detention, time may be important not simply in terms of duration, but also in relation to uncertainty. Reports (HMIP and ICIBI, 2012; LDSG, 2009) and qualitative studies frequently mention the difficulties detainees face in not

knowing when or whether they will be deported, removed or released (Bosworth, 2012; 2014). In Australia, which has a similarly open-ended system, such matters were found to have a direct impact on detainee wellbeing. In Katz' terminology, the problem is one of "self-determination" (Katz et al, 2013). Without the ability to control the outcome of their lives, he found, detainees are likely to withdraw and fall into depression. A similar explanation is offered in qualitative accounts of detention (Bosworth, 2014) and in reports from visitor groups (LDSG, 2009), in which detainees identify the uncertainty of the duration of their detention as a cause of low mood and frustration. While as yet no clinical studies have generated or documented a precise measure of uncertainty and its relationship to mental health outcomes, it is clear at the very least that uncertainty makes detention more difficult (see also Bosworth, 2014; 2012).

Communication and immigration case

Even in those systems like the UK, where the immigration case is meant to be resolved prior to detention, communication about the immigration case is commonly identified in much of the qualitative literature as a factor shaping mental health. In Australia, where detention is used to process refugee claims, the reason for this aspect is clear. People have usually travelled long distances from war zones and are waiting to be granted refugee status. Under these circumstances poor communication about their case makes them feel vulnerable and depressed (Katz et al, 2013).

In the UK, while such matters maybe somewhat attenuated, similar issues have been identified in the academic scholarship on the 'quality of life' (Bosworth and Kellezi, 2012; 2015). Questions about communication within the centres and, in particular, about the immigration case, elicit nearly universally negative responses. As HMIP and ICIBI reported in 2012, many detainees find it hard to understand what is happening in their immigration case. For both those who are willing to return and those who wish to remain, such lack of clarity is frustrating and contributes to their low mood (Bosworth and Kellezi, 2015).

Activity in detention

Qualitative accounts suggest that the lack of activity in many detention centres exacerbate the pains of detention (Katz et al, 2013; Bosworth, 2014). Precise measures of activity, however, have not been correlated with mental health. What we do know is that those who are depressed are less likely to report being engaged in activities (Bosworth and Kellezi, 2012; 2015). So, too, Katz' report (2013) suggests that those who feel they are unable to take the initiative in planning their time in detention are more likely to withdraw and either fall into depression or become angry and frustrated. Most centres do their best to offer activities. None has evaluated their impact on detainee mental health. This is another area about which more research is needed.

Vulnerable Groups

There are many overlaps between the causes of mental distress in detention and the vulnerable groups. Membership of certain groups, in other words, is highly correlated with mental distress. Below I list the most commonly identified groups. This list is not exhaustive, but reflects the current state of the academic literature.

Children

The literature on children is generally the most emphatic, with studies from all over the world finding a common set of problems. Detention, even of brief duration, leaves children anxious, depressed, with sleep difficulties and problems in academic and language development as well as social withdrawal and post-traumatic stress (see for example, Australian Human Rights Commission, 2014; Brabeck and Xu, 2010; Cutler, 2005; Crawley and Lester, 2005; Deans et al, 2013; Dudley et al, 2012; Farmer, 2013; Fazel et al, 2014; Fazel and Stein, 2004; Kronick et al, 2015; 2011; Newman and Steel, 2008; Lorek et al, 2009, Mares et al, 2008; Mares and Jureidini, 2004; Robjan, Robbins and Senior, 2009; Silove et al, 2007; Steel et al, 2004; Wales and Rashid, 2013). In the blunt words of Gillian Triggs, who has recently produced an extensive analysis of Australia's detention sites, "The evidence shows that immigration detention is a dangerous place for children" (Australian Human Rights Commission, 2014).

In large part because of this kind of evidence, the British Government officially stopped detaining children in December 2010. While small numbers persist, due to errors in case work, or as part of family groups, the scale has been significantly reduced (Home Office, 2015b). These days, other than a small number of families held briefly in IRC Tinsley House, or young women and men, who are held mistakenly as adults, children are largely concentrated in the pre-departure accommodation Cedars unit. No psychological or psychiatric studies have yet been produced about the impact on mental health of time spent in this centre.

Asylum seekers

In addition to children, asylum seekers are also consistently identified across all the literature as a particularly vulnerable group in detention (see inter alia, Cutler, 2005; BID, 2005; Steel et al, 2006; 2004; Silove et al, 2007; Green and Eager, 2010; Filges, forthcoming; Cleveland and Rousseau, 2012; Nadeau, Nicholas and Stevens, 2015). For many, their vulnerability relates to their pre-existing trauma and health problems (Hadkiss and Renzaho, 2014), and the fact that very few will have received psychiatric care prior to detention (Piwowarczyk, 2007). Placing trauma survivors in detention upon arrival, Robjant, Robbins and Senior (2009) found, can exacerbate matters, placing them at further risk of mental distress. There is often a gendered element to trauma, with women asylum seekers and irregular migrants reporting higher levels of sexual assault either as the cause of their flight or on the journey (Human Rights Watch, 2009; Medical Foundation for the Care of Victims of Torture, 2009; Filges

et al, 2014). When asylum seekers are children, matters are compounded (Huemer et al, 2009; Steel et al, 2004).

In one US-based study, published over a decade ago, authors found significant symptoms of depression in 86per cent of their sample of detained asylum seekers, 77per cent of whom exhibited anxiety and half of whom were diagnosed with PTSD (Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, 2003; also reported in Keller et al, 2003). Symptoms worsened the longer people were held in detention. One year later, in a study of refugee families held in a remote detention centre in Australia, Steel and colleagues (2004) found that detainees reported rates of mental disorder at a much higher level than the national average. All but one adult in this sample reported suicidal thoughts, and over half the children did as well. More recently, in a study in Canada (Cleveland et al, 2013), which compared 122 detained asylum seekers with 66 non-detained asylum seekers, scholars found that the proportion scoring above the clinical cut off for PTSD, depression and anxiety was far higher among those detained than in the community. Such consistency in findings through time and across jurisdictions is notable.

Torture Survivors

In 2013, Storm and Engberg (2013) published a systematic review of literature on the impact of detention on torture survivors in which they were only able to identify two studies that sufficiently met their inclusion criteria. While both reported severe effects of detention on detainees' mental health such small numbers make it difficult to understand specific effects. Instead we must turn to other reports and evidence on the impact of torture more generally (see for example MF, 2009). In so doing, it becomes clear that institutional matters, first identified by Pourgourides et al (1996) twenty years ago, remain relevant, as does the literature on pre-migration trauma (Sinnerbrink et al, 1997). Accounts of former detainees suggest that quite basic information about the procedures in place to safeguard them may be poorly understood (Arnold et al, 2006). As such, and as in much of the literature in this field, Storm and Engberg (2013) call for better identification of torture survivors and assessment of their mental health needs.

Women

Notwithstanding considerable qualitative evidence that women in detention suffer gender-specific mental health problems, there is very little clinical scholarship that concentrates on this group. Instead we must turn to qualitative accounts of detention (Bosworth and Kellezi, 2014), research with asylum seekers (Chantler, 2012; Baillot et al, 2013), reports on women in detention (IMB, 2014), and to the prisons literature (Plugge and Fitzpatrick, 2005; Piyal et al, 2014). Together, these different bodies of work present a growing body of evidence that women have distinct needs and thus, particular problems and vulnerabilities (Filges, 2014). In a self-report study of health needs in prison, for instance, Emma Plugge and Rebecca Fitzpatrick found that women in prison exhibited very poor mental and physical health that was significantly lower than

women outside prison in the social class with the worst health in the United Kingdom (Plugge and Fitzpatrick, 2005). So, too, psychiatric studies have found surging levels of self-harm among women in prison, at extraordinary rates of nearly 1 in 4 (Hawton et al, 2012). In the latter study, suicide risk increased with time behind bars.

So far, no clinical research has been concentrated on women in detention. However, studies and reports of Yarl's Wood routinely document women's concerns about their health (Bosworth and Kellezi, 2014; IMB, 2014). So, too, academic work suggests that women in detention share some characteristics with women in prison, at least in terms of their experience of sexual abuse and in their childcare responsibilities (Bosworth, 2014). At the very least, given that some women in detention have previously been incarcerated, we might assume low levels of physical and mental health among them. Given the research documenting the vulnerabilities to mental distress in detention of those with pre-existing trauma, we might anticipate that women in detention would suffer similar outcomes.

CONCLUSION

As states around the world increasingly turn to immigration detention to help manage migration, a corresponding body of research into the health and mental health correlates of detention has been established. This literature is varied in its disciplinary base and in its method. Research access to detention sites in all countries is hard to obtain, making it difficult to generate a comprehensive understanding of this practice and its effects. Nonetheless, across time and space, the literature converges. Findings from studies and reports conducted a decade ago (eg HEREOC, 2004) are replicated (eg Australian Human Rights Commission, 2014). Across all studies the common theme is that the practice of detention adversely affects mental health.

Compounding matters, research has also found that the negative impact on mental health endures beyond the period of detention. After release, clinical researchers have documented problems of PTSD and nightmares in adults (Cleveland and Rousseau, 2012; Ichikawa et al, 2006; Steel et al 2006) and among children (Lorek et al, 2009). Those who spent longer in detention are usually affected more and for longer, with some studies finding negative impacts on the mental health of adults three years after detention ceased (Robjant, Hassan and Katona, 2009; Kronick et al, 2011; Steel et al, 2006). There has, as yet, been no equivalent longitudinal study of the impact of detention on children.

Under these circumstances, and unless states are prepared to revisit the question of detention itself, the literature points to the need for greater attention to resilience and coping. We know quite a lot about who suffers in detention and who is vulnerable. We know far less about what helps people cope. One study, of the impact of music in detention, reveals the positive effect of creative practice on mental health (Underhill, 2011), while qualitative accounts of everyday life in detention point to the importance of religion, relationships and staff (Bosworth and Kellezi, 2014; Bosworth, 2014). This body of work has also found stress among staff to be quite high, suggesting that working in this environment may be particularly challenging, raising questions about secondary trauma and vulnerability.

In this overview of a quarter of a century of studies, this review has documented considerable convergence within the academic scholarship. Simply put, the literature shows that immigration detention injures the mental health of a range of vulnerable populations. While there is room for more research to help improve models of care and to identify risk populations, such findings are very concerning and raise urgent policy questions that lie at the heart of the wider review into the welfare in detention of vulnerable persons.

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Appendix 6: Report of all night observation at Yarl's Wood IRC from 22.30 on 31 March 2015 to 04.30 on 1 April 2015

Background

This second visit to Yarl's Wood by Debbie Browett from the review team was focused on reception as there had been reports of long delays at night during a previous fact finding visit. She was accompanied by Jose Luis Domingos from the on-site Home Office team.

Quarantine due to a winter vomiting virus had been lifted at the site on 30 March, and Serco staff reported a very high number of early afternoon and night moves on that day to move female detainees from short term holding facilities and police stations. There were long delays in reception reported, and an anecdotal report that some women who had arrived in vans at 14.30 were still waiting to be dealt with at 21.30. This poor performance because of volumes of arrivals was reported as having continued throughout the night.

It was reported to us that our observations on 31 March 2015 were of a more usual night shift, though it was difficult to predict demand as notifications of arrivals were sporadic.

Our arrival

We arrived at reception at 22.30, and found seven detainees in the reception area, a group of five women in one of the waiting rooms and an elderly couple in a second waiting room.

At first inspection it seemed that there was no Serco officer on duty, and personal property was left unsupervised in the main arrival area. We were able to move freely around the reception area, and into back offices.

One of the on duty officers was however in the second waiting room, talking to the detained couple, and a second Detainee Custody Officer (DCO) appeared from elsewhere 5-10 minutes after our arrival.

Timescales

Those who arrived at 20.50 were shown to their rooms by 22.45. Those who arrived at 22.15 were moved to bedrooms by 23.00. The last arrivals we observed (though not the last planned) arrived at 01.45 and left reception at 04.15.

The two officers were also expected to manage night moves out of the centre, and during our period of observation one officer had to keep someone who was moving to catch a flight waiting in order to settle new arrivals.

Observations of some individuals in the reception process

Detainee 1

A 58 year old woman who was going through the induction process when we arrived had been transferred from Birmingham Airport, having arrived there at 08.25 that morning. She arrived at Yarl's Wood at around 19.00, and was taken to bed in shared accommodation at 22.45. She had been asleep for approximately one hour when she was woken up for a pick up at 01.45 to return to the airport for a 06.00 flight home.

This seemed to be unfair to the woman herself, but also to the other person in the shared room who was woken twice in the space of one night, and who had a stranger she had not met put in the same room in the middle of the night.

Detainee 2

One of the women who transferred from Colnbrook was placed on Assessment, Care in Detention and Teamwork (ACDT) at the request of the nurse, after reporting violent tendencies. She spent some time waiting for an officer trained in ACDT to arrive, and when he did arrive he was flustered, and reported that the delay was due to waiting for cover to leave his post on a wing.

The ACDT interview was conducted at a desk in the main reception area, within hearing of new arrivals and with work such as baggage searches happening around the officer and the detainee.

Detainee 3

A single female arrived and was searched, and put through the reception process. She spoke limited English but it became apparent during the discussions with Serco staff that she had been in detention before. She was confused about flight times etc. but was spoken to in English at all times. Although she said that she was not hungry she was allowed to take food to her room.

Detainees 4 and 5

The couple who were detained were dealt with by a Serco employee who spoke their first language, and so was able to see them relatively quickly. He dealt with their possessions search quickly and sympathetically. They appeared to be seen together by healthcare, raising questions of privacy.

Discussions with detainees

We took time to discuss arrival and transfer conditions with two groups of detainees, those who were already in reception when we arrived and a subsequent group of arrivals.

Of those who were already waiting to be seen, one woman reported that she had taken four days to get to Yarl's Wood, having been detained at Belfast for three days. She reported being put on a flight from Belfast that arrived at Gatwick at 16.00, being left at Gatwick until 02.00, and being driven round in a van undertaking multiple pick ups before arriving at Colnbrook at 06.00 on 29 March. She was then given one hour's notice of a move from Colnbrook to Yarl's Wood on 31 March.

A fellow detainee had travelled with her from Colnbrook and corroborated the one hour notice of movement. She was shaking and reported that arrival at detention centres increased her anxiety. (See notes above re detainee 2)

A detainee who arrived at 01.45 had left at 14.30 the previous day for a flight from Heathrow, but had not travelled, allegedly because of disruptive behaviour. She reported that she had been subjected to abusive language in the holding area at Heathrow and that the holding area was cold, with plastic moulded chairs.

Another detainee had returned with her, having undertaken a similar round trip. Her return had been halted by a Judicial Review granted while she was at the airport.

Discussions with staff

We were able to talk to staff during the quieter periods.

Reception staff confirmed that their priority during busy periods was to have detainees seen by healthcare and moved to wings. They would try to complete all paperwork and search bags etc in between this, but bag searches could be done at a later stage. (There was a five day backlog of detainee requests to access baggage that was being held securely at the time that we were there.)

Two of the more experienced staff reported that they were definitely leaving and the third was looking for a new job. This was due to concerns about the new work schedules reducing staffing numbers and leading to less time with detainees.

Reception observations

The welfare room had a sign on the door from earlier in the day that read "No welfare officer – go to library".

There was food debris in the waiting areas that were in use, and this was not cleared during the time that we were present.

The management team and reception team posters in reception were out of date.

One officer was observed juggling the paperwork and reception processes for two detainees simultaneously.

Centre observations

We took the opportunity to walk round the centre during the course of the evening. The general atmosphere was calm, but there was some room juggling in evidence as the early days accommodation (Crane) was full, and so one arrival was taken from Crane to another part of the building before being found a room.

Staff were aware of those individuals who were on constant supervision in their own rooms and were on observation rosters. There was sympathy expressed for those detainees who were thought to require more specialist care, but who were finding a transfer to specialist facilities difficult.

Healthcare had two members of staff present, a male and a female. Both seemed to be familiar with the night-time regime. There was, however, a drugs cabinet left open and a bag of medical waste left in a corridor in healthcare.

Movements around the centre were emphasised by the sound of security doors being banged shut as people moved through them.

Appendix 7: List of organisations and individuals who submitted evidence to the Review of welfare in detention of vulnerable people

Organisations

- Amnesty International
- Anti-Torture Initiative, Medact
- Asylum Welcome
- Association of Visitors to Immigration Detainees
- Bail for Immigration Detainees
- Bail Observation Project/Campaign to Close Campsfield
- Birnberg Peirce & Partners
- British Medical Association
- Deighton Pierce Glynn
- Detention Action
- The Detention Forum
- Freedom from Torture
- Helen Bamber Foundation
- Immigration Law Practitioners' Association
- Medical Justice
- Mental Health in Detention Working Group
- MIND
- The Poppy Project
- René Cassin
- The Royal College of Midwives
- Royal College of Psychiatrists Working Group on Mental Health of Asylum Seekers
- UK Lesbian and Gay Immigration Group
- United Nations High Commissioner for Refugees
- Women for Refugee Women

Individuals

Lieutenant Colonel Freddie Cantrell
Charmian Goldwyn MB BS MRCGP
Jean Lambert MEP
Dr Nick Gill and Dr Rebecca Rotter, University of Exeter

Appendix 8: Meetings with Home Office officials and stakeholders

Home Office officials

- Ms Mandie Campbell, Director General, Immigration Enforcement and Mr Hugh Ind, Director of Compliance and Returns, Immigration Enforcement, 20 February 2015

- Mr Ian Martin, Director of Asylum Operations, UK Visas and Immigration, 26 February 2015

- Mr Glyn Williams, Director of Immigration and Border Policy Directorate, and Mr Andy Smith, Deputy Director, Immigration and Border Policy Directorate, 6 March 2015

- Mr Simon Barrett, Head of Detention Policy, Immigration and Border Policy Directorate, 16 March 2015

- Mr Daniel Smith, Head of Detained Fast Track, UK Visas and Immigration, 25 March 2015

- Ms Clare Checksfield, Director of Returns Directorate, Immigration Enforcement, and Mrs Karen Abdel-Hady, Head of Operations, Returns Directorate and Mrs Sally Edmunds, Head of Compliance, Risk and Operational Guidance, Returns Directorate, 29 April 2015

- Mr Benjamin Kelso, Director of National Removals Command, Immigration Enforcement, 29 April 2015

- Mr Andrew Jackson, Director of Criminal Casework, Immigration Enforcement, 12 May 2015

- Mr Marc Owen, Director, Border Force, and Mr Brian Dray, Assistant Director, Border Force, Heathrow, 13 May 2015

- Mr Philip Schoenenberger, Head of Detainee Escorting and Population Management Unit (DEPMU) and Ms Judy Simpson, DEPMU caseworker, Immigration Enforcement, 16 July 2015

Stakeholders

- Lord Toby Harris, Chair of the Independent Advisory Panel to the Ministerial Board on Deaths in Custody, 20 February 2015;

- Mr Nick Hardwick, HM Chief Inspector, and Mr Hindpal Singh Bhui, Team Leader, HM Inspectorate of Prisons, 26 February 2015;

- Mr Chris Bailes, Divisional Managing Director of Tascor and Capita Secure Border Services, 26 February 2015;

- Mr Michael Loughlin, Deputy Ombudsman, Prisons and Probation Ombudsman, 6 March 2015;

- Mr John Thornhill, President, Independent Monitoring Boards National Council, 6 March 2015;

- Mr Digby Griffith, Director, National Operational Services, National Offender Management Service, 16 March 2015;

- Lord David Ramsbotham, former HM Chief Inspector of Prisons, 16 March 2015;

- Ms Sarah Teather MP, Chair of the All-Party Parliamentary Group on Refugees, and Mr Jonathan Featonby, 23 March 2015

- Various stakeholders in two meetings held on 30 March 2015 and 30 April 2015, including Amnesty International UK, Association of Visitors to Immigration Detainees, Bail for Immigration Detainees, Bhatt Murphy Solicitors, Detention Action, Freedom From Torture, Garden Court Chambers, Helen Bamber Foundation, Hibiscus Initiatives, Immigration Law Practitioners' Association, INQUEST, Medical Justice, Mind, Mental Health in Immigration Detention Working Group, Refugee Action, Royal College of Midwives, Sutovic and Hartigan Solicitors, and Women for Refugee Women;

- Mr Colin Dobell, Managing Director, Mitie Care and Custody, Ms Jo Henney, Chief Operating Officer, the GEO Group UK Limited, Mr Wyn Jones, Director of Custodial Operations, Serco Custodial Services, and Mr Jerry Petherick, Managing Director, Custodial & Detention Services, G4S Central Government Services, 5 April 2015;

- Ms Natasha Walter, Director, Ms Sophie Radice, Communications Executive, and Ms Gemma Lousley, Policy and Research Co-ordinator, Women for Refugee Women (along with a number of former detainees), 14 April 2015;

- Ms Kate Davies OBE, Head of Public Health, Armed Forces and their Families and Health & Justice Commissioning, NHS England, and Ms Christine Kelly, Assistant Head, Health and Justice, NHS England, 15 April 2015;

- Dr Alan Mitchell and Dr John Chisholm, British Medical Association, 5 May 2015;

- Ms Claudia Sturt, Deputy Director, Custody, NOMS South Central Region & Immigration Removal Centres, and Mr Neil Howard, Operations Manager, NOMS South Central Region & Immigration Removal Centre, 12 May 2015;

- Professor Cornelius Katona, Clinical Director, Ms TJ Birdi, Executive Director, Dr Jane Hunt GP, Ms Rachel Witkin, and Mr David Rhys-Jones, Helen Bamber Foundation, 21 May 2015;

- Mr David Bolt, Independent Chief Inspector of Borders and Immigration, and Mr Stuart Harwood, Private Secretary, 23 June 2015.

Appendix 8: Glossary of abbreviations and acronyms used in the report

ACCT	**Assessment, Care in Custody and Teamwork** – the NOMS care planning approach to the prevention of suicide and self harm
ACDT	**Assessment, Care in Detention and Teamwork** – the immigration detention approach to suicide and self harm prevention, based on ACCT
ACRT	**Assessment, Care in Residence and Teamwork** – the approach to suicide and self harm prevention used in Cedars pre-departure accommodation, based on ACCT and ACDT
AIU	**Asylum Intake Unit** – the part of the Home Office responsible for screening planned asylum claims
AVID	**Association of Visitors to Immigration Detainees**
BAILII	**British and Irish Legal Information Institute**
BID	**Bail for Immigration Detainees**
BMA	**British Medical Association**
CCD	**Criminal Casework** – the part of the Home Office responsible for deporting foreign national offenders who have committed serious criminal offences
CSU/CASU	**Care and Separation Unit** – designated area of an IRC used for segregating detainees from others
DCO	**Detainee Custody Officer** – an officer certified to exercise custodial powers
DEPMU	**Detainee Escorting and Population Management Unit** – the part of the Home Office responsible for oversight and operational management of the immigration detainee population
DFT	**Detained Fast Track** – a Home Office process for making quick asylum decisions
DSO	**Detention Service Order** – a Home Office guidance document principally used by those running immigration removal centres and related escorting services

DTD	**Detainee Transferable Document** – a document that follows the detainee from one establishment to another to the point of removal, providing a continuous record of information
ECHR	**European Convention on Human Rights** – a treaty to protect human rights and fundamental freedoms
EHRR	**European Human Rights Reports** – reports of judgments made and opinions given in the European Court of Human Rights
EIG	**Enforcement Instructions and Guidance** – guidance and information for immigration enforcement officers
EWHC	**High Court of Justice of England and Wales**
FGM	**Female Genital Mutilation** - procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons
FNO	**Foreign National Offender** – an offender who does not have an absolute legal right to live or remain in the UK
HMCIP	**Her Majesty's Chief Inspector of Prisons**
HMIP	**Her Majesty's Inspectorate of Prisons**
ICIBI	**Independent Chief Inspector of Borders and Immigration**
IE	**Immigration Enforcement** – the directorate of the Home Office responsible for preventing abuse of, and increasing compliance with, immigration law, and for pursuing immigration offenders
IEP	**Incentives and Earned Privileges** – a system designed to incentivise and reward good institutional behaviour
ILPA	**Immigration Law Practitioners' Association**
IMB	**Independent Monitoring Board** – a statutory body, established by the Prison Act 1952, that monitors day-to-day life in prisons and removal centres
IRC	**Immigration Removal Centre** – institution used for detaining persons under Immigration Act powers
LGBTI	**Lesbian, Gay, Bisexual, Transgender and Intersex**
NAAU	**National Asylum Allocation Unit** – the part of the Home Office responsible for making allocation decisions in respect of asylum seekers
NASS	**National Asylum Support Service**

NICE	**National Institute for Health and Care Excellence**
NOMS	**National Offender Management Service** – an executive agency of the Ministry of Justice that manages prison and probation services in England and Wales
NRC	**National Removals Command** – the part of the Home Office responsible for the entire removals process from the point of detention to removal (or release), other than in criminal or detained fast track cases
NRM	**National Referral Mechanism** – a process to identify and support victims of trafficking
PDA	**Pre-departure accommodation** – the Cedars facility in Sussex
PER	**Person Escort Record** – a document used for communicating information about a detainee during an escorted move
PPO	**Prisons and Probation Ombudsman**
PTSD	**Post Traumatic Stress Disorder** - an anxiety disorder caused by very stressful, frightening or distressing events
RCM	**Royal College of Midwives**
RSRA	**Room sharing risk assessment** – a means of identifying and assessing the risk a detainee may pose to others if sharing accommodation
SAB	**Safeguarding Adults Board** – a local authority-based, multi-disciplinary board, established under the Care Act 2014, whose function is to help and safeguard adults with care and support needs
SLA	**Service Level Agreement** – an agreement between two or more parties, where one is the customer and the others are service providers
SSHD	**Secretary of State for the Home Department**
STHF	**Short term holding facility** – facilities for detaining individuals for limited periods

TCU	**Third Country Unit** – the part of the Home Office that manages asylum claims from those who have already made, or may have made, asylum claims in a safe third country
TSFNO	**Time Served Foreign National Offender** – an FNO whose sentence has been served
UKBA	**UK Border Agency** – the former agency of the Home Office responsible for the immigration and the asylum systems
UKLGIG	**UK Lesbian and Gay Immigration Group**
UKVI	**UK Visas and Immigration** – the part of the Home Office responsible for considering applications from visitors to come to or remain in the UK
UNHCR	**United Nations High Commissioner for Refugees**

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