Evidence for the Stephen Shaw Inquiry 2017

Gatwick Detainees Welfare Group
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Executive Summary

The focus of our evidence

Gatwick Detainees Welfare Group's evidence to the Inquiry focusses on people with a mental illness held in immigration detention between 15 March 2017 and 31 October 2017. We have focussed on assessing the position of detained people with a mental illness as it is widely accepted that immigration detention has a negative impact upon mental health, with this adverse effect increasing with the length of detention.[1]

Our assessment is that the Home Office continues to subject overtly vulnerable people to detention. Vulnerable people are not screened out of entering immigration detention, and when evidence of vulnerability arises during detention, this does not lead to the individual's release.

Evidence from working directly with detainees

At our drop-in sessions, GDWG staff helped 220 people held in detention in either Brook House IRC or in Tinsley House IRC between 15 March to 31 October 2017; more than 1 in 4 of these people disclosed they had a diagnosis of a mental illness. GDWG is particularly concerned at the complexity of the mental illness of the people we met, both in terms of people with multiple diagnoses and also the severity of their symptoms. We also saw a very high correlation between people with a mental illness or people disclosing a history of trauma who were also experiencing feelings of self harm. During the 7 ½ month period of monitoring for the purposes of this evidence, GDWG supported 11 people in detention who had symptoms of psychosis documented in their medical records.

In GDWG's sample of 50 overtly vulnerable individuals detained between March and October 2017, Home Office caseworkers' consideration of the Adults at Risk Guidance or issues of vulnerability did not result in a single decision to release any person.

Evidence concerning the operation of Home Office policies concerning vulnerable people

Our evidence of an analysis of 36 sets of medical records and 13 Home Office files indicated significant flaws in the role of healthcare departments within IRCs in both identifying vulnerable people and reporting clinical concerns to the Home Office. This is a particular focus of our evidence as a system of information exchange concerning vulnerability underpins the Home Office's ability to take careful account of an individual's welfare when making decisions concerning detention.

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[1] Conclusion of Professor Bosworth's review, appended to the First Shaw Report

Position Statement of the Royal College of Psychiatrists, October 2013: '…detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self harm.'

Centre for Mental Health: Immigration Removal Centres in England, a Mental Health Needs Analysis, January 2017: 'Research into the impact of detention has consistently highlighted that immigration detention has a negative impact on mental health; the longer someone spends in detention, the more negative an impact it has upon their mental health.'

We identified these key aspects in which the system of information exchange was ineffective:

- Evidence of vulnerability available to an IRC's healthcare department was not shared with the Home Office using Rule 35 systems of reporting unless the individual disclosed a history of torture, and there was confusion amongst medical staff about the role of Rule 35 reports;

- There were significant delays concerning detainees' access to medical practitioners for Rule 35 purposes;

- Evidence of increasing vulnerability was rarely communicated by healthcare to the Home Office, and detailed information was not provided;

- Systems of reporting information did not provide a full medical overview of issues of vulnerability, with the result that information provided to the Home Office concerning mentally ill detainees' behavioural difficulties were not given the appropriate clinical context.

Our assessment of a small number of Home Office files found the following recurrent themes:

- The files showed either very little information concerning vulnerability was provided to the gatekeeper, or no information at all. In all cases, detention was authorised by the gatekeeper. The gatekeeper made no requests for additional information, and did not identify when the basis for the proposed detention contained factual or policy errors.

- The entire sample of cases included documented issues of vulnerability available on the Home Office file, and so the decisions to detain should have been considered by caseworkers under the Adults at Risk Guidance. However, in 1/3 of the case studies, the Home Office did not consider the Guidance or issues of vulnerability at all.

- When medical evidence was provided by the IRC's healthcare department either under Rule 35 or by Part C, this was only considered as evidence level 2 under the Adults at Risk Guidance. The information did not obtain the individual's release.

- The Home Office caseworkers were slow to identify and consider issues of vulnerability, despite evidence of this being available from the outset of detention. There was no evidence of Home Office caseworkers proactively seeking comprehensive and up to date information concerning vulnerability, even when the individual had numerous factors to show they were at risk.

- There were difficulties with the caseworker's reasoning concerning detention decisions. When clinical opinion was silent on the issue of the adverse effect of detention, this was taken as positive evidence that the individual was not in difficulty during detention. Decision-makers relied on out of date clinical assessments and appeared confused as to the proper legal tests for detention.

- Assessments of immigration factors or the risks of individuals with a criminal offending history considered as a basis to justify detention were not explained and not supported by the Probation and Prison Service's Offender Assessment System (OASys) risk assessments or evidence.

- Home Office regularly did not complete detention reviews on time, and there were long periods of detention without caseworkers reviewing the file.

- There was evidence of no or very cursory planning for vulnerable people coming into immigration detention.

Additional issues concerning mentally ill people in detention

GDWG is concerned that the present regime of immigration detention allows people with a mental illness to be detained. We consider that the level of illness seen in detainees means that some individuals may lack capacity to understand their legal position, or to be able to engage with detention processes such as applications for bail or complaints systems. Immigration detention policy does not include provision for an assessment of mental capacity, save in connection with medical decisions.

The systemic failure to share information between healthcare and the Home Office identified in our evidence is likely to exacerbate the gaps in protections for people where there are concerns about capacity. It is noteworthy that the protections available to people who may lack capacity and have lost their liberty in other circumstances (such as detention in hospital or a care home) are absent in immigration detention.

Gatwick Detainees Welfare Group

Gatwick Detainees Welfare Group (GDWG) is a registered charity (no. 1124328) that works directly with people held at the two immigration removal centres (IRCs) next to Gatwick Airport.

We offer both practical and emotional support to people held in immigration detention. We started as a small group of volunteers in the 1990s, forming a visitors group to befriend people detained under immigration powers. As the numbers of people held in detention have grown and the complexity of their needs have increased, our organisation has developed in scope. Yet visiting to provide friendship and emotional support remains the core of our work.

Each year, supporting people in person and by phone, we work with over 1,000 people detained in Brook House and Tinsley House IRCs. Staff members hold a drop-in service three times a week at Brook House. Referrals of detainees to these sessions are on an informal basis. Staff listen, give practical advice and when appropriate refer detainees to external specialist organisations. Other aspects of GDWG's service include helping people in detention to maintain contact with families and others in the community.

We also seek to advocate on behalf of particularly vulnerable detainees. We provide a network of trained volunteer visitors who will visit people in detention and also often maintain close telephone contact. The most vulnerable detainees are allocated both staff and volunteer time.

In addition to this core work, we carry out research on the issues we identify from working directly with people in detention. In recent years we have authored several reports, including *Cutting Justice*, which considered the impact of legal aid cuts on those detained, and – most recently – *Don't Dump Me In A Foreign Land*, which concerns those who arrive in the UK as children and go on to be detained.

As part of the Detention Forum network and through our own Refugee Tales project, we also work to draw attention to issues surrounding immigration detention, and to call for an end to the detention of vulnerable people, a 28-day maximum time limit for all people who are subject to detention, and for judicial oversight of both decisions to detain and also to maintain detention.

Methodology

GDWG's evidence focusses primarily on detainees with a mental illness. However, we have also included information from our work with people who fall within the definition of vulnerability set out in the Adults at Risk in Immigration Detention Guidance, specifically individuals who have experienced trauma, have a physical disability or who are experiencing thoughts of self harm. The evidence for this inquiry has been broadly confined to information concerning people held in immigration detention in Brook House IRC and assisted by GDWG between: 15 March 2017 to 31 October 2017.

Timeframe for the evidence

We have used the timeframe of 15 March – 31 October 2017 concerning our contact with detainees to give the inquiry the most up to date information. We are aware from the recent case of *R on the application of Medical Justice and others v Secretary of State for the Home Department [2017] EWHC 2461 (Admin)* that the Home Office's evidence was that sampling of decisions under the Adults at Risk Guidance contained a high degree of error in the Autumn of 2016, but that they considered these difficulties had been resolved by the start of 2017. We also noted that the Home Office amended a number of policies relevant to vulnerable adults at the end of 2016[2], and so it appeared prudent to allow a short period for these policies to be introduced and considered by caseworkers.

Evidence collation

During the 7 ½ month period of monitoring, GDWG staff saw 220 individuals during drop in sessions. We recorded information disclosed by 105 detainees to indicate they were vulnerable, noting detainees' statements that they were currently suffering from a diagnosed mental illness, serious physical health difficulties and whether they volunteered that they were having thoughts connected with self harm. When appropriate, we followed the disclosure of this information with obtaining medical records for further details. GDWG advocacy coordinators are not medically trained and so did not seek to elicit clinical information on direct questioning, but recorded when the information was volunteered. Given this, our information is likely to represent an under-reporting of vulnerability.

We were also able to collate and analyse the records of 50 of the 105 individuals we had identified at drop-in sessions as likely to be particularly vulnerable. This comprised a review of the available medical records generated in detention and evidence of Home Office decision-making concerning detention. The set of data is not complete for each individual. Partly as due to time pressure, some Home Office records have been provided to us by legal representatives, and so we have not had access to the entire Home Office file. Regrettably, there have also been a significant number of difficulties with the Subject Access Unit at the Home Office providing delayed and incomplete sets of records. In other cases medical records were unavailable within the time required for submission of this evidence.

In addition to the thematic information contained in our main evidence, we have been able to complete an analysis of 36 sets of medical records of vulnerable people and 13 sets of Home Office files. This information is summarised in two annexes to this report. Annex I contains a summary of the medical records of vulnerable people and the limited extent to which information concerning vulnerability and any increases in vulnerability were shared with the Home Office. Annex II concerning a summary of Home Office detention decisions.

[2] DSO 09/2016 Detention Centre Rule 35 and Guidance on Adults at Risk in Immigration Detention, both published on 6 December 2016

Evidence of continuing high levels of overt vulnerability of people in detention at Brook House IRC

We recognise that GDWG sees only a limited proportion of people held at Brook House IRC. This is partly as we are a small charity. We also anticipate that there will be a number of practical impediments to people accessing our service, such as language and obtaining information about us. We also anticipate that it is likely that people with an ongoing mental illness may struggle with additional barriers to attending our sessions. The Home Office has policy commitments to advise detainees of the existence of visitors groups, but there are no formal procedures for facilitating detainees to contact us.

The prevalence of mental illness in the people seen by GDWG

With the limitations of access to our organisation in mind, the level of mental illness we have recorded in the people we have seen at face to face meetings in the last 7 ½ months appears high: more than 1 in 4 of the 220 people we have seen disclosed they had a diagnosis of a mental illness.

In addition to the numbers of individuals suffering from a mental illness, we were concerned at the complexity of multiple diagnoses and severity of their symptoms. Of the 61 individuals disclosing a mental illness set out in the table below, 11 people were experiencing symptoms of psychosis documented in their medical records whilst held in immigration detention.

Type of mental illness	Number of detainees
Clinical depression	24
Post traumatic stress disorder	8
Post traumatic stress disorder and clinical depression	7
Depressive and anxiety disorder	5
Schizophrenia	5
Bipolar disorder	2
Anxiety disorder with paranoia and clinical depression	1
Post traumatic stress disorder with psychosis	1
Anxiety disorder	1
Attention deficit hyperactivity disorder	1
Unstable personality disorder, depression, attention deficit hyperactivity disorder and adjustment disorder	1
Bipolar disorder with psychotic features	1
Schizophrenia with clinical depression and post traumatic stress disorder	1
Bipolar disorder or schizophrenia (diagnosis unresolved)	1
Unspecified psychosis	1
Attention deficit hyperactivity disorder, clinical depression and psychosis	1
Total	61

<u>Interaction with hospital mental health services</u>

We are aware that the current healthcare screening conducted by healthcare departments in IRCs contains provision for asking individuals whether they have previously been inpatients for their mental illness. We anticipate that this question is included as this is a likely indicator of the seriousness of a history of mental illness and so of vulnerability in detention. Of our sample of 61

cases of persons with a mental illness, 9 had previously required hospital admission for their condition.

In addition, 2 individuals from our sample deteriorated whilst in immigration detention to an extent that they required admission to hospital under the Mental Health Act.

Inpatient hospital treatment for mental illness	
People who had a history of a previous admission to a hospital for mental illness before detention in Brook House IRC	9
People who required transfer from Brook House IRC to hospital under the Mental Health Act 1983	2
Total	11

Length of detention under immigration powers for people who have had involvement with hospital mental health services

Regrettably, the two people GDWG assisted who required transfer to hospital under the Mental Health Act from Brook House IRC experienced a substantial period of time in detention within an IRC under immigration powers before this decision was taken.

People transferred from Brook House IRC under the Mental Health Act	
Case example 1: Length of time in immigration detention before a decision was made that a hospital transfer was necessary	106 days
Case example 2: Length of time in immigration detention before a decision was made that a hospital transfer was necessary	702 days

Both individuals also subsequently experienced prolonged detention at Brook House IRC before a hospital bed could be located and the transfer to hospital effected.

People transferred from Brook House IRC under the Mental Health Act	
Case example 1: Length of time in immigration detention in an IRC after a decision was made that a hospital transfer was necessary	27 days
Case example 2: Length of time in immigration detention in an IRC after a decision was made that a hospital transfer was necessary	29 days

Additional information concerning people who experience hospital admission and immigration detention

In addition to the two detainees directly in contact with GWDG referenced above, we are aware of a further 5 individuals subject to immigration detention in Brook House IRC and who also required hospital admission for assessment of a mental illness. These people were subject to immigration detention during 2017 but did not attend GDWG's drop in sessions between 15 March 2017 and 31 October 2017 and so their information is not included in the annexes or elsewhere in our evidence.

We understand 4 individuals in 2017 transferred directly from Brook House IRC to be assessed in hospital for treatment under the Mental Health Act. We have also recently had contact with an individual who was discharged as an informal hospital patient under the Mental Health Act directly into immigration detention at Brook House IRC.

Non-clinical emotional difficulties

We monitor our impact on the emotional well-being of detainees using various methods, including assessment forms completed by staff after drop-in sessions, feedback forms completed by volunteer visitors, and questionnaires sent to those detainees to whom we have assigned a volunteer visitor. Through all of these feedback routes, we try to capture levels of anxiety, isolation and signs of despondency amongst detainees.

Between 1st January and 31st October this year, detainees themselves reported feeling anxious in 82% of responses, and feeling isolated in 77%. Over the same time period, staff recorded 77% of detainees seen at our drop-in as anxious or seeming depressed, and 72% seeming notably isolated. Volunteers feeding back identified 84% of detainees as suffering from anxiety, and 82% notably isolated.

Information concerning detainees disclosing a history of trauma and/or torture to GDWG

The focus of GDWG's evidence concerns detainees who are suffering from mental illness. However where possible we have collated information to provide an overview of other aspects of vulnerability disclosed by the people seen during our drop in sessions. A summary of the other aspects of vulnerability from the 220 people seen between 15 March and 31 October 2017 is contained in the table below:

Issue of vulnerability	
Individuals disclosing a history of torture	21
Individuals witnessing the death or serious injury of others outside the UK	7
Individuals stating they had suffered sexual abuse within their family	2
Individuals suffering assault or serious injury in the UK	2
Total	32

Prevalence of self harm and detainees with numerous factors of vulnerability

Self harm

Our staff and visitors are aware of the prevalence of self harm and suicide attempts in Brook House IRC as this is an issue which arises on a frequent basis. If a detainee states that they are planning to hurt themselves or we consider that they are at imminent risk of harm, and the IRC are unware of the person's situation, we provide this information directly to the detention centre under safeguarding procedures agreed with G4S.

We are not clinicians and so do not raise questions concerning these issues at drop in sessions. However, when detainees make such disclosures to our staff we have recorded the information. As this information is based on self reporting from our drop-in sessions, we consider it is likely to represent an underestimate of the regularity in which detainees experience feelings of self harm. 17% of the people seen by GDWG in the period 15 March 2017 to 31 October 2017 disclosed feelings of self harm.

Detainees with numerous vulnerability factors

Of our sample of 220 detainees seen by GDWG staff during 15 March to 31 October 2017, the most vulnerable people had several different indicators of vulnerability, yet these had not operated to

prevent their detention or to ensure their release. The summary statistical information provided below is included to demonstrate the complexity of the position:

Mental illness and self harm

In addition to the prevalence of people raising issues of self harm, the high correlation between people who have a diagnosed mental illness and who are experiencing feelings of self-harm is particularly troubling. 75% of people in contact with GDWG during March – October 2017 who disclosed they had thoughts of self harm also had a diagnosis of mental illness.

Mental illness and a history of trauma

It is noteworthy that of the group of 32 detainees who disclosed a history of trauma to GDWG staff: 69% had a diagnosis of mental illness and 25% had both a diagnosis of mental illness and disclosed feelings of self harm

A history of trauma and self harm

We have also found a high correlation between the numbers of individuals disclosing a history of trauma to GDWG staff who also were experiencing thoughts of self harm: 34% of people of our sample had both a history of trauma and feelings of self harm.

Mental illness, self harm and a history of trauma

During the 7 ½ months of monitoring GDWG saw 8 individuals who had a diagnosis of mental illness, were experiencing feelings of self harm and also disclosed a history of trauma.

Other factors of vulnerability

In addition to monitoring aspects of vulnerability that are presently recognised in detention policy, GDWG has recently conducted research into the vulnerability of individuals who came to the UK as children (young arrivers) but following involvement with the criminal justice system are subject to deportation proceedings and then immigration detention prior to removal.[3] This category of person held in detention was identified in the first Shaw Review and concern expressed at the 'zero tolerance' approach and lack of sympathy by the Home Office towards such people.

In essence, our report concludes that young arrivers had significant vulnerability factors prior to their criminal conviction, including childhood trauma involving experiences of war, witnessing the killing of family members, attempts to force them into child soldier roles and violence when travelling to the UK. These experiences were then compounded by difficulties in the UK, including loss of family support, inadequacies in the care system and a childhood with a precarious immigration position.

Once held in immigration detention, young arrivers had complex legal cases and experienced prolonged detention. They often experienced a profound loss of identity as 'no longer British' when subject to deportation proceedings. Once in detention all participants in the research reported mental health problems. Symptoms experienced in detention involved feelings of isolation, loneliness, eating problems, lethargy, insomnia, bedwetting and suicidal thoughts.

[3] The full report is available here: https://www.gdwg.org.uk/perch/resources/dont-dump-me-in-a-foreign-land-1.pdf

Healthcare's role in the identification of vulnerable people

Under the structure of the Detention Centre Rules there is a requirement in Rule 34(1) that each IRC must complete a physical and mental assessment of each detainee within 24 hours of their arrival. This provides an initial opportunity for healthcare to notify the Home Office of issues of any issues of vulnerability relevant to the decision to detain.

Rule 35 concerns an ongoing obligation for the IRC's GP to inform the Home Office of any:

(1) Detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
(2) Suspicions of suicidal intentions of any detained person.
(3) Detained person who may be a victim of torture.

GDWG undertook an analysis based on a review of the detention centre medical records of 36 detainees we had identified as vulnerable. We assessed the level of information concerning vulnerability provided by healthcare departments in IRCs to the Home Office. We analysed both the information obtained at the reception screening undertaken on arrival in detention and information concerning vulnerability recorded at a later date.

Difficulties with the initial screening of detainees arriving at an IRC

It is clear that healthcare in various IRCs have a structured reception screening exercise, as this is set out in the medical records. The majority of the screening appears to be completed by nursing staff with a separate appointment afterwards with by a GP. However, the difficulties in timing of the screening identified in the 2016 review remain: these are often completed late at night and after a long journey. This has obvious implications for the extent to which people will disclose issues of vulnerability.

In addition, for people who have been transferred from prison or have a prior period of immigration detention, there is a significant amount of clinical information contained in earlier medical records which does not appear to be considered during screening. Key information available from the medical notes generated in prison and so accessible to the detention centre such as a documented history of self harm or a history of mental illness are simply not identified at screening.

The requirement under the Detention Centre Rules for a detainee to be assessed by a doctor within 24 hours could provide an opportunity for issues missed at screening to be rectified. However, delays in obtaining a GP appointment can then compound errors in the initial screening. Moreover, the notes of the initial GP appointment tend to be brief, containing very little information aside from prescribing decisions. There is no indication that available medical records from the period before the consultation are considered or addressed with the detainee, or that there is any specific consideration given to issues of vulnerability.

<u>Case studies of difficulties in screening</u>

Case study 1
▪ Information available from 7 years of medical records in prison: Longstanding anxiety disorder diagnosis, with symptoms of paranoia, insomnia and low mood.

Mental health assessments and mental health care plans are recorded in the prison medical records. Prolonged period of prescription of antidepressant medication.

- Information recorded at IRC reception screening:

No history of self harm and no previous prescriptions for mental health.

- 6 days delay before there is an assessment by a GP in Brook House IRC

At the GP consultation the detainee described worsening symptoms of anxiety and thoughts of suicide. He was prescribed both antidepressant and antipsychotic medication.

Case study 2

- Information available from medical records in prison:

History of anxiety disorder and clinical depression, with symptoms of 'hearing voices' and thoughts of using a ligature to self harm over the previous 2 ½ months immediately before transfer to the IRC. He arrived in immigration detention with a prescription for antipsychotic, sedative and antidepressant medication.

- Information recorded at IRC reception screening:

No history of self harm and no previous prescription of medical for mental illness,

- GP assessment in 24 hours:

Noted the previous prescription of medication but stated this cannot be continued pending confirmation of the previous prescription. There was then a delay of 1 month and 21 days until a further GP appointment was made to discuss mental health issues and an medication was prescribed.

Case study 3

- Information available from medical records for previous period of immigration detention:

In 2016 he had a diagnosis of clinical depression with a prescription for antidepressant medication and a Rule 35 report detailing symptoms of flashbacks and nightmares.

- Reception screening at IRC in 2017: No history of mental illness or prescription of medication is recorded.

One month after detention the detainee had an appointment with a GP to discuss his mental health difficulties and was prescribed antidepressant medication.

Case study 4

- Information available from previous period of immigration detention in 2017:

Disclosed he had a history of self harming when angry and was low in mood. Noted to have self harm scarring to his arms and to be "highly emotional" when discussing the loss of his family.

- Re-detained 4 months later the reception screening states:

No mental health issues or history of self harm. (This assessment was not rectified later in the medical records.)

Case study 5

- Medical records in prison and accessible to the IRC:

Repeated evidence of complex medical history of schizophrenia, clinical depression, symptoms of psychosis with suicidal ideation and a history of impulsive serious attempts at suicide when unwell. The individual was prescribed antipsychotic medication in prison and entries were made in his medical records shortly before his transfer to an IRC that he was 'greatly affected by the stress of his immigration issues.' A psychiatric assessment was arranged by the prison but did not take place as the detainee was transferred to an IRC before the appointment.

- Reception screening at first IRC:

No history of mental disorder and no history of prescription of medication for a mental illness. Had not tried to harm themselves in prison and had not seen a psychiatrist.

He then had a short period of detention in one IRC before transfer to Brook House IRC. The PER document stated he was at risk of self harm. No attempt was made to follow up the referral for a psychiatric assessment.

- Second reception screening at Brook House IRC:

No history of psychotic or depressive disorder, no history of self harm and no medication prescribed for mental health issues.

<u>Failures to rectify difficulties/omissions in screening</u>

Moreover when community medical records are later obtained by healthcare with new clinical information - such as confirmation of a medical diagnosis of illness or a history of self-harm - this often also does not result in a further assessment of vulnerability.

Case study 6

When taken into police custody, the individual disclosed he had a history of depression, but did not repeat this disclosure when taken through the reception procedures at the IRC. The Home Office contacted IRC healthcare for information concerning his mental health on the following day, and were advised that he had not disclosed any concerns and was not in receipt of medication.

Two days after the contact between the Home Office and healthcare, the individual had an appointment with a nurse and disclosed he had a longstanding diagnosis of clinical depression with a

continuous prescription of antidepressant medication for one year. 1 week after arrival at the IRC, his GP's records were provided to the IRC's healthcare department. These confirmed the longstanding mental illness diagnosis and that the individual was under the care of the Community Mental Health Team for two years immediately prior to his arrival at the IRC. None of this information was provided to the Home Office to address the earlier misinformation.

Information sharing between healthcare and the Home Office

GDWG has analysed the exchange of information between IRC's healthcare departments and the Home Office concerning both the identification of people who were vulnerable and reporting of any increases in vulnerability as detention continued. This is a particular focus of our evidence as the system of information exchange underpins the Home Office's ability to take account of up to date evidence of vulnerability when making decisions concerning detention.

At the outset, it should be recognised that the regime under Rule 34 and 35 is far from ideal as it is predicated on an assessment of vulnerability once the individual is already in detention. It does not seek to prevent the detention of vulnerable people and so to avoid the harm caused by incarceration.

We have identified 4 key aspects in which the current system is ineffective:

1. Evidence of vulnerability is not shared with the Home Office using Rule 35 systems of reporting when this is identified by healthcare

2. There is confusion amongst medical staff about the role of Rule 35 reports

3. Evidence of increasing vulnerability is rarely communicated by healthcare to the Home Office and detailed information is not provided

4. There are practical issues concerning detainees' access to medical practitioners for Rule 35 purposes

Evidence of vulnerability is not shared with the Home Office using Rule 35 reports when this is identified by healthcare

Annex I to this report is a table of the information from the medical records of 36 individuals GDWG assessed as vulnerable and who were held in immigration detention for periods between March – October 2017. The issues identified in the medical records appear to directly apply to the specific indicators of risk set out in the Guidance on Adults at Risk in Immigration Detention. In fact, many of the individuals had numerous different indicators of risk. Annex I also includes the details of some individuals who may fall within paragraph 12 of the Guidance concerning unforeseen conditions of vulnerability, for example detainees who witnessed the self-harm or suicide attempt of a cell mate.

We note that the Detention Service Order 09/2016 concerning Detention Centre Rule 35 published on 6 December 2016 included three detailed templates for reports concerning each of the three aspects of Rule 35. In cases of torture (Rule 35(3)) and detention adversely affecting the individual's health (Rule 35(1)) the template requires the doctor to assess both the impact of detention and the likely impact of further detention. The template report for Rule 35(2) concerning detainees suspected as at risk of suicide or self harm asks whether the risk can be satisfactorily managed in

detention. All three reports also require the provision of information about managing risk if the individual is released from detention.

The medical records we have analysed show very limited use of Rule 35 to report issues of vulnerability identified by healthcare to the Home Office. In essence, the only use of Rule 35 reports recorded in the sets of medical records has been in connection with detainees disclosing that they have a history of torture. However, none of the Rule 35(3) reports concerning torture in our set of records used the template included in the DSO 09/2016. Instead, another version was used which did not require information concerning the impact of detention, or an assessment of managing risk if the person was released. This meant that there was no recorded clinical assessment of these issues, and the Home Office was not advised of the clinician's opinion. There was nothing in the medical records to indicate that Home Office caseworkers addressed the difficulties raised by use of the incorrect templates, or sought additional information.

The DSO is also clear that doctors are required to complete separate template reports to address each aspect of individuals considered at risk of the 3 categories of harm set out in Rule 35. Of the cases included in Annex I in which individuals with a history of torture were also managed under Assessment Care in Detention (ACDT) procedures, none of the template reports regarding suicidal intentions were completed. Again, there was also nothing to suggest that the Home Office caseworkers requested this additional information.

The medical records we have reviewed provide no examples of reports being provided in connection with Rule 35(1) or Rule 35(2). We consider if the system of reporting issues of vulnerability to the Home Office was operating effectively, then at the very least some of these individuals from our sample would have had such reports provided to the Home Office.

Indeed, we were unable to locate any information provided to the Home Office by the IRC's healthcare to directly address the impact of detention. This lack of reporting is particularly alarming when the clinical notes themselves contain references to the IRC environment being unsuitable for a person managing a medical condition, or mental illness symptoms being exacerbated by detention.

GDWG notes that DSO 09/2016 requires an appointment to be made with a GP for detainees who disclose a history of torture during the healthcare screening process. However, the same clear requirement for an appointment does not arise for other indicators of vulnerability such as people with a mental illness, serious physical disability or a history of trauma which does not involve torture. We suggest that this gap in the DSO may partly account for the predominance of R35(3) reports concerning torture in our sample.

Clinicians appear to be confused as to the purpose and parameters of Rule 35 reports

The purpose of Rule 35 is clearly set out in chapter 55 of the Immigration Enforcement Instructions: to ensure particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. This remit is included in DSO 09/2016 and there is a clear explanation that the system of reporting by doctors in detention underpins the Home Office's Guidance on Adults at Risk. We also suggest that if Home Office decision-making about detention is to take careful account of fluctuations in vulnerability, then the system of reporting needs to be sufficiently accessible to allow for regular clinical assessment.

However our evidence is that GPs working at IRCs have not adopted this approach. In addition to the failure to assess the impact of detention, Annex I contains examples of GPs lacking clarity concerning

the parameters and purpose of Rule 35. This includes doctors recording in the medical records that they will not complete a report in circumstances when their patient:

- Wished to disclose a history of sexual abuse when a child and was also being subject to sexual harassment by other detainees at the IRC (case study 20 in Annex I)

- Had suffered a physical assault in the community in the UK (case study 33 in Annex I)

- Wished to disclose for the first time that he had a history of multiple rape in the context of other torture. A report was refused; an earlier report concerning torture but lacking this information had previously been completed 3 months ago) (case study 7 in Annex I);

- A report had been completed one month earlier and so another was not required (case study 18 in Annex I).

- A Rule 35(3) report had been completed 3 years previously (case study 12 in Annex I).

- An RMN (mental health nurse) assessment of a detainee noted he was a victim of torture and in detention was experiencing flashbacks, sadness and missing his family. He had thoughts of self harm and it was considered that his symptoms of mental illness were likely to be exacerbated by detention. 15 days later the individual was seen by a psychologist who recorded flashbacks and sleep disturbance due to his history of trauma. An appointment with a GP on the same day as the psychologist's assessment stated that a Rule 35 report would not be completed as 'this was done in 2015.' (case study 17 in Annex I).

- On another occasion the GP told his patient to seek legal advice and that the R35 appointment would not go ahead as in his opinion this was 'was unlikely to go through.' (case study 27 in Annex I)

A further factor of concern is we have noted two examples of GPs working in IRCs taking the approach that their Rule 35(3) reports are provided to indicate that the Home Office should further investigate the individual's case, rather than the report itself providing evidence of a history of torture. The wording concerning their conclusions was:

> "In my opinion he MAY have been the victim of torture and this needs further investigation please." [Emphasis as in original].
>
> "… leads me to believe that this may be a possible torture claim as per the Home Office definition. I would ask you to investigate and advise accordingly in greater detail."

This is in clear contrast to previous Home Office policy in which such reports were seen as capable of being independent evidence of torture and so forming the basis for the release of the detainee.[4]

The suggestion that the Home Office needed to investigate the case further appears unhelpful, as this approach is not founded in policy and the resources of the Home Office to obtain further evidence are unclear. There is certainly no opportunity for the Home Office to obtain other clinical opinion.

[4] Former editions of Chapter 55 of the EIG outlined those individuals who should normally be considered unsuitable for detention. This included people who had independent evidence of torture except "under very exceptional circumstances". Reports completed by medical officers under Rule 35 were capable of amounting to such evidence.

Evidence of increasing vulnerability is not properly shared by healthcare with the Home Office

Increasing vulnerability or a more informed assessment of vulnerability is rarely communicated by healthcare to the Home Office. We are not clinicians at GDWG and so we are unable to undertake a medical assessment of the impact of detention on an individual. However, we consider that if the system of Rule 35 was operating effectively then a written report to update the Home Office of the adverse effect of detention would have been included in some of the highly vulnerable individuals' medical records in our sample.

The detailed summary of clinical information is included in Annex I but as an overview it is striking that in the sample of 36 sets of medical records covering detainees exhibiting symptoms of psychosis, some requiring hospital transfer under the Mental Health Act and others with a mental illness engaging in acts of self harm, there was no use of Rule 35 procedures save for individuals with a history of torture.

<u>Information sharing that is not part of Rule 35 procedures</u>

Aside from 7 Rule 35(3) medical reports concerning a history of torture, the only other records available in our sample showing healthcare in IRCs sharing information with the Home Office concerning a detainee's vulnerability was under IS91 RA Part C (risk assessment) procedures.

Annex I shows use of Part C and not Rule 35 procedures in the following circumstances:

- (Case study no 13) At reception screening at IRC and subsequent GP appointment, the individual disclosed he had a diagnosis of schizophrenia and psychotic phenomena associated with self harm. The ACDT process was started, as he disclosed he had suicidal thoughts. The only information passed to the Home Office was via Part C procedures: a single sentence stating that ACDT process had started. No Rule 35(2) report was completed. This meant no information was provided by healthcare to the Home Office concerning the individual's diagnosis and its association with self harm, and no information was provided concerning the impact of detention.

- (Case study no 7) A detainee attended a Rule 35 appointment with the GP. He disclosed for the first time that he had suffered repeated rape over a period of months whilst in detention and when suffering other forms of torture. The GP refused to complete a further R35 report, but stated the information concerning rape would be passed on to the Home Office by Part C. The information provided to the Home Office was 3 sentences: it stated the individual had a Rule 35 report completed 3 months previously and he had now disclosed he was anally raped on a weekly basis during a 3 month period of detention in his home country. The information concerning the rapes was new and had not previously been disclosed. 'All other details remain the same.' The individual was identified as at risk of self harm and an ACDT process was already under way. This was not referenced in the information provided to the Home Office under Part C and no Rule 35(2) report was completed.

- (Case study no 20) A detainee attended healthcare for numerous appointments and disclosed a long history of clinical depression and that he was suffering from sexual harassment in detention by other detainees. He also wished to disclose he had suffered sexual abuse and rape by a male carer when a child and had thoughts of self harm. The doctor records in the summary of the consultation that he refused to complete a Rule 35 report as this was 'not appropriate'. The only information communicated by healthcare to the Home Office concerning this detainee

throughout his detention was a single sentence under Part C and related to his risk of infection when he had an episode of diarrhoea and vomiting.

- (Case study no 22) On arrival at the IRC the detainee disclosed a history of schizophrenia, antipsychotic medication and previous compulsory hospital admission and also drugs misuse. Once in detention, a decision was taken that he required a specialist mental health assessment and there were concerns about his mental health deteriorating. He later saw a fellow detainee attempt suicide by ligature and told medical staff he was suffering flashbacks from witnessing the incident. He subsequently began self harming. ACDT procedures were commenced and the individual required hospital treatment due to self-inflicted injuries. His medical records also indicate he was hearing 'special things' and his behaviour towards healthcare staff deteriorated with verbal aggression and time placed in isolation in the Care and Separation Unit (CSU). A member of nursing staff had safety concerns regarding his behaviour toward her if he was returned to the wing.

  The only information provided to the Home Office concerning his complex history was under Part C procedures. These updates provided no information concerning the individual's mental illness or his deterioration or commencement of ACDT procedures. Instead, the only information concerned brief summaries referencing the individual's behaviour without explaining the medical context. Healthcare recorded the following details: the use of abusive words to nursing staff and the nurse's concern for her safety if the person was moved out of the CSU. The only medical information concerned detainee's entry to hospital and the conclusion of the ACDT process. The start of the ACDT procedure and the outcome of ongoing assessments as part of the process were not reported.

- (Case Study no 14) Part C was used to notify the Home Office with the brief information that the individual had been placed onto a supported living plan due to his reduced walking capacity as he found it 'difficult to walk due to foot deformity/illness.' The medical notes show far more detail concerning his vulnerability that was not communicated to the Home Office; this individual was identified as at risk of falling and then subsequently fell in the shower. He had a traumatic history and his pain was not effectively managed in detention. Part C was later used again during this individual's detention with a single sentence to inform the Home Office that he had been placed on ACDT procedures.

- (Case study no 34) This individual had a history of severe trauma, having witnessed his father killing his mother and suffering physical abuse from him. At the time he also had a diagnosis of posttraumatic stress disorder, with possible bipolar disorder and clinical depression. When he arrived into immigration detention there was a delay of 16 days in provision of his medication, during which time his behaviour deteriorated. A summary of his agitated behaviour was provided to the Home Office under Part C, but no information was later provided to explain the medical context to the behavioural changes.

GDWG's research shows the additional use of Part C procedures to record information relevant to vulnerable people concerning the use of powers under Rules 40 and 42 of the Detention Centre Rules to isolate detainees from the general detained population. Both Rules require the isolated individual to be seen and assessed by the IRC's GP on a daily basis. The evidence from the Home Office files indicated Part C is used to record the use of Rule 40 or 42 powers against the individual, but provided no information concerning the medical assessment or any information relating to vulnerability.

Case studies on Part C and information sharing between the IRC's healthcare department and the Home Office when Rule 40 Detention Centre Rules was used

Case study 1:

The individual in this case study had no prior contact with the Home Office. He had a history of homelessness and rough sleeping in the UK. The only records hinting at any issues of vulnerability located on the Home Office file state that he was agitated when taken into police custody; he was spitting and shouting and that he did not listen to others when talking.

On arrival in the IRC, the individual stated he had mental health problems and was noted to have anti-depressant medication in his possession. Strange behaviour and 'social development' were observed by nursing staff. In police custody the previous day, a psychiatric nurse had advised he needed a mental health assessment. He is recorded at the IRC's reception screening as 'confused and disorientated'. He was then placed in the CSU due to his behaviour in police custody. When later assessed in the CSU, by nursing staff the medical records noted pressure of speech, disjointed thought processes and that he was repeating himself.

The only information provided to the Home Office concerning his vulnerability was that he had been placed onto Rule 40 for damaging centre property whilst in his room, had used threatening towards officers and when trying to converse, began spitting through the door and at the observation panel. No information was shared concerning his presentation and disclosure of mental health difficulties.

The detainee was seen on the following day by the GP at the IRC. He remained in the CSU and was assessed with the doctor outside the room, on the basis it was too messy to enter. Instead, the doctor held a conversation through the door, issued paracetamol, and advised the individual to drink water. No observations were recorded by the doctor concerning the person's mental state in his medical notes, and no information was provided under Part C. Community medical records available to the IRC's healthcare and to the GP making the assessment showed a history of psychiatric treatment in his home country, possible diagnosis of posttraumatic stress disorder, sleep disturbance, and non-aggressive but socially unusual behaviour.

During the first 5 days in IRC detention, the detainee was further assessed by the GP, who noted he was known to the community mental health team and that there were concerns about his behaviour. The IRC's mental health team sought to discharge him from their caseload on the basis that he did not wish to engage with them, but the GP requested they persist with contact. The detainee was noted to be calmer and to be able to be engaged in conversation but the Mental Health Nurse (RMN) also recorded that he exhibited pressure of speech, with disjointed subjects and was repetitive. None of this information was disclosed to the Home Office.

It was 6 days after arrival at the IRC that the detainee was able to be inducted and taken out of the CSU. He advised the Home Office he would kill himself if removed. The IRC was advised of these comments, but there are no records to suggest ACDT procedures were commenced.

Two weeks after induction, the only information concerning the detainee provided to the Home Office was again using Part C that he was placed in isolation in segregation for a second time. This was on the basis that he was 'refusing to dress appropriately to collect his food.' He was also prescribed antidepressant, sedative and antipsychotic medication during this time. Information concerning the threats of self harm and use of medication was not provided to the Home Office.

Case study 2:

The individual stated that he had a diagnosis of bi-polar disorder when he arrived in detention. On arrival at the IRC, he was noted to be using inappropriate speech and on the following day a serious incident report was completed concerning this behaviour. He was prescribed both antidepressant and antipsychotic medication. 7 days later he was transferred to another IRC at which he was immediately placed in the CSU due to aggressive behaviour. He then remained in isolation under R40 of the Detention Centre Rules for a prolonged period. Aggressive behaviour and violence towards the room was recorded during this time.

52 days after arrival in immigration detention the person had a full assessment by a psychiatrist. This concluded that the prescription of antidepressant medication had triggered episodes of mania, hypomania and mixed affective states. This had led to a number of behavioural consequences including irritability, impulsivity, hyperactivity and disinhibition. The antidepressant medication was stopped and the antipsychotic drug was increased. The detainee's behaviour then improved with the altered medication regime. No information was provided by healthcare to give the medical context to the detainee's behaviour.

In summary, these two case studies indicate a troubling imbalance in the risk assessment information made available to the Home Office. Evidence of agitated or aggressive behaviour was provided without any explanation of the mental health symptoms that were being treated. In such circumstances it is difficult to understand how issues of vulnerability could be properly considered by the Home Office when assessing whether detention should continue. Indeed, GDWG has concerns that such a focus on such behaviour without information concerning vulnerability would lend improper support to a risk assessment conclusion that detention was appropriate.

<u>The decision to use Part C or Rule 35 procedures</u>

References to Part C risk procedures are scattered in various Home Office polices, but most recently referenced in the Rule 35 DSO 09/2016. This provides the following guidance to clinicians:

> "Where IRC medical practitioners consider that a detainee's claim to have been tortured does not meet the definition of torture …, and does not therefore trigger the requirement to make a report under Rule 35(3), they may nevertheless have concerns arising from the alleged incident(s) or its consequences (eg physical or mental health problems) that the detainee may be particularly vulnerable to harm in detention. In such circumstances, medical practitioners must report their concerns. This may be by completion of a Rule 35(1) report, if appropriate, by completion of an IS91 RA Part C (risk assessment), or by passing the information direct to the Home Office Immigration Enforcement team at the centre."

The DSO also states:

> "The requirement to report need only be triggered by you having a concern that the detainee may have been a victim of torture. However, you should not make a report where the detainee's experience of harm or mistreatment does not meet the definition of torture given in section 3 above, or where you do not have clinical concerns that the detainee may have been a victim of torture, including instances where there is no basis for concern other than an unsupported claim by the detainee to have been a victim of torture. If, however, you do have concerns that the detainee may nevertheless be particularly vulnerable to harm in detention you must report those concerns, by completion of a Rule 35(1) report, if

appropriate, an IS91 RA Part C (risk assessment), or by passing the information direct to the Home Office Immigration Enforcement team at the centre."

It is noticeable that Rule 35 procedures require considerably more clinical assessment and reasoning. This also appears to offer clearer procedural protections for the individual detainee, as it requires a copy of the report to be provided to them and requires the Home Office caseworker to review the decision to detain. In contrast, information provided by Part C risk assessment or directly to the Home Office at the IRC does not require the same response.

As summarised above, the information GDWG has seen indicates that when using Part C procedures the information provided by IRC healthcare to the Home Office is very brief: 1 – 3 sentences. The issue of the impact of detention on the vulnerable individual is not addressed, and no information is provided concerning risk management either in the IRC or if the person is released. The Home Office files GDWG has seen do not suggest that on any occasion the relevant caseworker has sought any further information from the clinician, or that there has been any review of the decision to detain. This clearly detracts from the Home Office's ability to factor the assessment of vulnerability into detention decisions. The use of informal information sharing or Part C procedures has a further flaw in that this information is not provided to the individual detainee. There is therefore no opportunity to correct errors, and no assistance or update provided to any legal representatives.

The DSO seems to be worded to allow IRC clinicians to choose between Rule 35 procedures, IS91RA Risk assessment and passing the information directly to the Home Office team at the IRC. It does not explain on what basis a doctor should make such a choice. This appears a troubling omission in failing to delineate when the different procedures are required, given the possible consequences for the individual detainee. On a practical basis, it is clear that the clinical workload when engaging with the Rule 35 process is much greater than other procedures and so there is a potential risk that hard-pressed clinicians may select the speedier and less onerous option.

Practical issues concerning detainees' access to medical practitioners for Rule 35 purposes

GDWG's analysis of the medical records and the ability of healthcare departments in IRCs to provide a properly systematic approach to Rule 35 reporting shows two key difficulties. Firstly, access to an appointment for a Rule 35 report is delayed. Secondly, GPs at IRCs do not have regular and ongoing involvement with the most vulnerable detainees, such as those with a history of trauma and those with a mental illness. Much of the ongoing support and assessment of vulnerable detainees occurs within support groups in detention or is offered at individual appointments with RMNs. Whilst the GP as Medical Practitioner within the terms of the Detention Centre Rules has responsibility for reporting concerns to the Home Office under Rule 35, they are also removed from an understanding of variations in vulnerability, as they also have limited contact with the most vulnerable detainees.

<u>Delays in accessing Rule 35 and other medical appointments</u>

We have noted only a single occasion when the medical appointments with a GP (arranged within 24 hours as required by Rule 34 of the Detention Centre Rules) resulted in a Rule 35 report. In addition, the medical records we have analysed that were created between 15 March and 31 October 2017 show that on 9 occasions a GP appointment was arranged later than 24 hours after a detainee's entry to a detention centre. In 3 instances the delays to see a doctor were 3 days or less. However, the remaining 6 instances of delay were considerable:

- 5 days
- 5 days

- 6 days
- 11 days
- 26 days
- 33 days

Whilst GDWG is particularly concerned at the infrequent use of Rule 35 reports, a combination of the medical records we have considered and the information held in our office show on an anecdotal basis that, even when the need for such a report is recognised, there can be considerable delays in arranging an appointment.

We have noted the following delays between the decision that an appointment with a GP to assess the need for a Rule 35 report was necessary, and the consultation taking place:

- 5 days
- 5 days
- 6 days
- 7 days
- 9 days
- 11 days
- 11 days
- 14 days
- 19 days

Additionally, some medical records also refer to nursing triage appointments being arranged before the detainee was able to see a doctor for a discussion concerning a Rule 35 report, adding in additional delay before the appointment with the GP could take place.

A further theme GDWG identified in our analysis of the medical records was the number of medical appointments that were missed by detainees. On some occasions the detainee is recorded as attending healthcare at a later date, confused as to when a planned appointment was due, only to be told that it had already been missed. We also note that the Centre for Mental Health's Mental Health Analysis of Immigration Removal Centres commissioned in response to the first Shaw Review and published in January 2017 recorded a very high number of missed appointments at the Gatwick IRCs, especially when compared with other IRCs.

It is a clear gap in safeguarding procedures if detainees with a mental illness can miss medical appointments without follow up. This also represents a further practical gap in terms of the ability to assess vulnerability, and to then factor this into decisions concerning detention.

<u>The division in clinical responsibility between GPs and other medical staff</u>

Rule 35 is predicated upon the IRC's Medical Practitioner having responsibility for reporting concerns about a detainee to the Home Office. In practice, the medical records analysed in Annex I show clear differentiation within IRC healthcare departments in the care of people with mental illness, with detainees having limited access to and assessment by the GP. The detailed mental health assessments and ongoing mental health appointments are conducted by RMNs with some records also referencing referrals to group emotional support sessions. Our assessment of the records is that the entries completed by the GP generally concern issues of drug prescription and decisions concerning internal and external referrals. There is little information concerning the individual's presentation or the impact of detention.

The following case study examples from Annex I illustrate the difficulties of Rule 35 reports being solely the responsibility of the IRC's GP:

- Case study 4 – The detainee witnessed his cellmate attempting to hang himself and later attended healthcare for a nursing appointment to discuss insomnia after the incident. He had no contact with the GP.

- Case study 8 – At an appointment with an RMN the detainee was recorded as agitated and tearful. He stated his parents were captured when he was 13 and he had not seen them since. He had fled his country with his best friend but watched him drown in a boat on the way to Italy. He stated he would kill himself if removed. He had no contact with the GP after this appointment.

- Case study 10 – The detainee had a history of post-traumatic stress disorder, clinical depression and self harm. At an appointment with an RMN the assessment recorded variations in mood and that he was having recurrent memories of witnessing people being killed. When subsequently seen by doctor, the only issue noted was a medication review.

- Case study 12 – The detainee had a history of torture, self-harm and clinical depression. He was referred to the RMN after an initial appointment with a GP. The mental health nurse recorded he was experiencing anxiety related to being in detention and recommended prescription of anti-depressant medication. No subsequent GP appointment was made.

- Case study 15 – The detainee was seen by a GP within 24 hours of arrival at the IRC. He was recorded as having a history of schizophrenia, clinical depression and recent treatment in hospital under the Mental Health Act. He also had a history of suicide attempts, the most recent event having occurred in the last 2 weeks. The GP prescribed medication and he was referred to the RMN. He then had 4 appointments with mental health nursing staff during which he discussed the fact that he was having flashbacks, auditory hallucinations, insomnia and wished to return to hospital. His second appointment with a GP was 34 days after arrival at the IRC.

- Case study 25 - The reception screening of the detainee recorded a history of post-traumatic stress disorder, severe depression and previous hospital admission for these conditions with an attempt at suicide by ligature on the previous day. The GP appointment on the day of arrival at the IRC continued the prescription of antidepressant and antipsychotic medication, and referred the individual to the mental health team. Thereafter, the detainee did not attend mental health appointments and so was discharged from their caseload within 15 days of arrival at the IRC without assessment.

  The detainee asked - after 22 days of detention - when he was due to have a mental health appointment. This was provided 2 days later. This assessment with an RMN concluded that the detainee considered that being in detention and not knowing when he will be released was the worst of his problems, and that he had suicidal thoughts. The outcome of the assessment was that, as the detainee was compliant with medication, he should self-refer to the mental health team if he had any other concerns. The detainee's medical records show no contact with the GP after the initial appointment and no referral back to the GP by the RMN.

Home Office decisions concerning detention

GDWG has reviewed the available evidence in 13 cases to assess the impact of issues of vulnerability on the Home Office's decisions to detain. A summary of the information concerning Home Office decision-making is set out in Annex II.

In summary:

1. Consideration of the Adults at Risk Guidance or issues of vulnerability did not result in a single decision to release any individual, from our sample of cases.

2. The Home Office files showed that very little information concerning vulnerability was provided to the gatekeeper, or no information at all. In all cases detention was authorised by the gatekeeper. The gatekeeper made no requests for additional information.

3. When medical evidence was provided by the IRC's healthcare department either under Rule 35 or by Part C, this was only considered as evidence level 2 under the Guidance.

4. A comparison between the information concerning vulnerability available on the medical records and the information considered by the Home Office indicated a troubling gap in information exchange. This undermined the notion that vulnerability is properly considered as part of Home Office detention decisions.

5. There was evidence of poor quality decision-making in the following areas:

    a) All of the cases we have reviewed included documented issues of vulnerability available on the Home Office file, and so the decisions to detain should have been considered by caseworkers under the Adults at Risk Guidance. However, in 4 case studies the Home Office caseworkers did not consider the Guidance at all.

    b) In 3 cases, there was a considerable period of immigration detention before issues of vulnerability were recognised when decisions were made concerning detention and the Adults at Risk Guidance considered. This was despite the fact that this evidence of vulnerability was available from the outset of detention.

    c) There was no evidence of Home Office caseworkers proactively seeking comprehensive and up to date information concerning vulnerability, even when the individual had numerous factors to show they were at risk. When clinical opinion was silent on the issue of the adverse effect of detention, this was taken as positive evidence that the individual was not in difficulty during detention.

    d) Decision-makers relied on out of date assessments and appeared confused as to the proper legal tests for detention.

    e) Assessments of immigration factors or the risks of individuals with a criminal offending history were not explained and not supported by the Probation and Prison Service's OASys risk assessments.

6. Only one set of papers indicated that the file was reviewed by the Case Progression Team introduced by the Home Office in response to the 2016 review– no issues of vulnerability were considered and no assessment of the likely length of detention was made.

7. 5 files of our sample of 13 files showed that the Home Office did not complete detention reviews on time and there were long periods of detention without caseworkers reviewing the file.

8. There was evidence of no or very cursory planning for vulnerable people coming into immigration detention.

Errors in the initial decision to detain, and the role of the gatekeeper

Clearly, the role of the gatekeeper when considering decisions to detain will be limited by the information that the caseworker has provided. The Home Office files GDWG has seen have not recorded the details of the information that the gatekeeper is able to access, or the basis of the decision by the gatekeeper to approve detention. It is unclear whether the gatekeeper was able to access additional information to verify the basis for the proposed detention, or to challenge any errors and request additional details. However, the fact that evidence on the Home Office file was available to contradict the assessment of the caseworker but this error was not identified by the gatekeeper indicates the limitations of their role:

Case study:

Prior to detention, the individual had disclosed a history of clinical depression to the Home Office. Whilst in prison, his medical records recorded multiple concurrent diagnoses of mental illness: emotionally unstable personality disorder, clinical depression and adjustment disorder. He was prescribed both antidepressant and antipsychotic medication. He also had a history of self harm over a 15 year period and a previous admission to hospital under the Mental Health Act for suicidal thoughts connected with clinical depression.

When the individual was subject to immigration detention, the IS91 form stated that there were no risk factors. The case note on the Home Office file recorded 'no medical conditions and no issues under Chapter 55.10.' The file also briefly recorded that the case was accepted by the detention gatekeeper, but no details were provided concerning the information given to enable this decision.

Case study:

The Home Office file had evidence that the individual had a diagnosis of paranoid schizophrenia, requiring the prescription of both antipsychotic and mood stabilising medication. The case note recording the decision to detain stated 'no issues' regarding Chapter 55.10 and 'no record' of a history of mental illness.

In this case, the Home Office file had clear medical evidence that the individual had a complex mental illness, with diagnoses of depressive disorder with psychotic features and ADHD. There was also evidence he had previously had a period of admission to hospital under the Mental Health Act. The decision to subject him to immigration detention records 'no medical issues and no adults at risk factors.'

The gatekeeper's role when considering the weight given to issues of vulnerability and immigration factors in detention decisions

GDWG's review of cases also showed examples of decisions where the Home Office caseworker appeared to give inappropriate weight to the factors justifying detention and insufficient consideration to issues of vulnerability. The file notes concerning the decisions to detain also include factual errors concerning the individual's history. In these examples, the records show nothing to suggest the gatekeeper intervened, sought additional information, or challenged the caseworker's approach to decision-making. There was also no indication that the gatekeeper assessed whether evidence of vulnerability was sufficiently up to date.

Case Study:

The individual provided detailed medical evidence of a longstanding diagnosis of post- traumatic stress disorder and associated mental illness in the context of legal proceedings. The medical evidence was many months old when he was detained. He had family lawfully in the UK but he overstayed 4 months after the conclusion of unsuccessful legal proceedings to live in the UK. He had no criminal offending history.

Case Study:

The individual had two R35(3) reports completed for 2 separate periods of immigration detention in 2014 and 2015. Both reports recorded a history of an attack in which the individual was beaten and his partner killed. During both periods of immigration detention, he was identified as at risk of self harm and managed on ACDT procedures. He had a history of complying with all reporting requirements and had no criminal convictions. When detained, no removal directions had been set and the person did not have a travel document.

The records of the decision to detain note a reference to the individual having 'claimed a history of depression and self harm.' He was assessed as at evidence level 2 of the Adults at Risk Guidance. The decision to detain also contained factual inaccuracies identifiable on a review of the Home Office file, such as a lack of Article 8 ECHR family life when the person had a heavily pregnant partner living in the community. The note also stated he had failed to comply with immigration controls, when the only evidence of this was a continued stay in the UK after the unsuccessful legal proceedings.

The gatekeeper approved detention despite the evidence of vulnerability during previous periods of detention, errors in the file note explaining the decision to detain and the limited immigration factors to justify the need for detention.

Case Study:

The Home Office file had evidence that the individual had a diagnosis of schizophrenia for more than 5 years, and that in 2016 he was prescribed antipsychotic medication. He was assessed as at evidence level 2 of the Adults at Risk Guidance. He had no history of criminal offending behaviour. The Home Office file indicated no involvement by the gatekeeper to request more up to date information concerning vulnerability, or to consider whether detention was necessary.

The Home Office file contained medical evidence from a psychiatrist dated 2016 that the individual had a low mood and was prescribed medication. The person had also separately disclosed he was suffering from anxiety and insomnia, and prescribed medication for these conditions. The records of the decision to detain recognised that the person fell within the Adults at Risk Guidance and this was

assessed as evidence level 2. The detention was justified on the basis that the individual was at medium risk of absconding and medium risk to the public. There was no OASys or other probation reports to support this assessment. The only factual information on the file was that the individual had a good record of complying with reporting conditions and his criminal history consisted of accepting 2 cautions for ABH over a period of 9 years. The file records no consideration by the gatekeeper and no suggestion that the decision-making by the caseworker was challenged.

Concerns about Home Office decision-making: timing of scheduled reviews

Chapter 55.8 of the Enforcement and Instructions Guidance (EIG) set out a clear timetable for reviews of detention and the seniority of the caseworker required to conduct the assessment. Reviews are required after 24 hours of detention, then after 7 days, 14 days, at 1 month and thereafter on a monthly basis. We suggest that in order for issues of vulnerability to be considered, especially those which are not raised via Rule 35 and so there may be no policy requirement to review detention, it is crucial that a standard timetable of review is maintained. Regrettably, our assessment of the Home Office files in our sample found that detention reviews were regularly missed:

Details of missing detention reviews:	
1.	No reviews after 24 hours of detention, 7 days of detention and 14 days of detention. First review was one month after detention
2.	No reviews after 24 hours of detention, 7 days of detention and 14 days of detention. First review was one month after detention
3.	No reviews after 24 hours of detention, 7 days of detention and 14 days of detention. First review was 21 days after detention
4.	No reviews after 24 hours of detention, 7 days of detention and 14 days of detention. First review was completed 24 days after detention
5.	No reviews after 24 hours of detention, 7 days of detention and 14 days of detention

We also found that, when a Rule 35(3) report was received, there were also delays in reviewing the decision to detain. One file in our sample showed a Rule 35(3) report was received but no re-consideration of detention occurred until 11 days later, when the standard timetable required a review to be conducted. This review made no reference to the Rule 35(3) report, or the issues of vulnerability that it raised.

Concerns about Home Office decision-making: Failure to review detention when additional evidence of vulnerability is disclosed

In addition to missing the detention reviews required by Chapter 55.8 EIG there was also evidence of the Home Office failing to complete a review of detention when new evidence of vulnerability came to light.

Case Study:

A young detainee aged 19 who wrote directly to the Home Office stating he had been raped by his mum's partner when a child and he was suffering flashbacks of this in detention. He also disclosed

he was the subject of bullying in the IRC. The Home Office file shows no evidence that this triggered an urgent decision to review detention.

Case Study:

A person with a serious physical disability, who had severely injured his feet was subject to detention. In the community he used 2 crutches or a wheelchair; however, neither mobility aids were available to him in detention. His medical records show concern from officers in the IRC and medical staff regarding his difficulties moving around the IRC, the risk of him falling, and his level of pain. The detainee directly contacted the Home Office to explain his difficulties and that he was in extreme pain. The Home Office file records no contact with healthcare upon receipt of the letter. Further, the letter did not trigger a review of detention.

Concerns about Home Office decision-making: factual inaccuracies and policy oversights

GDWG's analysis of the Home Office reviews of detention showed a lack of continuity of information about issues such as the diagnosis of a mental illness.

Case study:

The detainee had clear and recent medical evidence of a diagnosis of bipolar disorder with a prescription of antipsychotic medication and this was referenced in earlier detention reviews. A monthly review authorising continued detention incorrectly stated there was 'no professional evidence of a diagnosis'.

Case study:

The detainee had been identified in previous monthly reviews of detention as having a diagnosis of PTSD and clinical depression with psychosis and a history of self harm. A later monthly review of detention referenced a need to ask healthcare for up to date information concerning an ophthalmology referral, but did not address the serious mental health diagnosis or history of self harm.

Case Study:

The detainee had a diagnosis of clinical depression, adjustment disorder and unstable personality disorder. He disclosed he had a history of depression when taken into immigration detention and was assessed as at evidence level 1 of the Adults at Risk Guidance. The schedule of detention reviews requiring a fresh decision after 7 and 14 days was not completed. A detention review completed one month after detention stated that there were no Adults at Risk issues. At the time of the review, the individual was receiving antipsychotic medication in the IRC for his multiple mental health conditions.

Concerns about Home Office decision-making: the quality of reviews – using a lack of clinical opinion to justify detention

An additional concern is the Home Office's approach to assessing issues of vulnerability. In essence the files show an unwillingness to release people held in detention even when clear evidence of vulnerability was provided. In all of the cases we have considered when a Rule 35(3) report was provided, a failure by the clinician to state that detention was having an adverse effect on the

individual was used not only to assess the evidential level for the Adults at Risk Guidance, but also the absence of such an assessment was used to justify a decision to continue to detain.

Other files contained positive statements such as 'healthcare have no concerns' when the Home Office was assessing issues of vulnerability. However, this assessment appeared predicated on the fact that the IRC had not forwarded any concerns. There was no evidence that the Home Office had requested an update and been reassured that the individual was not at risk.

Case Study:

Within 24 hours of arrival in detention, the medical notes of the individual recorded a history of alcohol dependence, an adjustment disorder and a history of suicidal thoughts and self-harm. The medical records show no contact by the Home Office. Two days later the Home Office file recorded 'healthcare have no concerns.'

Case Study:

A monthly detention review noted that the individual had a history of bipolar disorder but stated that there were 'no concerns over medical condition since detained.' The medical records of the individual record no contact from the Home Office at this time, and instead the notes detailed extremely volatile behaviour, requiring an urgent mental health assessment.

The same individual's detention was reviewed one month later, with the assessment that the individual had 'his needs met within the detention estate.' Again, no contact between the Home Office and healthcare is recorded on the medical records, and at the time of the detention review the individual had been regularly held in the CSU as a result of his agitated behaviour.

A further detention review completed one month later followed the same pattern of the Home Office file recording a lack of concerns shared by healthcare, and so stating that the individual's needs were being met in detention. Again, the medical records indicate no suggestion of contact by the Home Office and they also show that the individual was highly distressed in his behaviour and regularly experiencing periods of isolation in the CSU.

Concerns about Home Office decision-making: the quality of reviews – the approach to assessing vulnerability

GDWG's analysis of the evidence of Home Office decision-making suggests reluctance by some caseworkers to recognise issues of vulnerability.

Case Study:

A Rule 35(3) report detailing a 6 month period of torture (completed on an out of date template) recorded that the individual was having anxiety when seeing officers in the IRC and was experiencing sleeping difficulties in immigration detention. The Home Office caseworker's summary was that the individual was assessed as at evidence level 2 under the Adults at Risk Guidance, as the doctor had not stated that detention was likely to cause harm. Detention was maintained.

A further difficulty with the examples of Home Office decision-making when assessing vulnerability is the confusion of different tests concerning aspects of detention. This has the unfortunate effect of moving the key focus in decision-making away from issues of vulnerability within detention. A

recurring issue was Home Office caseworkers referencing medical evidence concerning fitness to fly as evidence in support of detention; this then overrode any concerns about vulnerability.

This approach is problematic: the test of fitness to fly simply concerns the safety of the individual on an aircraft for the duration of the flight. The International Air Transport Association's Medical Manual 9th edition guidance on medical conditions and fitness to fly can be summarised as: Will the condition interfere with the safe conduct of the flight or will the flight environment exacerbate the medical condition?[5] These issues are significantly different to considerations of vulnerability or the negative effect of detention. Fitness to fly is also irrelevant to the specific considerations of Home Office policy contained in Chapter 55 EIG or the Adults at Risk Guidance.

Examples of Home Office caseworkers relying upon evidence of fitness to fly when considering detention:

Case Study:

A person with a diagnosis of post-traumatic stress disorder, clinical depression with psychosis and managed on ACDT procedures in detention, claimed asylum whilst in detention. During the asylum interview, he told the interviewing officer of his diagnoses, together with the fact that he was hearing voices and had previously been subject to hospital admission under the Mental Health Act.

At the following monthly detention review, this information was not considered when assessing his vulnerability and no attempt was made to contact healthcare for further information. Instead, the caseworker relied upon a medical assessment conducted 9 months previously that the person was fit to be transferred between detention centres and another report completed 2 months beforehand that the individual was fit to fly in order to justify continued detention.

A detention review completed 2 months later again referenced the medical evidence of fitness for transfer (by now 10 months old) and fitness to fly (at this time 4 months old). No up to date information from healthcare had been sought in the meantime.

Case Study:

A review of the decisions to detain in the case of an individual with a diagnosis of bipolar disorder after 8 and 9 months of detention authorised further detention on the basis of 7 and then almost 11 month old evidence that the person had been considered fit to fly. Again, there was no indication that up to date clinical opinion had been sought concerning the effect of detention.

[5] The full test is available at http://www.iata.org/publications/Documents/medical-manual.pdf is: 'Does the individual require medical clearance before flying because they: (a) suffer from any disease which is believed to be actively contagious and communicable; (b) are likely to be a hazard or cause discomfort to other passengers because of the physical or behavioural condition, (c) are considered to be a potential hazard to the safety or punctuality of the flight including the possibility of diversion of the flight or an unscheduled landing; (d) are incapable of caring for himself and requires special assistance; (e) have a medical condition which may be adversely affected by the flight environment. Passengers not falling into the above categories normally do not need medical clearance, however, if in doubt, medical advice should be obtained.'

See also 'Fitness to Fly - Hilary Pickles and Naomi Hartree *Journal of Forensic and Legal Medicine* 47 (2017) 55e58

Isolation and detention

The recent Panorama program provided troubling evidence of abuse and neglect at Brook House IRC. It is important to consider the context in which such an environment could develop without being identified by external organisations such as the Independent Monitoring Board or Prison and Probation Ombudsman or by methods of accountability such as the complaints process.

The reluctance of people in detention to use complaints mechanisms

Our experience is that people in detention are scared of complaining for fear of reprisals, or that their complaints could affect their immigration cases. A further additional factor is both the high level of vulnerability of individuals as evidenced above. The prevalence of detainees suffering from mental illness and/or thoughts of self harm will clearly inhibit access to external organisations and complaints mechanisms. An effective policy to prevent or reduce the detention of such vulnerable people would overall enhance the ability of the detained population to engage with complaints mechanisms. However, even with a more effective policy for screening to protect the most vulnerable from being detained, detainees are clearly still in a disadvantaged position when making a formal complaint about the circumstances of their incarceration.

Isolation in detention

Legal issues

People experience long waits for legal advice surgery, and there are widespread issues with restricted access to legal aid. There is considerable evidence of the difficulties people have accessing immigration and asylum legal advice. See our report Cutting Justice for an exploration of these issues[6], Amnesty International's report[7] and the recent legal advice survey data produced by Bail for Immigration Detainees[8].

Internet access

Key websites (including BBC, Refugee Council and indeed ours, amongst many others) are blocked for periods. HMIP's recent reports have highlighted these issues: 'Legitimate websites should be accessible, including those facilitating legal assistance, Skype and social networking. There should be effective procedures for permanently unblocking such sites.'[9] In addition, there are poor computer systems, lack of access to a scanner, complaints of faxes not working, and poor phone reception.

Privacy issues

People in detention have reported to us that they have experienced that their phones were checked while being held in property, property went missing when their room was searched, and solicitors' letters having been opened by staff.

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[6]CAPE-DAVENHILL, L. (2015) Cutting Justice: The impact of the legal aid cuts for people detained at Brook House and Tinsley House IRCs. Available at: https://www.gdwg.org.uk/perch/resources/cuttingjusticeexecutivesummary.pdf

[7]Amnesty International (2016) Cuts that hurt: The impact of legal aid cuts in England on access to justice https://www.amnesty.org.uk/files/aiuk_legal_aid_report.pdf

[8]Bail for Immigration Detainees. (2017) Legal Advice Survey. Available at: https://hubble-live-assets.s3.amazonaws.com/biduk/redactor2_assets/files/213/Legal_Advice_Survey_-_Spring_2017.pdf

[9](4.26) - HM Inspectorate of Prisons. (2017 (ibid)

Following the additional of 100 extra beds to Brook House and Tinsley House between 2016-17, many cells that were previously holding two people are now holding three, exacerbating issues around a lack of privacy and well as adding to the tensions and suffering within the IRCs. GDWG is aware that a legal challenge to the conditions of detention is currently proceeding at the High Court (court reference numbers Sensitive/Irrelevant and Sensitive/Irrelevant) and the case is due to be heard in January 2018.

Adults lacking capacity

GDWG is concerned that some of those we have seen in immigration detention appear to be mentally unwell to a degree where it is difficult to be sure that they have understood the simple information a member of staff has given them during a drop in session. Our sessions concern practical issues such as arranging for a visitor, understanding if the person has any clothing needs or requires help contacting their legal representative or a referral for legal advice.

Our concerns about capacity may seem unsurprising, given the evidence provided earlier in this report concerning the severity and complexity of the mental illness diagnoses of the people we meet, including those who are experiencing symptoms of psychosis or who subsequently require hospital treatment under the Mental Health Act. Annex I also provides a case example of an individual who was recorded to have learning disabilities when screened into reception but this issue was not pursued by healthcare.

On a review of the people we have seen during drop-in sessions between 15 March to 31 October 2017, GDWG staff saw 9 individuals at our drop in sessions who appeared to have an inability to engage in a reciprocal conversation or to demonstrate an understanding of the limited topics discussed. Clearly, GDWG is unable to provide conclusions about capacity as this requires a medical assessment, but we recorded our concerns on our internal systems and where possible we sought to refer detainees for independent medical assessment and legal advice.

The individual's capacity will need to be assessed (and may also vary) according to the decision under consideration. However, as a background, we anticipate that most people in immigration detention will need to engage with complex decisions requiring an understanding of technical and complex information including the following:

1. Whether to exercise rights to apply for bail

The Home Office is required to provide this information under DSO 06/2013 Reception, Induction and Discharge Checklist and Supplementary Guidance, point 30. The individual will also need to use and understand B1 form before making an application:
http://hmctsformfinder.justice.gov.uk/HMCTS/GetForm.do?court_forms_id=2744

If an individual decides to apply, they will also need to understand legal documentation such as the Notice of Bail Hearing provided by the Tribunal and any Bail Summary provided by Home Office in opposition to the grant of bail. Failure to obtain a grant of bail following an application or an improperly prepared application can have long term consequences, as it may adversely affect the individual's immigration position.

2. Whether to engage with voluntary returns process

The Home Office is also required to provide this information (para 30 and twice in annex D of DSO 6/2013 Induction etc). Online guidance is here: https://www.gov.uk/return-home-voluntarily/who-can-get-help and the form is here:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/552474/Assisted_return_application_form.pdf

The decision to engage the voluntary returns process is a complex issue, as this can impact on the individual's future ability to make additional asylum or immigration applications and the failure to agree to the process is an immigration factor that can increase the likelihood of immigration detention.

3. Access legal advice

This evidence contains a number of references to the difficulties of accessing legal advice in detention. This causes an additional difficulty as an ability to obtain such an appointment means the individual will not have the benefit of the opportunity for a legal advisor to consider their understanding of their legal position and to consider whether capacity to make legal decisions needs further investigation.

4. Whether to consent to fingerprinting in circumstances in which force can be used if consent is not given: DSO 15/2012 https://www.gov.uk/government/publications/mandatory-instructions-for-fingerprinting-detainees

5. The extent of sharing of confidential medical information: DSO01/2016:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524505/DSO_01-2016_Medical_Information_Sharing.pdf

GDWG's first concern is that immigration detention is an inappropriate environment for people with a mental illness. Additionally, the fact of immigration detention means that detainees will need to understand complex and sometimes technical information, and make decisions with long term consequences in a both an emotionally highly charged situation with restricted access to external support. These pressures are likely to exacerbate the difficulties of people who may lack capacity.

GDWG considers that the fact that the system of immigration detention is not operating to prevent the detention of mentally ill people or to ensure their early release means that there is a high likelihood that some individuals will be detained who may lack capacity for some key decisions. This assessment is supported by research, which identifies both that psychiatric patients are likely to lack capacity in relation to decisions concerning their care[10] and that there is a higher prevalence of lack of capacity in patients with psychosis, mania or dementia.[11]

The system of immigration detention does not include provision for an assessment of capacity, save in connection with medical decisions. DSO 01/2016 referenced above requires an assessment of capacity and other specific situations, such as food and fluid refusal also require a system of recorded assessments (see DSO 03/2017 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/654239/dso_3_2017_care_management_of_detainees_refusing_food_fluid_v1_0ext.pdf)

However, in the absence of specific policy triggers for an assessment of capacity or medical decisions where capacity is a key issue, the issue is unlikely to be considered. This is particularly true for circumstances concerning an absence of decision, such as a failure to apply for bail. Moreover, the fractured system of detention, with individuals rarely having direct contact with their Home Office caseworker, further increases the chances that any problems with understanding will not be recognised. Perhaps the most significant flaw arises from the systemic problems with healthcare

[10] Okai and others: Mental Capacity in Psychiatric Patients: Systematic Review *Br J Psychiatry 2007*

[11] Lepping and others: Systematic review on the prevalence of lack of capacity in medical psychiatric settings *Clinical Medicine 2015 Vol 15 No 4*

reporting concerns to the Home Office as this is likely to exacerbate the gaps in protections for people where there are concerns about capacity.

A detailed summary of the comparative safeguards available to those who may lack capacity and are not subject to immigration detention is outside the scope of this evidence. However, it is noteworthy that in other circumstances where individuals are denied their liberty and may not have capacity, clear systemic safeguards are in place. In brief, people held in hospital under the Mental Health Act have a right of access to the Mental Health Tribunal system, supported by publicly funded legal representation. In addition, other methods of assisting individuals who lack capacity involve the need for independent advocates (see for example decision-making under the Mental Capacity Act 2005, the Mental Health Act and the Deprivation of Liberty Standards used for people who may lack capacity and require detention within a hospital or care home in their best interests). In all such situations, there is a specific requirement for medical assessments of capacity of the individual.

Regrettably, immigration detention entirely lacks such safeguards. Arguably, people in immigration detention who may lack capacity are at greater disadvantage than UK citizens held in hospital and or care homes. The detainee population in IRCs is likely to face significant practical difficulties causing isolation such as language and cultural barriers, combined with additional factors such as the physical inaccessibility and prison-like settings of IRCs.

The lack of safeguards also raises additional concerns about the Home Office's policy approach to people who may lack capacity. Concepts such as decision-making with an independent element and with the best interests of the incapacitated individual at the crux of the decision underpin other administrative decisions for managing people who lack capacity. It is striking that these factors appear absent from Home Office policy.

<u>GDWG case studies of detainees lacking capacity when detained referred to solicitors</u>

The following case studies pre-date the time-frame of the sample of evidence for this report. We have decided to include them as both individuals were detained in 2017 and yet did not benefit from the changes in policy following the introduction of the Guidance on Adults at Risk. They are also included as evidence of the difficulties people who are profoundly mentally unwell have in accessing help whilst in immigration detention.

In the case of *R on the application of MDA v Secretary of State for the Home Department [2017] EWHA 2132,* the High Court has already determined that the Home Office was on notice of his vulnerability and so under a duty to investigate his capacity to at the time he was detained in October 2015. The Claimant was referred to GDWG by a firm of solicitors who had been made aware of concerns regarding his behaviour and been provided with a set of medical records indicating he lacked capacity. If the detainee seemed unwell and seemed to us to lack capacity, we agreed in principle to act as Litigation Friend for the purposes of the first steps of a judicial review in order to enable the instruction of the Official Solicitor. We made 4 attempts to see MDA at a drop in session in 2017 but the officers were unable to bring him to the meeting room as he refused to attend. At this time, other detainees and officers advised us that he seemed very unwell and he was urinating on the floor in his room and in communal areas.

Finally, an officer was able to persuade this individual to come to the visits corridor and a member of GDWG staff was able to greet him, albeit through a barred door. He responded by swearing at her. He did not make eye contact and his eyes were fixed on the ceiling. He appeared markedly unwell. On the basis of his presentation, our member of staff was able to agree to act as Litigation Friend pending the involvement of the Official Solicitor. He was transferred out of detention under the

Mental Health Act 9 weeks later. The legal judgment in his case which considered his treatment by the Home Office in detail identified no occasions in detention in which MDA's capacity was considered or that he was enabled to access external independent sources of help.

Another case study where the person was detained within the last 6 months concerns an individual with a mental illness, although the psychiatrist was initially unclear as to whether the correct diagnosis was schizophrenia or bipolar disorder. We received an informal referral within the IRC concerning this detainee, as he was displaying bizarre and agitated behaviour and his speech was paranoid in content and hard to follow. An initial appointment at the drop in session failed as he did not attend. Contact with 3 separate organisations in an effort to facilitate a meeting was unsuccessful, although all who had contact with him were highly concerned for his welfare.

The detainee was able to attend a drop-in session, following encouragement by a detention custody officer he knew well. However, he was only able to remain the room for a brief period until he became upset; he was agitated after being asked to sign a form of authority to allow GDWG to obtain his medical records, and he abruptly left the session. At the time he appeared highly paranoid, and stated he believed the officers were poisoning him. He had evidence of self harm cuts to his neck. On the basis of this very brief meeting, GDWG were able to refer him to a solicitor and to complete an application for public funding as his Litigation Friend to enable the investigation of legal proceedings concerning his detention. He was then moved to hospital under the Mental Health Act 19 days after the brief meeting with GDWG.

<u>Example of a detainee who appeared to lack capacity when we could not refer him to solicitors</u>

Within the last 6 months, we received an informal referral concerning a detainee who appeared to lack capacity. We made a number of unsuccessful attempts to see him. An independent medical charity agreed to examine him and concurred that capacity was likely to be an issue for both medical and immigration decisions. He was then transferred from the IRC and we were unable to locate him or have any further contact with him. We were unable to refer this individual to a solicitor.

GDWG consider that these three case studies show the precarious nature of referrals of very unwell detainees to us as an organisation, and also the arbitrary nature of whether we are able to even meet detainees, let alone help them access external sources of support or assessment. We are also well aware that people who lack capacity may not present with overt symptoms of illness, which further inhibits our ability to help or make referrals based on concerns about capacity.

Conclusions

GDWG's experience of working directly with detainees, together with our analysis of the evidence medical information and Home Office decision-making leads us to conclude that the introduction of the Adults at Risk Guidance has not operated to allow an appropriate focus on vulnerability for decisions concerning detention.

GDWG evidence is that the Guidance on Adults at Risk has not led to its stated aim of broader categories of vulnerability being considered and so limiting the detention of vulnerable people. Instead, whilst the policy has been drafted to refer to wider issues of vulnerability, it has failed to protect the welfare of detainees, as considerations of immigration factors can be used to justify the detention of overtly vulnerable people. The earlier Shaw Review highlighted the need for reform to allow for a broader definition of vulnerability, but it did not also require a re-drafting of policy to include additional factors to justify detention of the vulnerable.

Fundamentally, it seems illogical for policy to be drafted to place people who are recognised as likely to be at particular risk when detained, (such as people with a mental illness), within a complex system when they are then required to obtain specific clinical evidence that their individual detention is likely to be harmful to them. This places a high burden on IRC healthcare departments already caring for a detained population with complex needs. Moreover, our evidence is that the systems within detention to assess and report vulnerability via healthcare are ineffective. This situation then undermines the Home Office ability to be compliant with their own policy.

Detention policy reform

GDWG's experience of working directly with detainees is that detention is ineffective and the impact of incarceration is often inhumane. Our approach is that no vulnerable person should lose their liberty for immigration purposes. However, we recognise that the legal position is that detention for immigration purposes can be permissible, subject to limitations and safeguards. In order to assist with this Review, this section provides our suggestions for further policy amendments to develop effective procedures for ensuring vulnerability is better identified and plays a key role in decisions concerning detention.

We are aware that prior to 26 August 2010 the Home Office's approach to decisions to detain various categories of vulnerable people, including those suffering from a mental illness, was that they would be considered suitable for detention only in 'very exceptional circumstances.' This seems a simpler approach, as it took account of the coherent body of evidence that immigration detention has a negative impact upon mental health. The policy position was also predicated on the assumption that detention of such an individual should be rare and once the individual was identified within a category of vulnerability this placed the burden on the Home Office decision-maker to justify detention. This appears a more straightforward policy approach, rather than requiring a vulnerable individual to obtain medical evidence of the likely harm that would be caused by detention; in circumstances where their vulnerability, isolation and lack of resources mean they cannot easily make up for any systemic failings.

GDWG considers that such a 'category-based' approach to detention should not preclude the Home Office from also allowing caseworkers to have a discretion to recognise additional reasons for vulnerability and so factoring this into considerations of whether detention is appropriate. This would enable the wider approach to vulnerability espoused in the first Shaw report without the current loss of protection presently in place as a result of the Adults at Risk Guidance.

We recommend an amended detention policy is drafted to:

(a) Ensure that vulnerable people are promptly identified by the Home Office with a focus on recognising likely issues of vulnerability prior to any decision to consider whether to detain.

(b) Where there is clear research-based evidence that a category of person is likely to be vulnerable (such as those with a history of trauma or mental illness)[12], there should be a very strong presumption against detention, without the individual needing an individual assessment that detention had harmed them or was likely to cause harm.

(c) As well as providing a category-based approach to vulnerability to allow for simpler decision-making, there should also be the opportunity for caseworkers to take a wider look at issues of vulnerability which would militate against detention.

(d) Require all community-based alternatives to detention are explored, with existing and successful schemes expanded. We would particularly highlight and endorse the points raised by Detention Action relating to alternatives, in both their submission to your present review and in their report *Without Detention*.

(e) Require the detention assessment is strongly weighted against detention for vulnerable people save for managing exceptional circumstances.

(f) Once an individual was held in detention; require a regular medical assessment with a transparent process of information sharing and clear and resourced pathways out of detention for those assessed as vulnerable.

(g) If policy included an approach of identifying some aspects of vulnerability on a category basis, ensure that the type of medical assessments required to operate the policy are straightforward and appropriate to the General Practitioner background of doctors attending IRCs. One method would be for doctors managing people with mental illness, learning disability or serious physical illness to give their clinical opinion concerning a diagnosis relevant to categories of vulnerability, as this would be sufficient for the individual to gain the protection of the policy. This would avoid the doctor being required to make complex assessments concerning unclear future events such as the impact of the length and circumstances of further detention.

The need for wider detention reform

GDWG's assessment is that the current complexity and opacity of medical assessments, information exchange and decision-making within immigration detention means that radical reform is needed. The difficulties of the Home Office detaining overtly vulnerable people are longstanding. The current policy is not operating to prevent long term detention of vulnerable people. A straightforward solution to mitigate the current situation would be a clear and short time limit to detention.

We also support the approach of judicial scrutiny of detention decisions; supported by sufficient resources to enable detainees to engage with such a process. This would mitigate the perennial difficulties of vulnerable detainees being held for long periods with no simple or easily accessible mechanism for an independent review of the Home Office decisions. This could also allow for

[12] GDWG would also invite consideration of additional categories of vulnerability to include those such as the young arrivers subject deportation proceedings referenced above.

detainees with issues concerning their capacity to be identified and for gaps in medical assessments or other relevant information concerning vulnerable people to be recognised.

Our final recommendation would be for a regular opportunity for a systemic review of the Home Office's use of immigration detention. The first Shaw Review identified a lack of research, strategy and planning for the immigration detention estate. These difficulties cannot be addressed by the present system of scrutiny based on individual and localised assessments of detention centres. Given the longstanding problems concerning the Home Office's exercise of the power to detain migrants, the opportunity for a regular and thematic approach to gathering evidence is essential.

In order to inform any further systemic reviews, it would be sensible to ensure a system of publication of information concerning both the Home Office's and IRC's healthcare's decision-making relevant to the operation of detention policy, and to consider effective methods of scrutiny of both elements of the detention process.