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Gatwick IRCs

Food & Fluid Policy

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CONTACT POINT: Head of Safeguarding

RESPONSIBLE MANAGER: Centre Director

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CONTENTS

This document draws to gather and provides information on the current guidelines on food refusal and offers practical assistance for those dealing with detainees who may be refusing food and/or fluids whilst detained at Gatwick IRC'S.

Is the refusal of food/fluids a form of self-harm?

The department of health NICE Guidelines of self harm define, self-harm as intentional self-injury or self poisoning, irrespective of the apparent purpose of the act.

The refusal of food/fluids is certainly highly self –injurious, especially for those who refused food for long periods or who refuse fluids. It can result in extreme weakening of the body, difficulties in mobility, vision impairment and brain damage.

However the DSO guidance and procedures for dealing with food refusal (including reporting procedures) differ from those dealing with self harm. This is because the motivations of those who refuse food are (often) different from the motivations of detainees who self harm using methods such as cutting, and also because the legal framework with food refusal has some unique features.

Why do detainees refuse food/fluids?

Most commonly people in detention who refuse food/fluids do so as a means of protest: for example, a political protest associated with a belief or regarding detention matters such as removal directions or transfer. They may also use food refusal as a bargaining tool: i.e. using food refusal to try and negotiate a release from detention or a change in conditions.

In such cases, death is not the objective, as there is hope that the demands will be met. In these situations, the action, even when it results in death, it is not considered to be suicide under English Common Law.

Occasionally in very severe mental illness, such as depression, or severe physical illness, food refusal occurs. The onset of food refusal in these cases is insidious and part of a general decline in physical and mental well-being. Food refusal can also be associated with other mental health disorders – such as schizophrenia (the person may think that someone is poisoning their food) or anorexia nervosa (the person has an unrealistic view of their body)

How will I know if a Detainee is not eating and / or drinking?

Detainees protesting via food refusal will often let staff know that they are refusing food/fluids. But detainees with more complex grounds for refusing food may be harder to identify: they may stay in their rooms more, and may not participate in activities or general association: those with delusions of persecution may conceal their food refusal.

Wing officers are required to monitor detainees taking the lunch and evening meal, and record the names of all detainees who have refused or declined those meals.

What should I do when I discover a detainee is refusing to eat and/or drink?

Ask the individual why they are refusing food. It is important to find out how long the detainee has been refusing food or liquids for: whether the detainee is refusing all food, some food or food and liquids. Someone else may know some of the reasons for the individual refusing food.

Food refusal should all always be taken seriously. Even if the detainee appears to be using food refusal as a means of gaining something, it is still a desperate act and the detainee should be helped to find a constructive way/ways to meet the underlying issue. Detainees using food refusal

as a means of protest may be prepared to eat and drink once they have access to an alternative means of pursing a grievance.

- An individual who fears deportation/ removal from the country may need assistance in contacting the relevant agencies and legal advice. They may also value support from some one from their own faith or ethnic community.
- Request or complaints procedure
- Independent Monitoring Board
- Contacting a solicitor or a Member of Parliament.

Officers should involve healthcare. Someone refusing food and/or liquids needs a physical examination and also assessment for mental health problems and suicidal intent. People who are so depressed or mentally disturbed that they are eating little should be seen by healthcare staff as a matter of urgency.
A psychiatric assessment will show whether the detainee retains the capacity to make decisions about how they eat. Healthcare staff may wish to involve their local PCT to obtain the assessment.

Detainees protesting via food refusal may do so repeatedly: This serves as an important reminder that staff should not become complacent regarding a detainee who repeatedly refuses food. Growing accustomed to detainees eating habits may lead staff to underestimate the seriousness of the detainees deteriorating condition.

Most food refusers do not stop eating completely. Some people often those who are depressed, will take a little food that they like. Encourage drinking fluids, for example sugared water, or those containing vitamins, such as fruit juice, milkshakes and nutritional supplement drinks (which will be supplied by healthcare) .it may also be helpful to encourage the detainee to arrange visits from friends and family. Some detainees may eat during visits or consume food from their own resources, such as the shop or cultural kitchen. But refuse to take food from the servery. Detainees who have delusional ideas that the food is poisoned may eat packaged food that they open themselves.

Nearly all food refusers start eating again on their own. It is important not to put the detainee in a position whereby eating again would be involve a loss of face. Pressure to finish what is in front of them is unlikely to help. It can be dangerous for individuals who have refused food for long periods to suddenly start eating normal food again. Advice from healthcare must be sought on how to return the individual to normal eating patterns.

How should food refusal be recorded?

During both the lunch and dinner time servery officers will perform a physical role check and account for all detainees in the centre. Attention should be paid to those who have not attended the servery for their meals; Officers should then locate and ask the detainee the reason why they are not eating. The detainees name, the meal they are refusing and the stated reason should then be recorded on the missed meals log. Those missing meals should be reported to the wing Detainee Custody Manager

How should food refusal be reported?

DCO - Responsibilities
DCOs are required to monitor detainees taking breakfast, lunch and evening meal, and record the names of all detainees who have refused or declined those meals in the wing diary (Brook House) Food/Fluid Refusal Book (Tinsley). It is important to establish and record the reason why the detainee is refusing food. The detainees shop account must be checked and an update added to the DAT system and the detainee's history sheet.

Night Oscar - Responsibilities

If there is no evidence to suggest that the detainee is eating or drinking from another source the Night Oscar must complete the food/fluid refusal form (Annexe A) and email to the following:
Healthcare
Duty Directors
Head of Care and Residence
Safer Community Coordinators
Deputy Director

If the detainee continues to refuse food for more than three days an ACDT plan must be opened. If the detainee is refusing fluid an ACDT must be opened immediately.

The role of Healthcare
Healthcare will meet with the detainee as soon as practicable and establish the following using the attached questionnaire (Annexe B):
When the detainee last ate and the amount
When the detainee last drank and the amount
The detainee's base line observations

The results of the consultation will be passed on to the following immediately (Using Annexe C):
Oscar1
Duty Directors
UKBA Managers

It is the responsibility of Healthcare to complete the process outlined above using the questionnaire for every 24 hour period. Healthcare staff are also responsible for continued monitoring on a daily basis and for escalating any change in condition

Oscar 1 - Responsibilities
It is the responsibility of Oscar 1 to complete the daily handover as per the example below using the information supplied by Healthcare.

Fluid/Food Refusals being monitored

ACDT to be opened after 72 hours of food refusal, immediately for fluid refusals - 48 hour fluid refusal requires Healthcare bed as per the DSO

Name	Room	Food/Fluid	Remarks	Last	Last
John Smith	C-013	Food & Fluid Refusal	**Healthcare comments**: *Detainee claims to have stopped eating on the 15th November. Lost weight during refusal period. Presents as dehydrated. John stated he is not eating until he is released. Healthcare bed to be requested for 20/11/12* **Staff Comments:** *Not eating from shop, no evidence of friends supplying food. ACDT opened 1200hrs 15/11/12, offers of food and drink documented in ACDT at every conversation.*	15/11/12 12:15hrs	18/11/12 1800hrs

The daily handover must contain the following information:

Date and time of when the detainee has last eaten (Information provided from healthcare)

Date and time when the detainee last took fluids (Information provided by healthcare)

Any soft information i.e., detainee is eating from the shop; being fed by friends etc will be recorded within the remarks.

Statement on ACDT progress.

Confirmation on request for Healthcare bed if required. DSO 7/2004 states *'Food/fluid refusers requiring nursing care should be managed in one of the centres with 24-hour nursing. Centres without such facilities are advised to seek the transfer of fluid refusers at 48 hours and food refusers at 14 days'.*

The detainee must normally remain on normal location, unless advised by healthcare and or the Duty Director. It is also the responsibility of Oscar 1 to copy the daily handover to the Healthcare department on a daily basis.

Where a detainee has continued to refuse food an ACDT should be opened of the forth day, should the detainee refuse fluids this will need to implemented as soon as practicable and on advice from healthcare. This is due to the potential risk of suicide or self harm. This is true even where it is clear that the detainee refusing food is doing so in order to: for example, bring about some change in their circumstances.

The ACDT process:

- Will allow staff to put in to place a regularly reviewed and monitored care plan, which may
  - Target the delivery of improvements of the well being of the detainee,
  - Address the needs behind the action and
  - Ensures that appropriate social support is being given to the detainee.
- Will help communication between the duty director, UKBA and the healthcare staff.
- Closer supervision may also prevent the detainee turning to alternative means if self harm.
- Will enable the detainee's motivation to be monitored over time, as this may change.

The detainee should be involved with all stages of the ACDT process.

What ever the detainees motivation, if the food refusal lasts more than a short time, it will be essential that the person is managed using a multi – disciplinary care plan of some sort, so that all people involved in their care are aware of what to do and ensure that regular reviews take place.

It may be decided that a detainee refusing food/ fluids should be admitted to E Wing unit so that their state of health can be monitored and medical management regularly reviewed. This will be on the authority of the Duty Director in conjunction with advice from healthcare.

Food/fluid refusers requiring nursing care should be managed at one of the other centers with 24hr inpatient health care. Consideration to transfer by UKBA should be made be made of fluid refusers at 48 hours and food refusers at 14 days. UKBA staff should follow advice given by their healthcare advisors. Full details of the food/fluid refusal should be submitted on the IS91 Part C so that the most appropriate accommodation can be arranged.

Healthcare staff involved in the care and management of the detainee due to his refusal of food/fluids should be involved in the care planning and reviews of the care plan process. This will allow for a better continuity of care between healthcare and officers. Although healthcare will be documenting the detainees care in their own records, they should also document the detainees care within the ACDT plan.

It is not necessary to record details of the detainee's treatment or mundane activities, in the ACDT plan. But any information pertaining to risk of suicide or self harm including mood changes, key circumstances or events in the detainees' personal life and relation to progress in their immigration case or significant changes in routine (withdrawal from activities, cessation of visits) should be included. Medical in confidence should always be considered however consideration to the following will be given.

DSO 16/2012 Handling information about detainees in immigration detention facilities.

The following statement is designed to promote greater sharing of information whilst at the same time ensuring compliance with the relevant law.

"The failure to share relevant information appropriately within the criminal justice system can lead to deaths or serious injuries. This in turn can lead to legal liability and/or serious reputational damage. There is a duty to consider information sharing where it is relevant to the identification of a risk of self harm/suicide, violence to others or an individual's healthcare needs. It is therefore important for staff within the criminal justice system to contact their line managers and/or legal teams if they are unsure whether information should be shared, rather than simply withholding it. Line managers or lawyers will be able to provide advice on whether information can be shared. The Data Protection Act 1998 does not prohibit the sharing of information, but requires it to be fair and lawful.

Can a Detainee refusing food/fluids be force-fed?

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation or providing personal care for a patient. This respect for people's rights to determine what happens to their won bodies is a fundamental part of good practice. It is also a legal requirement. The fact that a patient is also a detainee does not affect their right to determine whether or not to accept treatment.

Healthcare professionals cannot legally examine or treat of Detainee who has not specifically agreed to the examination or treatment. Consent is required on every occasion an examination or treatment is offered, except in some emergencies, or where the law prescribes otherwise. People who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point. Consent can be verbal, written or implied by acquiescence. Acquiescence when a patient does not know what the intervention entails, or that there is an option of declining, is not valid consent.

Not everyone may be able to provide valid consent. Conditions that may interfere with the giving of valid consent include intellectual disability, organic brain dysfunction, and the effect of drugs, the level of consciousness, mental illness and tiredness. Therefore, before consent is sought, the person must be judged to be capable of giving it. This is known as "capacity" or "competence" to consent to treatment.

Decisions relating to a detainees capacity to give or withhold consent to treatment and determining what is in an incompetent detainees best interests are a matter for the responsible treating doctor in consultation with other members of the healthcare team who are on duty at the time. All decisions relating to consent and actions taken and must be fully documented in the detainees ACDT plan.

Advance directives (Annexe D)

a detainee who is currently competent may wish to make a *"living will"* or *"advance directive"* specifying how they would like to be treated in the case of future incapacity. Where a detainee refusing food/fluids wishes to make such an advance directive, they may want their own legal adviser to draw it up. This is acceptable. Alternatively, a model version is attached to this Order.

Detainees are unlikely to be aware of the ability to make an advance directive. As soon as a detainee begins to refuse food and fluids, and after a detainee has refused food for five days, he should be made aware of this facility. It is preferable that both the health professional and the IS manager (either the contract monitor or the CIO) are present when the ability to make an advance directive is being explained to the detainee. The purpose of an advance directive should be spelt out to the detainee, as well as the fact that once an advance directive is made, whether written or oral, the detainee has the right to reverse this decision at any time during which they retain competence.

Case law requires that previously expressed wishes regarding medical treatment made by a detainee who is not, at the time of the treatment, in a state to express his wishes, shall be taken into account. An advance refusal of this kind is only valid if made voluntarily, by an appropriately informed person, with full capacity. Failure to respect such an advance directive may result in legal action against the practitioner.

Ideally the directive should be made in writing, signed by the detainee and the health professional determining capacity. However, it should be noted that it is not legally necessary for the refusal to be made in writing or formally witnessed. An oral directive must be followed if sufficient evidence of it, its terms and validity exist. As in the case of a written directive, a suitably qualified health professional will need to assess whether or not a person is competent to give an oral directive. A record of an oral directive should be made and formally signed by the health

professional determining capacity.

Other forms of care, provided they are consistent with the terms of the directive, should continue to be provided. Basic or essential care includes keeping the detainee warm, clean, and free from distressing symptoms such as breathlessness, vomiting, and severe pain. However, some detainees may prefer to tolerate some discomfort if that means they remain more alert and able to respond to family and friends.

UKBA are under no duty to administer treatment to a food/fluid refuser who has made a valid advance directive and a court declaration is not needed to establish this.

Role of the health professionals

Where a competent detainee refusing food and/or fluids is also refusing medical treatment at a time when a doctor judges it is becoming necessary, whether or not an advance refusal of treatment has been made, the doctor must explain the consequences of these refusals to the detainee, in the presence of another healthcare professional. These explanations must include the following information
That the deterioration in their health will be allowed to continue without medical intervention unless they request it;

That continuing food/fluid refusal will lead to death. This must include a description of the process of dying in terms of pain, what can be offered to ameliorate those symptoms and the physical effects of refusal of nutrition;

That prolonged food and fluid refusal which does not result in death may lead to permanent disability and organ damage.

It is important that this information is provided in a form that the detainee can understand. This may involve using an interpreter and every effort should be made to obtain the services of an interpreter as soon as possible. Should the detainee wish to use a fellow detainee or member of his/her family to interpret the doctor's explanation then this would be acceptable.

The doctor must:

Write a full record of what has been said to the detainee, and the doctor, the second healthcare professional and the interpreter, if used, must sign to say that they were present when this advice was given. The doctor may wish to repeat this procedure from time to time;

Consider the appropriateness of transferring the detainee to the healthcare centre that can provide inpatient healthcare

Inform the IS Manager (the contract monitor or CIO) that this stage has been reached and request that the detainee is transferred to a IRC that can provide inpatient healthcare

Detainees lacking capacity;

Where a detainee is refusing food, is judged to lack capacity, and has not made an advance directive, healthcare must consider administering whatever treatment is in the detainee's best interests. It would be appropriate in these circumstances to try to arrange for the patient to be transferred to another centre with inpatient healthcare or NHS hospital both for treatment and further observation and assessment. If the detainee has a serious mental health problem, there would also be the option of transferring them for treatment under the mental heath Act 1983.

Detainee with capacity treated under the Mental Health Act:

A detainee suffering from severe mental illness may be transferred to a psychiatric hospital for treatment (including administration of artificial nutrition and hydration) Under the Mental Health Act even though the detainee may retain the capacity to consent or refuse treatment. However, such compulsory treatment of competent patients (or those who have lost competence, but made advance directives whilst competent) can only take place in a hospital setting under the terms of the Mental Health Act.

What happens when a detainee continues to refuse food despite their deteriorating condition?

It is important to act early. This will avoid having to discuss what might happen when the patient may have lost the capacity to determine his own future.

Informed decision making by the detainee is crucial. From the outset, the doctor must therefore outline the risks and consequences of refusing food and /or fluids over time.

If the detainee continues to refuse food, other forms of care (provided that they are consistent with the terms of the advanced directive) should none the less continue to be provided. Basic and essential care includes keeping the p[patient warm, clean, free from distressing symptoms such as breathlessness, vomiting and severe pain. How ever some patients may prefer to tolerate some discomfort if that means they remain more alert and able to respond to family and friends.

It may be appropriate to move the detainee to a hospital or another detention centre that is more equipped to deal with such a patient.

Role of the IS manager

A detainee who is refusing food and/or fluids may be using this as a way of pursuing a grievance.

It will be for the IS contract monitor or CIO (the IS manager) to establish whether there is a grievance and what this may be. The IS manager must ensure that the detainee will be supported in pursuing a grievance through all legitimate channels (eg the Immigration Service, legal representatives, the centre manager or the Visiting Committee). Detainees using food/fluid refusal as a means of protest may be prepared to eat and drink once they have access to an alternative means of pursuing a grievance. The IS manager will wish to check every couple of days that the detainee's grievance/concern is being pursued.

The IS manager must explain to the detainee, in the presence of a second IS officer, that continued food and fluid refusal:

- will not lead to the progress of the detainee's immigration or asylum case being halted or delayed;
- will not lead to removal directions being deferred;
- will not lead to permission to stay in the UK;
- will not lead to release from detention in order to prevent death.

The IS manager must write a full record of what has been said to the detainee, and both the manager and the second IS officer must sign to say that they were both present when this advice was given. The IS manager may wish to repeat this procedure from time to time.

It is important that this information is provided in a form that the detainee can understand. This may involve using an interpreter and every effort should be made to obtain the services of an interpreter as soon as possible. Should the detainee wish to use a fellow detainee or member of his/her family to interpret the IS manager's explanation then this would be acceptable.

Annex A

Food and Fluid Refusal Referral form		
Date:	Completed by:	
Detainees Name	**CID Ref**	**Room Number**

As per the instructions in Notice to Staff 27/2012 The Night Oscar must complete food/fluid referral form and email to:

- Healthcare (Sandra Calver, Jay Dix, Michael Wells).
- Duty Directors (Michelle Brown, Mark Demian, Dan Haughton, James Begg, Steve Laughton, Sarah Newland, Scott Hamilton).
- Conway Edwards, Lucas Fallbrown.
- Sara Edwards.
- Deputy Director (Steve Skitt).

Annex B

Food/fluid Refusal

Name _____

Wing _____ Room _____ _____

Date of birth _____

Date/ time last ate _____

What did they eat _____

Date/time last drank _____

What did they eat drink _____

Present weight _____

Weight change from day 1 of Food refusal

_____

Urinalysis _____

BP _____ BM _____ _____

Reason for refusal _____

_____

Seen by _____

Date _____

Copy for medical records

Annex C

Food/fluid Refusal

Name _____

Wing _____ Room _____

Date of birth _____

Date/ time last ate _____

What did they eat _____

Date/time last drank _____

Weight change from day 1 of refusal _____

_____

Reason for refusal _____

_____

Seen by _____

Date _____

Copy for Oscar1, Duty Director, Home Office

Annex D

HOME OFFICE IMMIGRATION DETENTION: ADVANCE DIRECTIVE

PORT REF.	
DC REF.	
HO REF.	

I, [*name*] currently detained at [ ] Immigration Removal Centre, wish to state the following:

1.[I do not intend to eat]*.

2. [I do not intend to drink or otherwise receive fluids]*.

3. I do not wish to receive any treatment.

4. I do not consent to the administration of nutrition or hydration or any form of medical treatment whether resuscitation or otherwise designed to keep me alive, in the event that there is a deterioration in my condition

- [unless there is a loss in consciousness]* [and/or in the event of a loss of consciousness]*
- [unless I sustain any injury to my person howsoever caused] *[and/or in the event that I sustain any injury to my person howsoever caused]*.

5. I do/do not* consent to any medical or nursing care designed to keep me comfortable and free from pain in the event of serious deterioration in my condition [*If there is consent to some care, give details of any particular care that is offered and accepted by the detainee*].

6. It has been explained to me that if I refuse treatment in this manner, that my medical condition could deteriorate, that I could be in a great deal of pain, that I could lose consciousness and that I could die as a result of the refusal to consent to treatment.

7. I have read and had the contents of this directive read over to me [in [*language*], a language I understand] and I fully understand its contents and its effects.

8. I have been advised to take legal advice from an independent legal adviser on the contents and effect of this Directive. I have carefully reflected on the terms of this Directive, and have been advised to discuss its terms with my next of kin before signing it.

9. I am aware that I can change my mind and revoke this Directive at any time if I remain capable of making decisions about my medical treatment.

Signed ……

Date of Birth ……

Witness A	**Witness B**
Name: **Signature:** **Address:**	**Name:** **Signature:** **Address:**

Ideally one of the two witnesses should be the healthcare professional determining capacity

- *Delete as appropriate*