# Expecting Change:

## The case for ending the detention of pregnant women

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Medical Justice
seeking basic rights for detainees

## Medical Justice

Medical Justice assisted all the women who participated in this research. We are the only organisation in the UK which is able to conduct research on the cases of immigration detainees that it has been directly involved with.

Medical Justice is a small charity that exposes and challenges inadequate healthcare provision to immigration detainees. We deal with approximately 1,000 individual detainee cases a year. Most of the work is carried out by volunteers, co-ordinated by four full time equivalent paid workers. We are the only organisation that focuses on arranging for independent clinicians to visit men, women and children detained, writing medico-legal reports (MLRs) documenting scars of torture and serious medical conditions. We help detainees to access competent lawyers who properly harness the strength of the medical evidence we generate.

Medical evidence from our casework feeds into our research and media work. We discuss policy changes with the Home Office to help secure lasting change. Where this fails, we may undertake strategic litigation.

**If you would like to make a donation, our bank details are: CAF Account. Sort Code: 40-52-40. Account number: 00021167.**

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# Executive Summary

This report presents an analysis of the immigration detention of pregnant women. The results show that the current policy of detaining pregnant women is ineffective, unworkable and damaging.

The Home Office does not know how many pregnant women are detained. Without knowing or recording how many are detained, it is difficult to see how the Home Office is able to implement its own policy of detaining pregnant women in only very exceptional circumstances.

The primary purpose of detention is removal, yet this research and a previous Medical Justice audit show that only around 5% of pregnant women were successfully removed. This is because in the majority of cases, there is no medically safe way to return them.

Following the case of *Chen* earlier this year, the Home Office is now unable to use force on pregnant women, save to prevent harm to the woman herself. Given that the use of force, which the Home Office had deemed essential, is now unlawful, pregnant women should no longer be detained as there is now an even smaller prospect of removal.

Experts agree that travel to malarious areas should be avoided because pregnant women have an increased risk of developing severe malaria and a higher risk of fatality compared to non-pregnant women. Home Office policy outlines that women should be offered malaria prophylaxis prior to their removal. In all the cases where anti-malarials were offered, Yarl's Wood healthcare team failed to follow the relevant medical guidance.

The data results show that the healthcare pregnant women receive is inadequate. There is evidence that the level of care falls short of NHS equivalence and the National Institute for Health and Care Excellence (NICE) standards. Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy.

Asylum seeking women have poorer maternity outcomes than the general population. Many women in the sample were victims of rape, torture and trafficking. However, there appeared to be no appreciation by Yarl's Wood healthcare staff that even without complications, this is a group of vulnerable women who need to be managed as complex cases.

People can be held in immigration detention indefinitely and the decision to detain is not subject to automatic judicial oversight. Self-harm, hunger strikes and reports of assault and racism are common. In four separate cases in the past two years, the High Court has ruled that the care of four detainees amounted to inhuman and degrading treatment. Detention is no place for a pregnant woman.

According to the Independent Monitoring Board, 93 pregnant women were held in Yarl's Wood in 2011. With limited prospects of removal, it is our recommendation that the government should stop detaining them. Detention is not serving any purpose: the costs are great and the damage to women's health can be dramatic. This recommendation is in line with Asylum Aid's Charter of Rights of Women Seeking Asylum that is supported by 337 organisations, including the Royal College of Midwives.

## Case Examples:

This report contains case examples showing some of the adverse outcomes suffered by the women in the sample.

- Maria was restrained and forcibly removed to her home country by four escorts. A few months after her return, she suffered a stillbirth.
- Aliya developed acute psychosis after she was prescribed anti-malarial medication in anticipation of her forced removal.
- Anna who had complained for three weeks about abdominal pains was sent to A & E where she miscarried with two guards in attendance. She subsequently attempted suicide and was admitted into a psychiatric ward.

# Forewords

## The Royal College of Midwives:

The Royal College of Midwives (RCM) welcomes this ground-breaking report. It demonstrates how detaining pregnant asylum seekers is ineffective, harmful and a cruel and unusual punishment for women fleeing persecution. As the organisation with the authority to speak on behalf of midwives and issues of care for *all* pregnant women, the RCM supports the report's recommendation that pregnant women should not be held in immigration detention. The conditions in these centres are not conducive for these women, who often require complex care and have other underlying medical conditions.

Many of these women are vulnerable, may have suffered traumatic experiences, been victims of sexual violence or human trafficking. Thus, they may have significant and complex health and psychological problems, and may be in need of urgent and continuous care from a midwife that they know and trust. There is incontrovertible evidence that pregnant asylum seekers have poor pregnancy and neonatal outcomes and complicated pregnancies with increased morbidity and mortality; they also have multiple health needs and have a higher prevalence of mental health issues. They are generally in poorer health and do not access antenatal care early, if at all, requiring more intensive and expensive treatment at a later stage, increasing the financial implications on the NHS.

This is a system that many will find to be an archaic and abhorrent treatment of those fleeing persecution. Yet, pregnant asylum seekers are still detained for immigration purposes without uncontested evidence that such a policy works and at a time when these women are most unlikely to abscond.

We are particularly concerned that this report addresses that the significant risk factors of these women are often not identified or adequately managed. The detention of pregnant asylum seekers increases the likelihood of stress, which can risk the health of the unborn baby. The very process of being detained interrupts a woman's fundamental human right to access maternity care. It is for these reasons that the RCM strongly believes that the detention of pregnant asylum seekers should cease and we support the report's recommendations.

Midwives can only work in the context of what they are allowed to do by their managers. The detention system makes it very difficult for midwives to put women at the centre of their care. It is important for all pregnant women to have free access to care and we have concerns that the system in place actively inhibits the provision of good care. This is an untenable situation for midwives.

We believe that the treatment of pregnant asylum seekers in detention is governed by outmoded and outdated practices that shame us all. Midwives must care for and serve ***all*** mothers and babies regardless of their immigration status. We, therefore, encourage and urge the Home Office to act on the report's recommendations without delay.

**Louise Silverton, director for midwifery, The Royal College of Midwives**

*The RCM is the professional organisation and trade union that represents the vast majority of practicing midwives in the UK. It is the only such organisation run by midwives, for midwives.*

"We believe that the treatment of pregnant asylum seekers in detention is governed by outmoded and outdated practices that shame us all."

## The Royal College of Obstetricians and Gynaecologists:

We are all aware of the high maternal mortality and morbidity rates in under-resourced countries and the UK is often upheld as the shining example of how change through activities like better access to care and maternal audit lead to good outcomes.

It is therefore shocking that in this present day and age, some women continue to have poor healthcare in the UK. This new report reveals to us the very real but not insignificant difficulties that a small number of women are put through whilst seeking a new life here. Until now, their voices were silent and we applaud Medical Justice for speaking out on behalf of them.

In the UK, pregnant immigrants are detained and have their freedoms curtailed until their status is clarified. On the surface, this seems like a sensible policy but many of these women are vulnerable, having escaped brutal conflict, violence or enslavement, only to have their movements restricted when they arrive in the UK. Detention centres are not the sanctuary they had hoped for – the conditions are basic but more importantly, the stress and strain felt by them mean they continue to suffer indignity as they are subject to substandard, at times, uncaring treatment. And there are long term impacts on their babies' future health that must be considered.

It is unacceptable that pregnant asylum seekers and refugees are being incarcerated. We support Medical Justice's humane recommendations and urge the Home Office to agree to these proposals. NICE should update its clinical guideline *Pregnancy and complex social factors* to reflect these recommendations.

**Dr Tony Falconer, President of the Royal College of Obstetricians and Gynaecologists (RCOG)**

## Ex-Detainee:

I don't want to remember those horrible moments of my life which I spent in detention, when I cried for food and cried due to pain. I was in a detention centre for seven months. I had severe morning sickness which lasted five months. I couldn't eat the food which was provided for detainees. I remained there living just on fruit, juices, biscuits, crisps and popcorn for five months. I got weaker day by day.

I lost 6kg of my actual weight – it should increase in pregnancy. The doctors and nurses there shouted at me many times. They mentally tortured me by saying that I was on hunger strike. I was never on hunger strike: I love my baby so why would I go on hunger strike? I requested and begged the officers many times to allow me to go to eat something in the cultural kitchen because I always felt hungry – but they refused.

The health care staff were very rude, uncooperative and untrained. Every time when I went to health care for a problem, they didn't care and told me to go and take paracetamol – even though I told them that I can't take paracetamol because it made me vomit. I suffered a lot in terms of physical, emotional and mental health. Health care never give importance to pregnant ladies. They treated us like things, as though we are not human beings.

I was very weak and I stayed in my room all the time. I got mentally sick. People stopped coming to see me and I got more and more lonely and mentally unwell.

I face risks to my life in my country. That is why I cannot go back to my country. And this is the reason why I suffered this awful situation and faced hardship for seven months as a detainee.

UKBA put me and my unborn baby's life at risk as well. I was not criminal: I never breached the law in the UK. I just claimed asylum and asked for refuge. But UKBA put me there and kept me in a detention centre for seven months as a pregnant woman, for no reason. A pregnant woman needs more care, good food, a healthy environment and freedom because she has to nourish a baby. Detention affects the unborn baby mentally and physically as well. They kept me in detention centre a long time and due to this, I got weaker internally and now I don't have energy or courage.

My question to UKBA is that if anything happens to my baby physically and mentally, then who will be responsible for that? Is claiming asylum and asking for shelter in this country a crime?

**A pregnant woman who was detained at Yarl's Wood**

## Acronyms

| | |
|---|---|
| **ACDT** | Assessment Care in Detention and Teamwork |
| **ACMP** | Advisory Committee on Malaria Prevention |
| **AIT** | Asylum and Immigration Tribunal |
| **ARV** | Anti retroviral |
| **AVR** | Assisted Voluntary Return |
| **BHIVA** | British HIV Association |
| **BNF** | British National Formulary |
| **CBT** | Cognitive Behavioural Therapy |
| **CSIP** | Care Services Improvement Partnership |
| **DCR** | Detention Centre Rules |
| **DFT** | Detained Fast Track |
| **DH** | Department of Health |
| **DOM** | Duty Office Manager |
| **DSO** | Detention Service Orders |
| **EDM** | Early Day Motion |
| **EIG** | Enforcement Guidance and Instructions |
| **ETD** | Emergency Travel Document |
| **FNP** | Foreign National Prisoner |
| **FOI** | Freedom of Information |
| **FTT** | Freedom from Torture |
| **G4S** | Group 4 Securicor |
| **GP** | General Practitioner |
| **GUM** | Genitourinary Medicine Clinic |
| **HAC** | Home Affairs Committee |
| **HCMIP** | Her Majesty's Chief Inspectorate of Prisons |
| **HIV** | Human Immunodeficiency Virus |
| **HMIP** | Her Majesty's Inspectorate of Prisons |
| **HMP** | Her Majesty's Prison |
| **HoL** | House of Lords |
| **HPA** | Health Protection Agency |
| **IATA** | International Air Transport Association |
| **IDI** | Immigration Directorates' Instruction |

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| **IMB** | Immigration Monitoring Board |
| **IND** | Immigration and Nationality Directorate |
| **IPCC** | Independent Police Complaints Commission |
| **IRC** | Immigration Removal Centre |
| **MBU** | Mother and Baby Unit |
| **MLR** | Medicolegal report |
| **NASS** | National Asylum Support Service |
| **NaTHNaC** | National Travel Health Network and Centre |
| **NICE** | National Institute of Health and Care Excellence |
| **NGO** | Non Governmental Organisation |
| **NHS** | National Health Service |
| **PCT** | Primary Care Trust |
| **PLN** | Pregnancy Notification Form |
| **PPO** | Prison and Probations Ombudsman |
| **PSO** | Prison Service Order |
| **PTSD** | Post traumatic stress disorder |
| **PV** | Per vagina |
| **RCM** | Royal College of Midwives |
| **RMN** | Registered Mental Health Nurse |
| **SAR** | Subject access request |
| **SIP** | Service Improvement Plan |
| **SSHD** | Secretary of State for the Home Department |
| **STI** | Sexually Transmitted Infection |
| **TA** | Temporary Admission |
| **TB** | Tuberculosis |
| **UKBA** | UK Border Agency |
| **UN** | United Nations |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **USS** | Ultrasound scan |
| **UTI** | Urinary Tract Infection |
| **WHO** | World Health Organisation |

# Contents

# Chapter One – Introduction

This report will offer a background to the history, policy and legislation that relates to the immigration detention of pregnant women. It will present a profile of the 20 participants and then go on to detail the healthcare and antenatal care they received. A discussion and key recommendations emerge from the findings.

Home Office policy outlines that:

> '*Pregnant women should not normally be detained. The exceptions to this general rule are where removal is imminent and medical advice does not suggest confinement before the due removal date.*'[1]

The Home Office does not know how many pregnant women are detained. They have no clear and functioning mechanism in place to record women's pregnancies and thereon review their detention. This begs the question as to how they are able to actually implement their policy that pregnant women should not normally be detained for immigration purposes.[2] Thus, in many cases this rule is flouted, as highlighted by this report and by Her Majesty's Inspectorate of Prisons.[3]

Health outcomes for asylum seeking women and their babies are poor.[4] The results show that women do not always receive NHS equivalent care in detention and the factors that could put them and their babies at risk are not always identified. Information given to detained women about antenatal care is limited; informed consent is rare; mental illnesses are not detected or treated effectively; high risk pregnancies are not always identified; and inappropriate malaria prophylaxis is regularly prescribed.

Pregnant women should be at the centre of maternity care.[5] However, for women held in detention, they have no choice over when they see a midwife, or in the midwife that they see. The overwhelming majority of women who are detained are not removed but released back into the community later in their pregnancy: 95% of our sample were not removed. With detention not resulting in removal, pregnant women are subject to interrupted care: the antithesis of what is central to good practice in maternal care, as outlined in national and international guidance.

# Chapter Two – Methodology

## Background to this report:

The inspiration for this dossier arose out of the results of an audit conducted by a Medical Justice independent doctor of 75 pregnant women held in immigration detention between 2005 and 2011. The results are detailed in the table below.

The audit showed that the majority of detainees were typically released during their pregnancy and not removed to their countries of origin. The profile of the participants indicated a largely vulnerable group with histories of rape, torture and/or mental health problems being common.

Concerns over the care quality of healthcare were raised in the majority of cases, which mostly related to the failure to administer any or appropriate anti-malarial medication for those with planned removals to high-risk malarial areas. The results raised a number of issues, which formed the basis of the aims of this research.

## Research Aims:

1. Literature review of the policy and legislation pertaining to pregnant women in immigration detention
2. Analysis of whether pregnancy was factored in to the decision to detain and maintain detention
3. Assessment of the quality of healthcare and experiences of pregnant women held in Yarl's Wood Immigration Removal Centre (IRC)

## Research Questions:

1. Is Home Office policy on pregnant women being implemented in practice?
2. What are the mental and/or physical health issues of the pregnant women in the sample?
3. Was the healthcare of the pregnant women in the sample held in immigration detention of NHS equivalent standard?
4. Did healthcare prescribe malaria prophylaxis in line with good practice guidance and the Immigration Directorates' Instruction (IDI), ie were contraindications and time to establish tolerance factored in?

## Methodology:

This research is based upon the Medical Justice clients who were pregnant whilst held in detention between January 2009 and September 2012.

Tracing people, particularly those held in detention at the earlier stages of the sampling timeframe, proved difficult: this is often because people change their mobile telephone numbers upon leaving detention and also may move addresses several times. However, the majority who were successfully traced agreed to participate, with eight women then failing to return the consent forms and only one declining participation. In total, 20 women were able to be traced and gave informed consent to participate in the study.[6]

**Previous Medical Justice Audit Results**

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|---|---|
| Outcomes | • Only 4 known to be deported<br>• 52 known to be released |
| Mental Health | • 22 women had mental health issues<br>• 4 were admitted into psychiatric wards after being released from detention |
| Anti-malarials | • 40 removals planned to high-risk malarial areas<br>• In most cases, either no or inappropriate anti-malarials were prescribed |
| Rape and Torture survivors | • 2 people missed HIV medication due to being detained; 2 had removals attempted without their viral load and drug toxicity results<br>• Many women had a history of rape and/or torture – STI results not routinely offered |

In order to fulfil the research aims, diverse sources of data were relied upon. Data sources included: IRC healthcare records; immigration records from the Home Office; and medicolegal reports (MLRs) or medical letters written by Medical Justice independent doctors.

For every individual in the sample, a Subject Access Request (SAR) was made using the Data Protection Act 1998 to access the full immigration case file held by the Home Office. This includes case notes, case correspondence, application forms, solicitors' representations, supporting documents and forms served by the UK Border Agency (UKBA)/ Home Office.

The immigration case files were used to assess how pregnancy was factored into the decisions to detain and maintain detention; the stage of the immigration case at which an individual was detained; the places and length of time of immigration detention; and to chart removal attempts and outcomes.

Healthcare notes were requested from the IRC for everyone in the sample. This data allowed the researchers to document what mental and physical health issues were reported prior to and during detention; what health problems relating to pregnancy there may have been and how they were dealt with; medication prescribed; and the level of antenatal care, including scans and screenings that patients received.

The healthcare notes enabled an analysis of the level of care received in immigration detention. Indicators were developed using contemporaneous published policy and good practice guidance in order to gauge the quality of care, from the following sources:

- Civil Aviation Authority, *Assessing fitness to fly,* May 2012
- Health Protection Agency (HPA), *Guidelines for Malaria Prevention in Travellers from the United Kingdom,* January 2007
- International Air Transport Association (IATA) Medical Manual, January 2011
- National Institute for Health and Care Excellence (NICE), *Antenatal care*, June 2010
- National Institute for Health and Care Excellence (NICE), *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors*, September 2010
- National Institute for Health and Care Excellence (NICE), *Antenatal and Postnatal mental health*, 2007
- UKBA, *Detention services order 03/2012, Pregnant Women in Detention,* March 2012
- UKBA, *Immigration Directorate Instruction, Chapter 1 Section 8 Medical,* February 2007
- UKBA, *Detention Services Operating Standards manual for Immigration Service Removal Centres*, January 2005

The healthcare notes were contrasted with the medical letters and/or MLRs written by independent Medical Justice doctors. Typically, this data source detailed the patients' mental and physical health and commented on either the fitness fit to fly or the impact of detention on the mother and unborn baby.

The use of the varied sources of data allowed the researchers to cross-check data, identify commonalities and corroborate findings. Researchers communicated with the (ex) detainees and/or their legal representative to track the stage of their immigration case and any final outcomes. This was done after the main data collection phase and approximately two months prior to publication.

Full interviews were held with six women. The interviews were important to create a holistic understanding of these women's cases and address areas that are impossible to understand from the sole reliance on immigration files and healthcare notes. It allowed the researchers to integrate women's own experiences and viewpoints into the research and in particular, to provide insight into their maternal care before, during and after detention. Interviews were semi-structured and followed topic guides covering the key thematic issues that arose from the research and their personal experiences. In instances where the participants were happy to have their interviews recorded, the interviews were later transcribed, but in other cases, shorthand notes were taken.

## Ethical Considerations:

All women who fell within the sampling frame were approached to participate in the project. An initial telephone call was made and was followed up with a project information sheet detailing the aims and purpose of the research and how the information was going to be used. Consent forms were provided and informed consent was received in every case detailed in this report.

At the initial stages of methodology design, in-depth interviews were planned with a greater number of women. However, many of the women in the sample were vulnerable and the priority for researchers was to protect people from harm rather than increase the sample size. Women who had been removed or were considered to be highly vulnerable were not approached to be interviewed. Many women felt uncomfortable speaking about their experiences, expressing the ongoing trauma they feel as a result of their detention; some declined to participate as they were scared. For those who did participate, interviewees were explained the purpose of the interviews and of the project; how their information would be used; and reserved the right to stop the interview and/or withdraw from the process at any time.

All data was coded throughout the research with information stored in a safe and secure location. Everyone who participated in the study did so with a guarantee of anonymity. All names have been changed and identifiable

features removed from case studies in order to uphold this commitment.

## Limitations:

The research is based on an analysis of immigration case files and healthcare records. There were significant delays in receiving immigration case files from the Home Office and in some cases the files received were incomplete. This was particularly the case with regards to the detention reviews.

In 17 of the 20 cases, Subject Access Requests (SARs) were made. (In the other three cases, Medical Justice already had the files). Of these 17 cases, 12 SARs arrived in time for data analysis. The average length of time it took for the Home Office to send these files was 94 days, which is significantly over the prescribed 40 working day timeframe. In the remaining five cases, the SAR files never came and researchers had to access the documents directly from solicitors. As of 22 January 2013, when a decision had been reached to stop waiting for disclosure, the average waiting time for these five files was 165 days.

An interesting theme that emerged from the data was the disruption to the continuity of antenatal care. It would have been useful to have access to the full maternity records and to analyse GP and hospital records for each individual pre and post detention.

# Chapter Three – The Legal and Policy Framework for Detaining Pregnant Women

## Background to immigration detention

Since the 1970s, the UK government has detained people for immigration purposes with the power to detain originally enshrined in the 1971 Immigration Act. The 1998 White Paper *'Fairer, Faster and Firmer - A Modern Approach to Immigration and Asylum'* stated that whilst immigration detention should be used for immigration control, there was a presumption in favour of temporary admission and release and where possible, alternatives to detention should be sought.

Immigration detention centres are closed, prison-like establishments. They are filled with desperate people, where self-harm, hunger strikes and reports of assault and racism are common. People can be held indefinitely and there is no automatic judicial oversight on decisions to detain.

Concerns regarding immigration detention in the UK include the lack of any statutory time limit in detention; the outsourcing to private contractors with limited monitoring and accountability; the existence of the Detained Fast Track (DFT) and Detained Non-Suspensive Appeals (DNSA) and their associated accelerated timeframes, which do not allow for evidence gathering; and the inadequate healthcare provision in IRCs.

In four separate cases in the past 18 months, the High Court has ruled that the care of four people held in immigration detention has breached Article 3 of the ECHR, amounting to inhuman and degrading treatment.[7]

Chapter 55 of the Enforcement Instructions and Guidance (EIG) outlines the Secretary of State for the Home Department's (SSHD's) policy of detaining people for immigration purposes.[8] The key overriding principles about how immigration powers should be exercised are that:

i. There is a presumption in favour of temporary admission or release and that, wherever possible, to use alternatives to detention. (55.1.1)

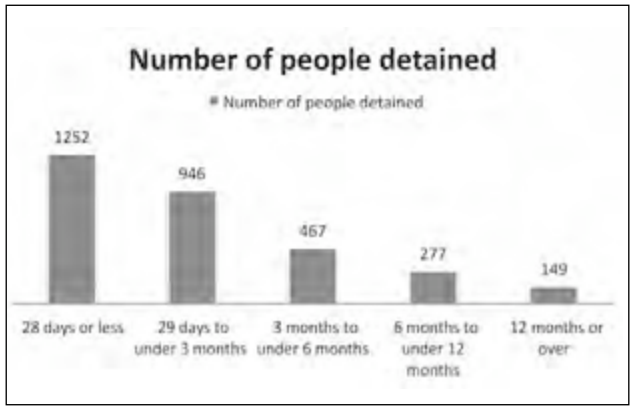
ii. Detention would most usually be appropriate: to effect removal; initially to establish a person's identity or basis of claim; or where there is reason to believe that the person will fail to comply with any conditions attached to the grant of temporary admission or release. (55.1.1)

iii. Detention must be used sparingly, and for the shortest period necessary. It is not an effective use of detention space to detain people for lengthy periods if it would be practical to effect detention later in the process once any rights of appeal have been exhausted. (55.1.3)

However, immigration detention is on the rise and is not solely being used "sparingly". Approximately 27,000 people are now detained each year under immigration powers with 2000 to 3000 individuals detained at any one time.[9] There are arbitrary targets on the numbers to detain, remove and deport. In 2008, the Immigration Minister Liam Byrne committed to expanding the size of the immigration estate by 60%.[10] He stated, 'Even though asylum claims are at a 14-year low, we are removing more failed asylum seekers every year. That means we need more detention space'.

In 2011,[11] there were 27,181 people (including 130 children) held in immigration detention. These figures do not account for foreign national prisoners who are held in prisons after their sentence has expired;[12] or those held in short term holding facilities, non-residential holding facilities, pre-departure accommodation or in hospitals. Of these, 16,836 were removed; 175 were granted to leave to enter/remain; 8,088 were granted temporary admission/release; 1,820 were bailed and 262 left detention for another reason. In this year, amongst asylum cases, there were 5,774 enforced removals and 4,303 voluntary departures.

As at 30 September 2012, Home Office statistics show that 3,091 people were detained.[13] The majority (40%) were held for 28 days or less and 14% were held for 6 months or over.




The average cost of detaining someone for one night in immigration detention is £102.[14] By comparison, the cost to support an asylum seeker who is in the community has been estimated at £150 per week.[15] Thus, the cost of

detaining one individual is roughly £80 per day or £30,000 per year more expensive than supporting them in the community.

## Home Office Policy on the detention of pregnant women

The Enforcement Instructions and Guidance (EIG) contain provisions for the detention of pregnant women, notably in sections 55.9.1 and 55.10. Section 55.9.1 outlines that:

> '***Pregnant women should not normally be detained***. *The exceptions to this general rule are where removal is imminent and medical advice does not suggest confinement before the due removal date.*'

Section 55.10 highlights groups considered unsuitable for detention:

> *'The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons: (…)*
>
> *c)* ***pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this*** *(but see 55.4 above for the detention of women in the early stages of pregnancy at Yarl's Wood);'*

The rules above have not yet been subject to scrutiny by the senior courts and so the parameters of the very exceptional circumstances, which would justify detention according to this policy, have yet to be defined.

For women detained under the detained fast track (DFT) process, the policy is slightly different. DFT was introduced in 2003 as a tool to manage asylum applications that Home Office caseowners have identified to be claims that can be decided quickly. The DFT procedure, Section 2.3 outlines the Suitability Exclusion Criteria and states that:

> *'UK Border Agency policy is that certain individuals are unlikely to be suitable for entry or continued management in the DFT or DNSA processes. These persons are: (…)*
>
> • *Women who are 24 or more weeks pregnant;'*

Chapter 45.2.5 details guidance on the enforcement policy with regard to pregnant women. It states:

> *'For the purpose of enforcement action, a pregnant woman is any woman who has been medically certified as being pregnant, or who claims to be pregnant unless a medical assessment has found no evidence of pregnancy. Local Immigration Teams can ask to see confirmation of the pregnancy and the medical notes from the hospital which would include the due date. If a pregnant woman claims to be having problems which would preclude her from flying, the onus is on her to produce medical evidence to support this. This would apply at any stage in the pregnancy. (…)*
>
> *A check should be made with the UK Border Agency's ticketing agent before setting removal directions. The International Air Transport Association (IATA) guidelines allow airlines to carry pregnant women in excess of 32 weeks, but this will depend on the pregnancy e.g. whether it is a single or multiple pregnancy, and whether there are any known complications. If a pregnant woman claims to be having problems which would preclude her from flying, the onus is on her to produce medical evidence to support this. This would apply at any stage in the pregnancy. For further information please see the Detention Services Order on Pregnant Women in Detention.*
>
> *If a pregnancy is only revealed during a visit to arrest and escort the family either for removal, or to pre-departure accommodation, the authority of the assistant director should be obtained if the OIC feels that the removal should go ahead. This should be noted in the written record of the visit. All information should be noted on section 7 of the FWF which should be sent to The Family Returns Unit while the family is en route.*
>
> *The woman should be advised to take any records relating to her pregnancy. She should also be advised that she will have access to medical care while at the pre-departure accommodation.'*[16]

The Detention Services Order (DSO) 03/2012[17] and 02/2013[18] provide information for all UK Border Agency staff on the detention of pregnant women. It details the policy on detention of pregnant women (as noted above) and guidance on a pregnant woman's fitness to fly.

### Home Office DSO Guidance on Fitness to Fly

| Pregnancy status | Accept | Unfit to fly | Comments |
|---|---|---|---|
| Single (one baby) and uncomplicated pregnancy | Clearance not required up to 28 weeks (based on estimated due date) | – | Medical certificate required after 28 weeks. This can be given by a GP or midwife. Specialist clearance required after 36 weeks. This must be given by an obstetrician. |
| Multiple (twins, triplets and so on) and uncomplicated pregnancy | Clearance not required up to 28 weeks (based on estimated due date) | – | Medical certificate required after 28 weeks. This can be given by a GP or midwife. Specialist clearance required after 32 weeks. This must be given by an obstetrician |
| Complicated Pregnancies | Individually assessed | Individually assessed | The most common complications are bleeding and hypertension. |
| Miscarriage (threatened or complete) | Once stable, with no bleeding and no pain for at least 24 hours | Active bleeding. Abdominal pain. | |

The DSO supports the EIG in placing the onus on the pregnant woman to produce medical evidence to support a claim of having problems that would preclude her from flying. The DSO also advises caseowners to check for individual variations in carriers' thresholds for carrying pregnant women (as required by Chapter 45.2.5 of the EIG). The guidance relies on the International Air Transportation Association (IATA) criteria for fitness to fly:

## Detention Centre Rules and Processes for Pregnant Women

In 2001, the government introduced the Detention Centre Rules.[19] This statutory instrument makes provisions for the regulation and management of IRCs.

Rule 34 of the Detention Centre Rules states that detainees will be given a mental and physical examination by a GP, within 24 hours of arrival. Rule 35 provides that the medical practitioner shall report to the manager of the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention. However, pregnant women are not specifically referred to in this provision, despite it clearly being relevant to this group. This translates in practice and Rule 35 reports are not produced on the basis of pregnancy. Instead, pregnant women's detention is reviewed as per Rule 9 of the Detention Centre Rules, whereby detainees receive written reasons for detention at the time of initial detention and thereafter monthly.

Home Office caseowners should be made aware of a woman's pregnancy through the "Pregnant Lady Notification" Form (PLN). The practice of using a PLN form does not appear to be based on any published policy and it is unclear how the practice feeds into Home Office decision-making. Rather, it is only if the medical practitioner raises a concern will detention immediately be reviewed.[20]

The Home Office has national operating standards, which seek to ensure that private contractors comply with UK policy. There is very little reference paid to the treatment of pregnant women and the only specific standards are: [21]

> *'Families with children: 10 The Centre must ensure that children, pregnant and nursing mothers have access to food outside normal mealtimes.*
>
> *(…)*
>
> *Healthcare: 25 The Centre must arrange access to specialist services for the care of detainees in respect of dental, maternity (in those centres where females are detained)… and any other secondary care services in order to meet the needs of the detainees. The Centre must arrange for these to be provided either within the centre (where facilities exist for this purpose) or from outside services. The Centre must ensure that the healthcare team establishes formal arrangements with outside services where they are to be used.'*

The Operating Manual also states that women should be provided with a female GP when requested. However, as noted in the Yarl's Wood Needs Assessment of June 2011, there was only one woman GP, attending one day per week. 'This may particularly be an issue for women who have a history of sexual abuse, violence or torture. The issue of access to female GPs has been highlighted elsewhere (HMCIP, 2009).'[22] At the present time, there is still only one female GP employed to work one day a week (2 sessions) at Yarl's Wood Immigration Removal Centre (IRC). An additional female GP resource (for 1-2 sessions per week) is not currently available due to maternity leave. A female locum GP is sometimes on duty at weekends but this depends upon availability.[23]

There is also a weekly pregnancy welfare meeting at Yarl's Wood that is attended by the deputy healthcare manager, members of the residential team, security and Home Office representatives.[24] However, despite Home Office attendance at such meetings, they do not know how many pregnant women are held at Yarl's Wood.[25] In addition, there was no consistent reference made in the healthcare notes to the welfare meetings taking place; in most cases, they were not recorded at all.

Regardless of the contractual arrangements for providing medical care, the Detention Services Operating Standards Manual for IRCs sets out that 'all detainees must have available to them the same range and quality of services as the general public receives from the National Health Service'.[26]

Whilst primary healthcare is delivered by Serco Health, antenatal care is commissioned and delivered by NHS Bedfordshire. There are no midwives employed directly by Serco Health. The midwives who visit Yarl's Wood are employed by NHS Bedfordshire. The Home Office reports that midwives from the Bedfordshire NHS Trust visit the IRC once a week on a Friday. Length of attendance is determined by demand and the visiting midwives will decide how frequently they need to see a patient. However the woman can reportedly make a request for an additional routine midwife appointment through Yarl's Wood Healthcare if they wish. In addition the centre's GP or nurses can be accessed seven days a week and can refer any specific concerns to the antenatal clinic, Early Pregnancy Unit in hospital or other appropriate service if necessary.[27]

## Processes in place for pregnant women in Yarl's Wood IRC

**1. Pregnant Lady Notification Form (PLN):**
The Duty Office Manager (DOM) must be informed of any women who are pregnant. This is done through the PLN form normally by a member of the healthcare team. The

form documents the date and time of the conversation with the DOM and is written confirmation that the woman is pregnant. It lists the date of the positive pregnancy test and the number of weeks pregnant she is.

The DOM then: 'cascades this information along with a IS91 part C [risk assessment form] to the local UKBA office and DEPMU. The local UKBA office forward the IS91 part C and the notification to the caseworker. Once the pregnancy is confirmed, the doctor will consider the woman's fitness for detention and raise any concerns with UKBA (locally and to the caseworker).'[28]

What remains unclear at this point is whether the PLN form stimulates a detention review. Policy guidance does not cover this and the form has no instruction, which again begs the question as to how the Home Office is able to apply its policy. According to Emma Ross of Detention Services: 'Information that a woman is pregnant *should* lead to a review of detention by the caseowner'.[29] However, this is yet to be confirmed as there is no formal mechanism linking the practice of using a PLN form and detention review.

**2. Maternity Care Log:**
The maternity care log is completed following a positive pregnancy date. The form acts as a check to ensure that certain steps are taken:

- Referred to midwife? Date of referral
- Additional milk and fruit ordered?
- Pregnacare prescribed?
- Varicella status bloods taken? Varicella status results?

**3. Special Diet Request:**
This form is for healthcare to alert the catering services that the detainee is pregnant. Pregnant women are entitled to additional milk and fruit. Detainees can access 250mls of milk three times a day and one extra piece of fruit three times a day.

**4. Full Medical Admission Review:**
This review must be completed for all detainees and is usually done by a nurse. Basic health details are taken and relevant pregnancy and maternity questions are as follows:

- Do you have any gynaecological problems? Details.
- Do you believe you are pregnant now? Date of last menstrual period?
- Have you ever been pregnant? Details
- Are you currently using any form of contraception? Yes/No
- Date of last cervical screening (smear test)? Date

**5. Rule 34:**
Rule 34 is a health assessment by a GP that should take place within 24 hours of admission. It details: past medical history, current medication, physical and mental assessment, outcome, allergies and a note about whether malaria prophylaxis has been prescribed, if required.

**6. Fit to Fly Assessment:**
Doctors are asked to complete a form that states whether a detainee is fit to fly or not. If the detainee is not considered fit to fly, the doctor must detail the reason(s).

## Public Law Responsibilities

The statutory power to detain is limited. *R v Governor of Durham Prison ex parte Hardial Singh* [1984] 1 WLR 704, held that detention under the Immigration Acts is limited to the period reasonably necessary for the machinery of deportation or removal to be carried out. Detention must also be in keeping with the principles enshrined in Article 5 of the European Convention on Human Rights (ECHR), which protects the right to liberty.

Detention is subject to restrictions imposed by the Secretary of State's policies which are published as operational guidance. This duty to abide by published policy was reaffirmed in the Supreme Court case of *R (Lumba and Mighty) v SSHD [2011] 2 WLR 671*. The Supreme Court found that a breach of that duty will render detention unlawful if the breach was a material error which bears on and is relevant to the decision to detain.

The case has served to highlight that the Home Office must have clear published policies on the use of detention and only follow these in order for detention to be lawful. In the cases of pregnant women therefore, one needs to assess whether there is a clear prospect of early removal as well as considering any relevant medical advice and consider whether there are very exceptional circumstances to justify detention.

The Secretary of State also has a public law equalities duty. The Equality Act 2010 is the law which promotes equal opportunities by outlawing discrimination. A number of characteristics are protected under this legislation, including pregnancy and maternity. The Equality Duty under section 149 of the Equality Act 2010 requires public bodies to advance equality of opportunity, eliminate discrimination and foster good relations. This can manifest itself in a number of ways but of relevance, in the operational implementation of policy and safeguarding individuals: the Home Office must consider the equality implications of its immigration policies and processes.

The Home Office has been criticised in the recent case of *R (on the application of HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 (Admin)*[30] for amending its detention policy in relation to mental ill persons without conducting an equality impact assessment on the effect of policy changes on holding mentally ill people in detention. In a judicial review brought by a detainee with paranoid schizophrenia, Mr Justice Singh QC ruled that the changes were unlawful

as they failed to have due regard to equality duties owed by the Home Secretary under discrimination legislation. The Claimant was found to have been unlawfully detained for over six months. The circumstances of the Claimant's detention were also found by the Court to have constituted inhuman and degrading treatment in breach of Article 3 of the European Convention on Human Rights.

The equality duty does not mean that a particular output is demonstrated. Rather, it simply requires that 'due regard' is given to the relevant matters. However, with regard to disabled detainees, the courts have held that the equality duty requires substantive consideration of the particular circumstances of the individual detainee, not simply having a policy in place: *R (on the application of BE) v SSHD* [2011] EWHC 690 (Admin) and *R (on the application of D) v SSHD* [2012] EWHC 2501 (Admin). In the case of *BE*, no reference to his disability had been made in his detention reviews and there was no evidence of due consideration being given to Section 55.10 of the EIG. Thus, where decisions are challenged, the SSHD needs to be able to demonstrate that it had due regard, and in the case of *BE*, she was unable to do so.

With regards to pregnancy and maternity, policy guidance is relatively thin and it is questionable whether the existing policies and processes are robust enough to ensure their public law duties are discharged. Public authorities are required to gather and use information on how policies and practices affect characteristics, including pregnancy and maternity, in operational delivery. However, given that the Home Office do not even know how many pregnant women are held in detention, they are thereon unable to gather and use such information.

There is no guidance on how pregnancy should be weighed up against very exceptional circumstances. In order to comply with policy and her duties, pregnancy should be factored in to the decision to detain (where the pregnancy is known) and/or during monthly detention reviews. The PLN does not have any comments boxes; and it does not trigger a Rule 35 report. So, it seems there is no fool proof policy, guidance or consistent feedback loop in place with which to alert caseowners about care and fitness for detention and for caseowners to in turn review detention.

# Chapter Four – Background to Yarl's Wood

## Background

In 2011, 3,560 detainees were held at Yarls Wood IRC, most of whom are women. There are 3397 spaces for immigration detainees across the ten main immigration removal centres. The capacity of Yarl's Wood is 405 or 12% of the total detainee population.[31] The vast majority of pregnant women will be held in Yarl's Wood but they can also be held in Tinsley House IRC, Dungavel IRC, short-term holding facilities or Cedars detention centre.

The precise number of women who are pregnant and held in immigration removal centres is unknown. This was exposed in a recent response to a parliamentary question:

> ***Dr Huppert:*** *To ask the Secretary of State for the Home Department how many pregnant women were detained for immigration purposes in 2010-11; and how many of them were released in the late stages of pregnancy because their pregnancy meant that they were not able to fly. [76621]*
>
> ***Damian Green:*** *If a pregnant woman chooses to inform the UK Border Agency of her condition, the detail would be held on her medical file which is confidential between patient and doctor. The UK Border Agency does not hold such information centrally.*[32]

However, based on the number of referrals made to Medical Justice, it was hypothesized that more pregnant women are being detained in recent years than previously. This is supported by the Health Needs Assessment conducted by NHS Bedfordshire in June 2011 that found that: 'The highest number of quarterly referrals was for midwifery, having risen from 8 in 2007 to 43 in 2010.'[33] The IMB also found: 'During 2011, 93 pregnant women were detained at Yarl's Wood'.[34]

Yarl's Wood is one of ten IRCs in the UK. Up until 2011, Yarl's Wood detained children. Since it opened in 2001, it has had a long history of scandal, involving a fire, protests, hunger strikes as well as numerous reports of racism and assault.

## Management of Yarl's Wood

Healthcare provision in IRCs should be of NHS equivalent standard.[35] UKBA was responsible for healthcare commissioning and provision within IRCs and devolved its duty for service delivery via contracts to other organisations. As of April 1, 2013, NHS England takes responsibility for healthcare commissioning in IRCs. However, little is known about the process of handover and it is likely that the contracts with private companies will be maintained.

The fact that healthcare in IRCs was not previously the direct responsibility of the Department of Health led to concerns that it was not subject to the same clinical accountability and governance mechanisms that prevail in the NHS[36] and clinical governance systems within IRCs have repeatedly been criticised. [37]

Yarl's Wood is currently run by the private company, Serco, which internally sub-contracts primary healthcare provision to Serco Health. Secondary and tertiary care services were, up until recently, commissioned by NHS Bedfordshire; but there were no specific contracts in place for this. GP services are sub-contracted out by Serco to a local GP practice.[38]

According to the Health Needs Assessment, published in June 2011:

> *'There is lack of clarity about the commissioning of secondary care services - in particular relating to mental health services and some substance misuse services. Service level agreements do not currently stipulate the Yarl's Wood population as a separate group because they are considered to be part of the local community.'*[39]

Pregnant women in Yarl's Wood are visited by midwives from Bedford Hospital's Community Outreach Team. In addition, women visit the hospital for scans, check-ups, obstetric referrals and other appointments. The service level agreements do not currently stipulate the Yarl's Wood population as a separate group because they are considered to be part of the local community.[40] Whilst NHS Bedfordshire provides support to Yarl's Wood for pregnant detainees, it has no specific contracts in place for the provision of maternal healthcare for detainees at Yarl's Wood.[41]

Whilst the plan for the transfer for commissioning of all healthcare services is now underway, little is known about what the terms of reference will be. This is despite the commissioning handover to the NHS Commissioning Board taking place on 1 April 2013. A Freedom of Information Request (FOI) response states:

> *'From 01/04/2013, commissioning of primary, secondary and substance misuse services to detainees in IRCs passes to the NHS Commissioning Board, and again, currently NHS Bedfordshire's role is to support this transition process. It has recently been announced that the team which will cover Yarl's Wood will be the London Offender Health Team. (Despite its name, the London Offender Health Team will cover not only offenders but others held in detention). At present, a transition board is in place, which is addressing all the issues you list – number, risk status/ complexities and elements of care, etc.'*[42]

The 2011 Yarl's Wood Health Needs Assessment found that between 2007 and 2010, referrals to Bedford Hospital for midwifery and obstetrics/ gynaecology rose. In response, commissioners were encouraged to bear in mind the resource implications of this when developing the commissioning framework in the future.[43]

NICE guidelines additionally state that records should be kept on the number of women presenting for antenatal care with complex social factors. (The guidelines recognise recent migrants, asylum seekers and refugees as being a "complex social factor"). However, having sent an FOI request to find out how many of such women presented at Bedford Hospital, the response was that, 'our commissioners have not requested this information in their contract with us, and therefore it is not kept.'[44]

Freedom Of Information (FOI) 1148[45] revealed the following information:

*'2009/10 – Bedford M/W's saw 7 women at Yarlswood*

*2010/11 – Bedford M/W's saw 2 women at Yarlswood*

*2011/12 - Bedford M/W's saw 3 women at Yarlswood*

*All of the above figures are for women seen by Bedford Midwives at the IDC [Immigration Detention Centre] site. In addition, in 2009, 3 women were seen in Bedford Hospital NHS Trust all seen on one occasion only. In 2010, 1 woman was seen on 4 occasions (2 gynaecology appointments and 2 Obstetric appointments). Since then no IDC women have been seen In Maternity on site at the hospital.'*[46]

Given that the IMB notes that 93 pregnant women were detained at Yarl's Wood in 2011,[47] these figures seem remarkably low. When compared to the data we have, it is clear that in fact they are incorrect. For example, the FOI stated that since 2010, no pregnant woman has been seen in Maternity at Bedford Hospital, which is wrong (i.e. not consistent with number of antenatal visits recorded in healthcare notes). It is of concern that as the commissioning landscape is changing, unreliable statistics are being relied upon with which to base resource allocation. However, with the NHS taking the reins, it is hoped that basic things like record keeping as well as standards of healthcare will improve.[48]

## HMIP inspections of Yarl's Wood

Her Majesty's Inspectorate for Prisons (HMIP) conducts regular inspections of IRCs across the UK. In 2006, inspectors also wrote a thematic review on the quality of healthcare across IRCs.

The inspectors found:

> '1.3 (…) underpinning systems were inadequate and the healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being.'

Concerns were raised about the "complex set of management arrangements" and "inadequate clinical support" for healthcare managers (1.4). Mental healthcare provision was deemed "insufficient" (1.5) and the review team concluded:

> '1.6 (...) the inadequacy of healthcare systems in the IRC was compounded by the unresponsiveness of the IND [Immigration and Nationality Directorate] to clinical concerns about an alleged history of torture or adverse medical consequences of continued detention.'

The weak governance systems were also noted:

> 'The delivery of healthcare was undermined by a lack of needs assessment, weak audit and clinical governance systems, inadequate staff training (particularly in relation to trauma) and insufficiently detailed policies and protocols…' (1.5)

In 2011, HMIP inspected Yarl's Wood IRC and found the following:

> '…. Too many pregnant women, who should only have been held in exceptional circumstances, were detained in the centre. One of these women had had a four day journey from Belfast to Dungavel IRC in Scotland and then to Pennine House at Manchester Airport where she had collapsed; from there she had been taken to hospital before completing her journey to Yarl's Wood.'

In this inspection, concerns about UKBA's decision to detain and detention review processes were raised. In their recommendations, HMIP stated:

> 'A number of pregnant women were detained and there was evidence of poor case owner reviews of their detention, which took no account of the pregnancy.[58] Recommendation: Pregnant detainees should not normally be detained. In exceptional circumstances, continued detention should be considered in line with the UK Border Agency's (UKBA) published policy on the detention of pregnant women.'

With regards to support for pregnant women, HMIP found that this was reasonably good, although two of the women's ultrasound scans had been delayed (5.17) and that mattresses were not suitable for some people, including pregnant women (2.4).[59]

In HMIP's 2009 inspection of Yarl's Wood, the use of force on pregnant women was noted and examples of submissions for approval to use force to carry out removals were observed. In the more recent HMIP report on Cedars in 2012, the theme of the use of force was revisited, having noted the use of force on six families. The report stressed that using force on pregnant women is simply impossible to do safely:

> 'We were very concerned to find that force had been used to effect the removal of a pregnant woman, using non-approved techniques. There is no safe way to do this while protecting the unborn child and it is simply not acceptable to initiate force for such purposes.'

HMIP reported that substantial force, involving non-approved techniques, had been used on one pregnant woman resisting removal. She was placed in a wheelchair and when she resisted moving to the departures area, escorts tipped-up the wheelchair with staff holding her feet. At one point she slipped down from the chair and the risk of injury to the unborn child was significant.

The inspectors concluded:

> 'Force had been used against a pregnant woman for the purposes of removal rather than because of an imminent risk of harm. This posed an unacceptable risk to the unborn child.
>
> Recommendation: Force should never be used to effect the removal of pregnant women or of children. It should only ever be used in relation to such vulnerable groups in order to prevent harm.'

However, the Service Improvement Plan (SIP), which received ministerial agreement on 21 December 2012, rejected the recommendation.

> 'If we were to rule out physical intervention in all circumstances as a matter of policy, there would be a strong incentive for pregnant women to refuse to comply, or for women to claim to be pregnant, with the result that removals would not take place until after the baby had been born.'

UKBA reversed this policy following a High Court case in February 2013,[60] whereby force can only now be used in very exceptional circumstances where it is absolutely necessary to prevent harm.

## Longstanding concerns over pregnant women held in detention

Aside from HMIP, a number of organisations have raised concerns over holding pregnant women in immigration detention. In the IMB's recent report on Yarl's Wood, the Board raised concerns about the effect of the stress of detention on pregnant women; stated that force should not be used on them during removals; and warned of the negative health impacts on distressing removals. The report stated:

> '4.4 The Board raises concerns about the detention and removal of pregnant women.
> Recommendation (for the Minister): that the policy of detention of pregnant women should be reviewed and in the interim, detention be used as a last resort.'

The detention of pregnant women has also been condemned by UNHCR. The 2012 guidelines on immigration detention state:

> '58. As a general rule, pregnant women and nursing mothers, who both have special needs, should not be detained. Alternative arrangements should also take into account the particular needs of women, including safeguards against sexual and gender-based violence and exploitation. Alternatives to detention would need to be pursued in particular when separate facilities for women and/or families are not available.'[61]

There is limited research on pregnant women held in immigration detention in the UK. A joint publication by Bail for Immigration Detainees, Maternity Alliance and the London Detainee Support Group in 2002 and a Birth Companions publication in 2008 seem to be the only discrete pieces of work in this field. In both cases, gaps in service delivery were identified: the standard of care did not meet expectation; there were complaints about diet; interpreting services were inadequate; and the process of being detained caused emotional distress. One report found, 'The healthcare centres in the detention centres were perceived by the women as at best useless, and at worst colluding with the detention centre regime against the best interests of the mother and child.'[62]

At the time of publication, 337 organisations had endorsed the Asylum Aid Charter of rights of women seeking asylum.[63] The Charter contains the provision:

> *'4. Women seeking asylum have the right to be treated with dignity in a way that is appropriate to their needs as women and that ensures their safety if in detention or during removal.*
>
> *To realise this right, the UKBA should:*
> *(…)*
> *d. not detain women who are breastfeeding or at any stage of pregnancy'*

Organisations endorsing the Charter are both international and domestic and include women's organisations, religious groups, human rights organisations, charities, legal firms and the Royal College of Midwives.

## Yarl's Wood Timeline

**2001:** Yarl's Wood Immigration Detention Centre opened in November 2001 and cost approximately £100 million to build with a capacity to hold 900 asylum seekers. GSL won the contract to manage the centre.

**2002:** In February, a huge fire destroyed half the building, reportedly triggered after a 51 year old woman was physically restrained by staff. When the fires started the Head of Group 4 security ordered all staff to exit the building, locking the detainees and some staff inside the timber framed building where sprinklers had not been fitted. Five people were injured in the fire.[49] The undamaged half was reopened the following year.

**2003:** An undercover Daily Mirror reporter took a job as a security guard at Yarls Wood. The front page of the newspaper found he 'discovers a culture of abuse, racism and violence that SHOULD appal us all.'[50]

**2004:** The Ombudsman published a report on the investigation into the Daily Mirror's allegations. 30 recommendations are made.[51] The report concluded: "I conclude that most of the things Mr Sommerlad said happened did happen. However, I have also concluded that these do not indicate a culture of racism and improper use of force."

**2005:** Manuel Bravo, an asylum seeker from Angola, commits suicide in Yarl's Wood. He fled to the UK after his pro-democracy activity led to attacks on his family, including the murder of his parents. He was due to be forcibly returned to Angola where his wife and other child had been returned to and subsequently either disappeared or were imprisoned. In fear of future persecution, he took his own life, hoping his son would be allowed to remain safely in the UK.

**2006:** HMIP did an investigation into the quality of healthcare and found weak governance systems, insufficient training and policies and that healthcare service was not geared to meet the needs of those with serious health problems. In response to the Inquiry, Alistair Burt MP said; "[The inquiry] was 'appalling' in what it revealed and should be a source of shame to those involved .. I am not totally surprised at the results, though shocked and genuinely appalled at the depth of failures revealed and inadequacies of those with care and responsibility for detainees ... [IND's] repeated attempts to removed sick detainees went beyond comprehension and decency". [52] In the same year, Legal Action for Women found that 70% of female detainees had been victims of rape in their home country and some detainees reported sexual and racial intimidation by guards.

**2007:** There was a hunger strike involving over 100 women. In this year, Serco takes over the management of the centre from GSL.

**2008:** The Independent Monitoring Board (IMB) notes in their report on Yarl's Wood: 'the existence, as we see it, of a culture of scepticism about detainees' medical conditions.(…) The plight of mentally-ill and disturbed detainees continued to concern the IMB in 2008.'

**2009:** The Independent Monitoring Board, in its 2009 annual report, reported its concerns about the healthcare department's responsiveness and about psychiatric provision. In 2009, HMIP noted inadequate support mechanisms and poor management of self- harm: "Many women were extremely anxious about their future, and the quality of support procedures for those at risk of self-harm was not consistently good, though there was some caring individual work. There had been no assessment of adult mental health needs."

**2010:** Up to 84 women go on hunger strike in protest against the poor conditions, separation from their children, poor health care, insufficient legal representation and their indefinite detention. Yarl's Wood hunger strikers clash with staff after women are trapped in an airless corridor. Over 50 women are left in the corridor for six hours without water or toilet facilities, and four women faint during this time. Allegations of staff beating some of the women, racial abuse and using riot shields are reported.[53] Early Day Motion (EDM) 919[54] is tabled in response asking for an immediate inspection by Her Majesty's Inspectorate of Prisons (HMIP). 51 MPs signed the EDM.

**2011:** A guard who is found to have got a detainee of Yarl's Wood pregnant is dismissed.[55] The Guardian also uncovers that women detained at Yarl's Wood immigration removal centre are being paid 50p an hour for menial tasks, leading to accusations of exploitation.[56] HMIP publish a report stating that: 'Too many pregnant women, who should only have been held in exceptional circumstances, were detained in the centre.'

**2012:** Damian Green MP confirms that restraining pregnant women to effect their removal is government policy.[57] HMIP later recommends (following an inspection of Cedars) that force should never be used on pregnant women as there is no safe way of protecting the unborn child. UKBA reject the recommendation. In this year, Yarl's Wood also started admitting male detainees for the first time since the 2002 fire.

**2013:** On 22 February 2013 following a judicial review on behalf of a pregnant woman and four children (R on the application of Chen and Others v SSHD CO/1119/2013) UKBA re-published a policy prohibiting the use of force on pregnant women and children save for where it is absolutely necessary to prevent harm.

# Chapter five – Maternity care in the England: principles, policies & evidence based guidelines

## Background information

In the last twenty years maternity care has been the subject of numerous policy documents that have sought to reflect, for the first time, the expressed views of women, as well as to advocate for vulnerable and disadvantaged groups.

*Changing Childbirth* emphasised women-focused care within the principles of choice, continuity of care and control.[64] Standard 11 of the National Service Framework for Children, Young People and Maternity Services proposed interventions in service organisation and delivery that would be necessary in order to meet the requirements of women and their babies during pregnancy, birth and after birth.[65] A number of these have particular resonance in the current investigation:

- Care pathways formalise evidence-based guidelines into direct, individual women-focused care and should result in the same high standard of care for all women. (p 9)
- Inclusive services that respond to the needs of women who are disadvantaged through being homeless, or refugees and asylum seekers, those in prison and other custodial settings, as well as 'women who may feel they have stigmatising conditions such as being HIV positive, misusing drugs, alcohol or other substances or are experiencing domestic violence'. (p 10)
- With particular reference to authorities with asylum seeker accommodation or a woman's prison in their locality, that they should 'have in place arrangements to link health care services for expectant women and mothers with newborns to local maternity services and ensure that these standards are applied in every setting.' (p 13)
- Quality of care managed though a clinical governance framework, and maternity services that are compliant with the National Institute for Health and Care Excellence (NICE) guidelines for the provision of high quality clinical care. (p 40)

Successive confidential enquiry reports have highlighted the importance of maternity care in reducing inequalities in pregnancy outcomes.[66] The past three confidential enquiries into maternal deaths in the United Kingdom have all cited newly arrived migrants, asylum seekers and refugees as being a particularly vulnerable group.[67]

In the first report black African women, including asylum seekers and newly arrived refugees were found to have a mortality rate seven times higher than that of white women.[68] In the second report this rate was six times higher and Black Caribbean and Middle Eastern women, to a lesser extent, also had a significantly higher mortality rate than white women.[69] This difference in mortality rates according to ethnicity was reported again in 2011 along with several deaths in women from the expanded European Union, many of whom did not speak English.[70]

The second report made reference to women asylum seekers who often may have had traumatic experiences or complex health and psychosocial problems, and be in need of urgent and continued care. The report highlighted the increased morbidity and mortality rate among asylum seekers because they often have complicated pregnancies due to serious underlying health problems, are generally in poorer health and do not access antenatal care early if at all. This results in poor pregnancy and neonatal outcomes requiring more intensive and expensive treatment at a later stage.

A number of explanations for the gross disparity in outcomes have been proposed. One review cites the challenges that recent migrants, whatever their immigration status, bring to the maternity services in the UK. Relevant factors include:[71]

- Poor overall health
- Underlying and possibly undiagnosed conditions such as cardiac disease
- Increasing instances of HIV/AIDS and TB
- The consequences of genital mutilation
- The medical and psychological effects of fleeing war torn countries

Another explanation given for the disparity in poor maternal outcomes has been attributed to the impact of staff attitudes:

> *'Health professionals who work with disadvantaged clients need to be able to understand a woman's social and cultural background, act as an advocate for women with other colleagues and address their own personal and social prejudices and practice in a reflective manner.'*[72]

Reviews of maternal death all found women who did not speak English were at increased risk and the use of professional interpreting services continues to be a top recommendation.[73]

All of the policy documents and reports cited in the preceding paragraphs recommend the adoption of relevant clinical guidelines to increase consistency in effective care for all women and to reduce disparities in poor outcomes.

## Maternity Care Guidelines

The National Institute for Health and Care Excellence (NICE) funds the National Collaborating Centre for Women's and Children's Health to develop clinical guidelines. The guidelines aim to improve the quality of care for women and their families and they are also used in training NHS staff. The Royal Colleges of Obstetricians and Gynaecologists, Paediatrics and Child Health, Midwives and Nurses all support the National Collaborating Centre as do a range of stakeholders including General Practitioners. As the implementation of NICE guidelines aims to ensure the best possible outcomes for patients, it is central to clinical governance in NHS settings.

NICE guidelines provide standards, which can be used to assess whether the care that pregnant women receive in Yarl's Wood is equivalent to that received in the broader community. Three NICE guidelines are of particular relevance in this report and have been used to assess the quality of care received by pregnant detainees:

1. Antenatal care CG 62
2. Pregnancy and complex social factors CG 110
3. Antenatal and postnatal mental health CG 45

**1. Antenatal care CG 62[74]**
While the guidance does not apply to women with a multiple pregnancy, or those with a medical condition prior to or developing in pregnancy, it provides standards for assessing equivalence in the antenatal care of women in all settings.

In 2012 NICE quality standards were introduced for the Antenatal care guideline.[75] NICE quality standards enable healthcare professionals to make decisions based on best evidence and practice; people receiving care to find out about the services they should expect; service providers to examine the performance of organisations; and commissioners to be confident that they are purchasing high quality care.[76]

**2. Pregnancy and complex social factors CG 110[77]**
Pregnancy and complex social factors CG 110 was first issued in 2010. The guideline describes the additional support women with complex social factors need. Examples of complex social factors include recent arrival as a migrant, asylum seeker or refugee status, difficulty speaking or understanding English, domestic abuse, poverty, homelessness, substance misuse, aged under 20 years.

The guidance provides ways to assess equivalence in the care of pregnant women who require additional antenatal support. These standards are in addition and continuous to those on routine antenatal care.

**3. Antenatal and postnatal mental health CG 45[78]**
The guideline makes reference to the serious consequences of maternal mental illness for the mother, baby and family. It makes recommendations on the prediction, detection and treatment of mental disorders in pregnant women and mothers up to one year after birth. These standards are in addition and continuous to those for both routine antenatal care and antenatal care for those with complex social factors.

As the implementation of NICE guidelines aims to ensure the best possible outcomes for patients, it is central to clinical governance in NHS settings. Whilst some of these standards are measurable in this project, others are not owing to incomplete records and data availability. See the Annex for the key indicators used in this project.

# Chapter Six – Summary of Results

This section will present the following:

a. Profiles

b. Results from the healthcare notes

c. Findings from independent doctors

d. Data from immigration files

## (a) Profiles

### Profile of Participants

20 women participated in the research. All the women in the sample were pregnant at some stage during their detention. At the time they were detained two of the women had been diagnosed with twin pregnancies. (One of these subsequently lost a twin. She thought this was due to the stress of detention). This woman aside, two women in the sample suffered miscarriages and one had a stillbirth.

The majority of women (15) came from Sub Saharan Africa. Two women came from South Asia and one women came from one of each of the following regions: the Middle East, Eastern Europe and the Caribbean.

The average age of the women in the sample at the time they were initially detained was 30 years old. The eldest was 37 and the youngest was 19. One woman had her age disputed by the Home Office: at the time of her detention, she claimed to be a minor but this was not accepted.

All the women in the sample were held in Yarl's Wood IRC and one was also held in Dungavel. In some cases, prior to being taken to Yarl's Wood, women were also held in short-term holding facilities.

Two women who had served criminal sentences immediately prior to immigration detention were transferred straight to Yarl's Wood directly from prison establishments following the completion of their sentence. Nine of the 20 women were released to places different to their address prior to being detained.[79]

Three women applied for leave to remain on other than asylum grounds, two based on Article 8 claims and one for European Economic Area (EEA) residency.
17 of the 20 women made asylum/human rights claims claims:

| Asylum and human rights claims | Number |
|---|---|
| (Imputed) political opinion | 5 |
| Trafficking | 2 |
| Risk on return | 2 |
| Particular social group (honour killing; assassination owing to family membership) | 2 |
| Fears persecution on basis of allegations of adultery | 2 |
| Race | 1 |
| Sexual abuse | 1 |
| Forced marriage | 1 |
| Sexual orientation | 1 |

Four women in the sample claimed asylum on arrival. One woman was a third country case (a process that enables EU states to return asylum seekers to the country through which they first entered the EU). Four women were on the detained fast track (DFT) process: a case management tool for cases when Home Office caseowners believe the claim can be decided quickly.

The DFT system has come under intense criticism since its inception from both national and international organizations, including UNHCR[80], the Chief Inspector of UKBA[81] and Human Rights Watch[82]. Much of the criticism has centred around the inadequate screening process, which often results in complex claims being routed into a system designed for much simpler claims. These people can be highly vulnerable with complex health needs and multiple vulnerabilities who should never have been found suitable for the process in the first place.

> ***'2.3 Detained Fast Track Suitability Exclusion Criteria***
> *UK Border Agency policy is that certain individuals are unlikely to be suitable for entry or continued management in the DFT or DNSA processes. These persons are:*
>
> - *Women who are 24 or more weeks pregnant;*
> - *(….)*
> - *Those for whom there has been a reasonable grounds decision taken (and maintained)*
> - *by a competent authority stating that the applicant is a potential victim of trafficking or where there has been a conclusive decision taken by a competent authority stating that the applicant is a victim of trafficking;*

- *Those in respect of whom there is independent evidence of torture.'*[83]

One of the women on DFT claimed to be a victim of torture and trafficking. Two women on DFT did have removal directions set whilst they were in detention and both were unsuccessful.

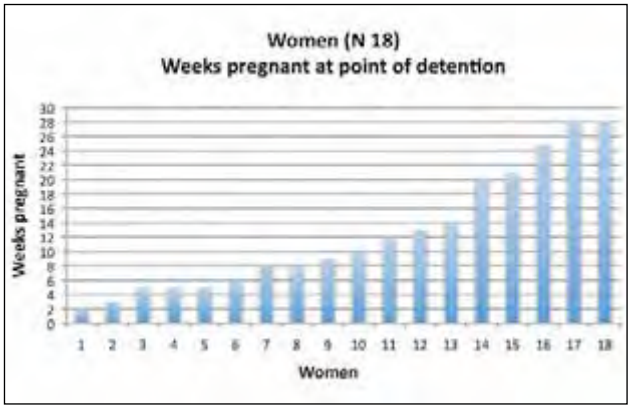
Three women on DFT spent roughly 5 or 6 weeks in detention. However, one woman was held for just over 20 weeks and was released in the 25th week of her pregnancy. All of these women were eventually released into the community, but two of them were released one to two weeks after the 24 week limit.

All those who were released into the community following detention (18) were released on temporary admission, except two who were granted bail.

Eight of the 20 had a history of absconding and/or being "underground" without attempting to regularise their status prior to being detained. Four had a criminal conviction and had served time in prison prior to being detained – three for immigration offences (possession of a false document) and one for shoplifting. Everyone in the sample had ties in the UK and 13 of the 20 had fathers of their child(ren) in the UK.

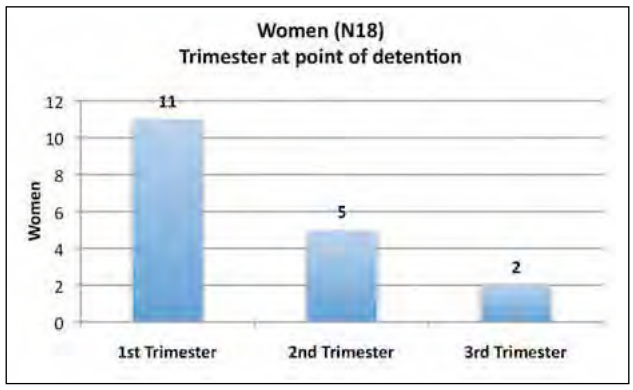
## Time spent in detention

18 women were pregnant when detained. Two became pregnant whilst in detention. Below is a chart detailing the number of weeks pregnant the 18 women were at the point of detention:




The average time the women in the sample spent in detention was 80 days. The shortest time was 15 days and the longest was 278 days. The two women who spent the most amount of time in detention both fell pregnant in detention. If we minus these women from the total, a revised average time spent in detention for the remaining 18 women is 60 days.

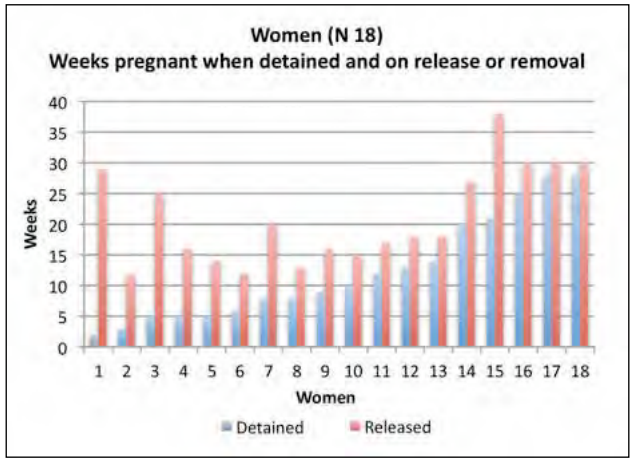
The majority of women were detained in the first trimester with only two detained in the third trimester of their pregnancies:



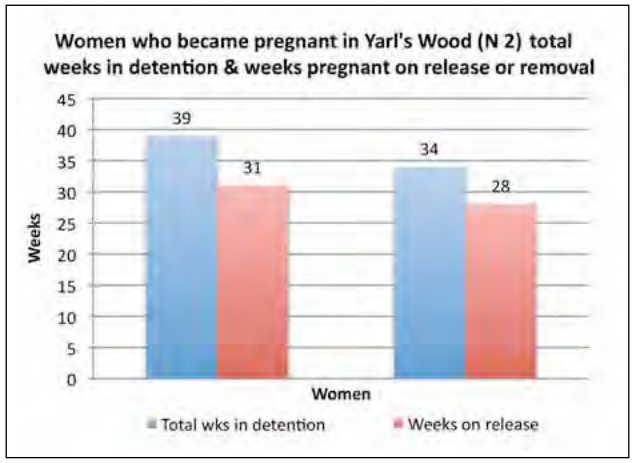

## Weeks in detention prior to release

The 18 women who were pregnant at the time of detention were held in immigration detention for a time period ranging from two to 27 weeks. One third was detained for 2-5 weeks; one third for 6 - 9 weeks; and one third for 10-27 weeks.

With the exception of one woman who was detained at 21 weeks and released at 38 it is clear that the earlier women were detained the longer they were likely to remain in Yarl's Wood before their release.




Of the two women who became pregnant in detention, one was released when she was 31 weeks pregnant and the other agreed to voluntary return when she was 28 weeks.



### Vulnerabilities

The women in the sample had a high prevalence of vulnerability:

- 5 claimed to have suffered domestic violence
- 3 claimed to be victims of trafficking
- 7 claimed to be victims of rape, one of whom was pregnant as a result of rape[84]

11 women disclosed that they had a history of torture. Eight individuals had Rule 35 forms completed during their detention, although two of these were non disclosure forms where it was noted that they were too upset to provide details. In addition, three people who had been detained on previous occasions had Rule 35 forms completed in their earlier spells in detention and were referred to in the healthcare notes examined.

In spite of the completion of Rule 35 forms, no women were released from detention. The quality of Rule 35 reports was poor, in line with the findings of Medical Justice's recent report, *The Second Torture: the immigration detention of torture survivors*.[85] There were instances of nurses completing Rule 35 reports, against Home Office policy, which requires doctors to do them; and in general, a failure to provide a clinical opinion of the account provided by the detainee. In no instances was an interpreter documented to have been used upon completion of the Rule 35 form. Caseowners ordinarily rejected releasing the women on the basis of either a lack of independent medical evidence contained in the Rule 35 report (for example, dismissing the report on the basis that the doctor failed to make a comment on the consistency of scarring with the account) and/or previous negative credibility findings.

Aside from the routine antenatal care tests, six women in the sample had complete sexually transmitted infections (STI) screenings. In three cases, the healthcare team was alerted to run the tests by the independent doctor who visited the centre and in one case it was asked for by the patient. In the remaining two cases, it is undocumented who requested the tests to be done but one may assume that a member of the Yarl's Wood healthcare team initiated the tests.

Four of the six women who had the complete STI screening had disclosed a history of rape. A further three women who had been raped did not have STI tests done but in one case it was documented that she had been offered it by the healthcare team but she declined to take it.

IRCs have self-harm reduction strategies in place to support detainees who are deemed to be at risk of suicide or self-harm. Assessment Care in Detention and Teamwork (ACDT) is the process used when an individual has been identified as being at risk. It involves an initial risk assessment and assessment interview.[86] Raised Awareness programmes are used for those detainees who require extra support and monitoring but are not suicidal and have not self-harmed.

The healthcare notes reveal that three women disclosed a history of self-harm, including previous suicide attempts, to members of the healthcare team. These same three women were placed on raised awareness at some point during their detention at Yarl's Wood.

In total, five women were placed on raised awareness and three on ACDT. In addition to these women, one woman was referred for counselling and another for a mental health and psychiatric assessment.

Two women were noted to go on hunger strike, one of whom did so as part of a mass protest. The other was incorrectly noted to be on "hunger strike": in fact, she found the food to be unpalatable.

## (b) Results from the healthcare notes

### Parity and previous pregnancy complications

Eight of the 20 women had previously had live births. In this group, two had also had previous ectopic pregnancies and two had miscarriages. Two women had had previous caesarean sections - one of these was performed to deliver an IUD (intrauterine death) to a woman who had suffered a placental abruption.[87] Of the 12 who had never given birth, five had a history of miscarriages.

### Health problems prior to Detention

Upon arrival at the detention centre, women are asked to disclose previous mental and physical health issues. Rule 34 of the Detention Centres Rules 2001 states that a doctor should also conduct a full mental and physical assessment of patients.

Mental health issues including, depression, self-harm and/or suicidal ideation were noted in four cases. In the majority of cases, it was simply documented that the patient "appeared mentally stable". However, in a further four cases, the doctor noted that the woman seemed stressed, emotionally subdued or tearful. In two of these cases, it was later determined by an independent doctor that they were suffering from PTSD.

Six women reported a history of gynaecological problems. These included: recurrent Urinary Tract Infections (UTIs); cervical cancer; ovarian cysts; fibroids; endometriosis; and vaginal discharge.

Three women also had STIs, each suffering either from HIV, Hepatitis B or Hepatitis C. Other physical health issues included: essential hypertension (2), hyperthyroidism and cellulitis.

At the point of detention, most women did not have their medication with them: this is because in most cases, they were detained unexpectedly. In cases where women had previously booked for maternity care, they were already on

pregnancy vitamin supplements and folic acid. Aside from that, women brought a variety of medication with them, including: antibiotics, paracetamol, antacids, carbimazole (hyperthyroidism medication), anti-hypertensives and an asthma inhaler.

## Commonly reported problems in detention

All of the women in the sample reported abdominal pain with or without bleeding at some point. Other common complaints were nausea with indigestion and back pain. On a few occasions abdominal pain led to a referral to Bedford Hospital for second opinion and ultrasound scan (USS). More often than not, this would simply be met with advice from the Yarl's Wood healthcare team to take paracetamol and reassurances such as pain being "normal" part of pregnancy.

For example, the following advice was given to a woman reporting intermittent abdominal pain who had a history of miscarriage, as noted in their medical notes:

> *'intermittent abdominal pain is not unusual due to the release of progesterone and the effect of this on muscles and ligaments'*

This advice is incorrect: intermittent abdominal pain may be of gastrointestinal origin or may represent uterine activity, ie contractions and the onset of miscarriage. In any case, this warrants further investigation.

## Record Keeping and Information

In all of the 20 women's cases reviewed, medical notes were incomplete. The documents that were typically missing included:

- Pregnant lady notification forms
- Blood results
- Scan results
- Rule 35 responses
- Hospital records
- Completed prescription charts

Information and informed consent are central to good practice in antenatal care. Women need to have information in order to make decisions and take care of themselves and their babies. The NICE guidance, Antenatal care CG 62[88] and Pregnancy and complex social factors CG 110[89] both make reference to the need for clear communications in a language women understand. In addition to evidence based information, women need support to make informed choices about their care.

A review of the medical notes revealed an absence of documentation around patient information. It was documented that a woman had received information on appropriate food to eat in pregnancy in only three cases and that she had received her blood test results in eight cases. In only three cases was it documented that there had been a discussion with the patient on anti-malarial medication. Ordinarily, it was simply noted when the drug was prescribed.

The lack of information given to patients was confirmed in interviews with the women. For example, one woman who had mental health problems explained how the risks of taking mefloquine were not explained to her:

> *'At that time, I was 3 months' pregnant and they gave me anti malaria tablets. I am a medical assistant so I know about medication. They issued me malaria tablets when I was 3 months pregnant, which is not normal. I did not take the tablets and threw them away immediately as I know there are risks. I asked them why they gave it to me, as at the stage, it risks miscarriage. I knew the risks but others who were given it, did not.'*

A discussion on appropriate food was documented in four cases. For example, as noted in one woman's healthcare notes: '*seemed very vague about various stages of pregnancy, i.e. about trimesters, also about health diet during pregnancy.*'

Nausea and vomiting in early pregnancy were both exacerbated by the lack of familiar and palatable food for the women. Hunger was documented in some of the healthcare notes. For example, one woman complained on several occasions about being hungry. However, she was repeatedly reminded that she was entitled to extra milk and fruit but if she wanted anything else, she would have to buy it at the shop. Detainees are only given £5 per week as an allowance, which some women stated was insufficient to meet their needs.

Other welfare issues aside from food that were found in the healthcare notes included single room requests; requests for extra pillows and mattresses; and clothing being too tight.

## Medication during detention

In contrast to the medication on arrival, there were high levels of prescription for the 20 detained women. Overleaf is a chart detailing what medication was prescribed.

The most common prescription was for malaria prophylaxis. This shall be discussed in depth in the following chapter.

It is notable that it was the midwife from Bedford Hospital who alerted Yarl's Wood healthcare staff to the fact that a woman (who had disclosed her HIV status on arrival) was not on antiretrovirals (ARVs). This prompted a referral to the Genitourinary Medicine Clinic (GUM) and thereafter appropriate blood tests and medication.

| Medication during detention | Women prescribed |
|---|---|
| **MALARIA PROPHYLAXIS*** | |
| **Mefloquine** | 14 |
| **Malarone** | 1 |
| **Proguanil** | 1 |
| **Antibiotics** | 12 |
| **Gastrointestinal** | |
| **Antiemetics** | 4 |
| **Indigestion** | 6 |
| **Constipation** | 5 |
| **Fluid replacement (D&V)** | 2 |
| **Antifungal cream (thrush)** | 5 |
| **Mental Health Related** | |
| **Antidepressant** | 2 |
| **Antipsychotic** | 1 |
| **Sedative** | 1 |
| **Insomnia** | 3 |
| **Aspirin (hypertensive and previous abruption)** | 1 |
| **Analgesia (apart from Paracetamol)** | |
| **Codeine phosphate** | 2 |
| **Co-codamol** | 1 |
| **Iron supplements for anaemia** | 2 |
| **Antihypertensive** | 2 |
| **Eye Drops** | 3 |
| **Skin condition (itching)** | 3 |
| **Methadone** | 1 |
| **Inhaler (asthma)** | 1 |
| **Retroviral HIV medication** | 1 |

* In some cases, women were prescribed more than one type of anti-malarial medication

## Screening and Protocols

On entering Yarl's Wood all women had a full admission health screening. The screening process should take around 30 minutes however in practice it may be very brief, often around 10 minutes.[90] Often detainees arrive without their medical files and therefore the information gathered is what detainees report.

The Detention Services Operating Standards Manual for IRCs outlines that specialist interpreters or a telephone interpreting service should be offered for any medical consultations with detainees who do not understand English.[91] However, interpreters are rarely used in the reception screening process.

The majority (11) of the initial health screenings took place in the middle of the night between 22:00 and 06:00. Often, the trips to Yarl's Wood will be long, detention is unexpected, and the journey and arrival to detention is a traumatising experience. Some journeys from women's homes were up to 200 miles whilst for others who were detained upon arrival in the UK, their travel time could take over 24 hours. After such long and traumatic journeys, it is questionable how reliable self-reporting on health issues and vulnerabilities will be. This is particularly the case for women with a history of trauma who may have difficulties with disclosure.

| Time of health screening | No. of women |
|---|---|
| **09:00 – 18:00** | 5 |
| **18:00 – 22:00** | 4 |
| **22:00 - 06:00** | 11 |
| **06:00 - 09:00** | 0 |

All women in the sample had a Rule 34 examination with a doctor. In 18 cases, their examinations fell within the 24 hour timeframe prescribed within the Detention Centre Rules 2001. However, two women had their examinations delayed. In both cases however, the delay was minimal and took place within 48 hours.

If a woman claims to be pregnant in the screening (and is not visibly pregnant), a pregnancy test will ordinarily take place and thereon a Pregnant Lady Notification form (PLN) completed.

In 15 cases, women stated they thought they were pregnant at the health screening and one woman was unsure; she had a pregnancy test the next day and her pregnancy was confirmed. The remaining four said they were not pregnant, two of whom had recent periods and found out they were pregnant following their next missed period in detention. The remaining two became pregnant in detention: one of these was detained alongside her husband.

An examination of the medical notes revealed that across the sample of all 20 women who were pregnant, a PLN form was only triggered in 13 cases. For those 13 cases, in the majority of cases (11) they were completed within 24 hours of the health screening. In the other two cases, one was completed five days after the health screening and the other 23 days after the positive pregnancy test.

With regards to the other pregnancy specific records, the following was observed from the medical notes:

- 16/20 had a special diet request form
- 8/20 had a maternity log form
- 14/20 had fitness to fly form(s)
- 1/20 had a pregnancy welfare meeting form

These results indicate that forms are not routinely completed and/or are not recorded in the patients' files. In addition, in the 20 records reviewed, only two contained a form or notes about the pregnancy welfare meeting that brings together healthcare staff and Home Office staff to discuss individual cases.

## Antenatal Care

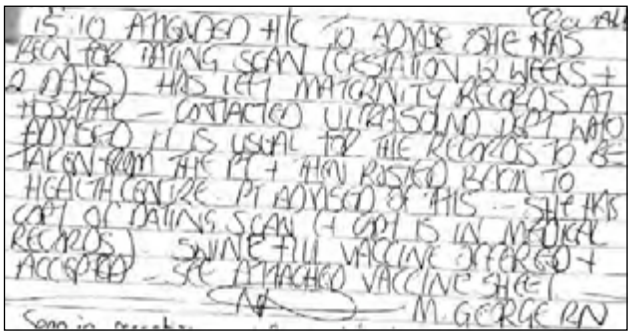
As noted earlier in this report, primary healthcare provision in Yarl's Wood is delivered by Serco Health. Secondary and tertiary care services were commissioned by NHS Bedfordshire but there were no specific contracts in place for this. Midwives from Bedford Hospital provide routine and specialist services for pregnant detainees.

A community midwife visits Yarl's Wood once a week to do the booking interviews with new referrals, or for subsequent antenatal appointments. They arrange for routine ultrasound scans, provide women with the routine schedule of antenatal visits of when they will be seen, and they leave the woman's maternity records at Yarl's Wood.

NICE states that, as a basic principle of antenatal care, 'Maternity records should be structured, standardised, national maternity records, held by the woman'.[92] All women who are pregnant have handheld maternity records. They contain explanatory notes, information on antenatal screening tests and growth charts, details of family history and prompt midwives to discuss public health issues and individual needs. There is no published guidance on the collection and treatment of handheld maternity records for pregnant women held in immigration detention. However, in response to a parliamentary question, the then Immigration Minister, Damian Green stated:

> *'Pregnant women who have been issued with hand held records or a medical book while in the community are permitted to retain these on entering immigration detention. While detained, such records are maintained by the immigration removal centre's healthcare department to ensure continuity of care'.* [93]

It is unclear whether the maternity records are held by the mother or by healthcare: the researchers received contradictory information on this point. The healthcare notes indicate that there is some confusion over who holds the handheld records in detention. For example, after one hospital visit Bedford Hospital kept the maternity notes in the belief that this was the principle to be followed. The scan below illustrates this:




## Routine midwifery appointments

Midwives rarely wrote anything in the Yarl's Wood healthcare notes that we reviewed. Instead staff indicated when a woman had been seen for an antenatal appointment with 'seen by midwife'.

The number of routine midwife visits women had during their pregnancy in Yarl's Wood ranged from one to five. In general, the longer a woman stayed in Yarl's Wood, the greater the number of routine midwife visits she had. The timing and number of visits was generally consistant with the National Institute for Health and Cinical Excellance (NICE) recommendations on Antenatal Care (NICE CG62).[94]

However this guidance does not look specifically at women who are pregnant with more than one baby, women with certain medical conditions or women who develop a health problem during their pregnancy. Nor does it cover the care of pregnant women with complex social factors:

> *'Examples of complex social factors in pregnancy include: poverty; homelessness; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse'.* [95]

One woman who had one visit from a midwife during her 12 weeks in detention had a history of two miscarriages, as well as abuse, trafficking and domestic violence. (Another scheduled appointment with a midwife was cancelled because the midwife was off sick.) In the current pregnancy she had vaginal bleeding shortly before she was detained. During her detention she experienced abdominal pain, further bleeding and pregnancy loss at 20 weeks.

Another woman, who was in detention for 17 weeks had a history of rape, torture, depression, and PTSD. Her pregnancy was complicated by urinary tract infection (UTI), vaginal discharge, Group B Streptococcus, depression, gestational diabetes, abdominal pain and back pain, as well as poor nutrition. She saw a midwife on two occasions only, and there were no missed or cancelled midwife visits recorded in the notes. A healthy low risk woman receiving routine antenatal care would have had four visits over a similar period. In the 17 weeks she was held in detention, she also did not have any routine scans.

Women did not have direct access to a midwife and according to those we spoke with they could not request a visit from the midwife. One was told by healthcare staff that a midwife was not going to come to Yarl's Wood, "just for her".

## Missed antenatal appointments

Nine women had not missed any antenatal appointments. Between them, the remaining eleven women missed fourteen appointments related to their antenatal care.

| Type of Appointment | Number missed | Reason missed |
|---|---|---|
| **Midwife** | 12 | Midwife cancelled x 2<br>Woman did not attend (DNA) x 10<br>• did not receive text message from Health Care x 4<br>• was late because of another appoinment. Midwife left x 1<br>• felt unwell and could not wait any longer for MW x 1<br>• declined visit with midwife x 4 |
| **Scan** | 1 | Woman declined |
| **GUM clinic** | 1 | Demonstration outside IRC |

When the midwife missed an appointment, a visit was rescheduled for the following week, presumably because there was no cover for the day and visits are only once a week. In contrast, midwives looking after pregnant women in Holloway Prison are able to cover the work of an ill colleague either on the same day or in the same week because they work as a team of three and also visit three times a week.[96]

The practice of staff informing women of an antenatal appointment by text message suggests that women did not know in advance when they would next be seen by a midwife. This might be the case if the woman had no written information about their next appointment as she would in handheld notes. In any event, some of the women who researchers spoke with reported that staff often claimed to have sent texts to detainees which were never received.

In one case, a woman with mental health problems missed her appointment with the midwife because she was being seen by the counsellor. More attention by staff when booking appointments and avoiding any clashes could avoid this. Loss of trust in healthcare and the staff at Yarl's Wood was also an important factor in women choosing not to attend apointments.

## Ultrasound Scans (USS)

Routine scans were carried out at Bedford Hospital to confirm and date the pregnancy. Six women had no ultrasound scans during their period of detention. Three of these were visibly pregnant on reception and the other three were released or forcibly removed before a scan was done. The remaining fourteen women had between one and two scans each.

An anomaly scan to exclude major structural abnormalities was offered for 21-22 weeks.[97] Five women had fetal anomaly scans at 18-20 weeks. Of the fifteen who did not have an anomaly scan result in their notes: three were too advanced in their pregnancies to have one or had one done prior to detention; twelve women were released and one was removed before the anomaly scan could be done.

## Down's syndrome screening

Seven women had screening for Down's syndrome while in Yarl's Wood. One woman had the screening prior to detention.

Twelve women did not have screening. Of those:

- One woman missed her early scan and screening appointment
- Two were too advanced in pregnancy to have screening
- There was no evidence that Down's syndrome screening was done in the cases of nine women. All of these women were eligible for the early or later screening test during the period of their detention

There was no evidence of a discussion about Down's syndrome screening in any of the records reviewed, although this would probably have been recorded in a woman's maternity records.

## Additional Appointments

| Type of appointment | Number of women | Number of appointments |
|---|---|---|
| **GUM clinic** | 3 | 5 |
| **Specialist mental health assessment** | 1 | 1 |
| **Specialist opinion (hypertensive disorder , PV discharge, reduced fetal movements)** | 5 | 5 |
| **Scan to exclude appendicitis** | 1 | 1 |

In some cases, women were taken to Bedford Hospital for scans or asessments. In interviews, it became clear that escorts attempted to handcuff some women when transporting them to visits and that women resisted.

## Visits to A & E or Labour Ward

Seven women had additional visits either to A & E or to the labour ward in Bedford. Some had more than one visit.

Overleaf is a breakdown for the reasons for visits to A & E or the Labour Ward at Bedford Hospital:

| Location | Reason for visit | Number |
|---|---|---|
| **Bedford** | PV bleeding | 3 |
| **Bedford** | Abdominal pain | 4 |
| **Other A & E** | - Assessment following road traffic accident after removal attempt | 1 |
| | - Assessment of abdominal pain following removal attempt | 2 |

None of the women were kept in overnight apart from one who had a late miscarriage and a blood loss of 1.5 litres. She suffered what was described as an acute grief reaction and attempted suicide twice. She was transferred to the acute mental health assessment unit and treated with anti-psychotic medication and did not return to Yarl's Wood afterwards.

### Additional health screening

Routine antenatal blood tests were done in all cases. Results to these were either in the healthcare notes as hard copies or recorded by healthcare staff. In some cases results were missing. This can happen for a number of reasons:

1. specimens are never sent
2. specimens are never received
3. specimens are never processed (labelling incorrect or incomplete)
4. results are received by telephone but not recorded in the records

The cases where specimens were never received or processed only became apparent in an emergency when a result was required urgently or when the midwife alerted Yarl's Wood staff to the problem. In one case where a woman was investigated for a serious complication of pregnancy the appropriate blood test was recorded as having been done, but no result was noted. It is normal practice in NHS maternity settings to 'chase' results if they have not been returned in a timely fashion and it is a concern that the healthcare team in Yarl's Wood do not work to a similar standard.

## (c) The findings of independent doctors

This sub-section presents a summary of the findings contained in reports by independent doctors who visited detainees.

All the women in the sample had Medical Justice independent doctors either write a medical letter or a medicolegal report (MLR) on their behalf. Seven of the 20 had multiple reports, often to cover both their mental and physical health issues. This section will present the clinical data contained in the letters and MLRs.

| Summary of findings |
|---|
| Mental health issues prior to detention (6) |
| Mental health issues identified in/immediately after detention (5-plus existing 6) |
| Mental health worsening in detention (6) |
| Women found unfit for detention (6) |
| Women found unfit to fly (13- plus 3 mental health risks) |

Six women had a history of mental health issues prior to detention: this included a history of one or more of the following: depression (3); previous suicide attempts (2); PTSD (2); and anxiety disorder (1). By comparison, the healthcare team only found four of these six had mental health problems at the initial health screening and Rule 34 session with the GP- however, the remaining two did have their mental health issues identified at a later stage by the healthcare team with one being placed on raised awareness and Assessment Care in Detention and Teamwork (ACDT)[98] and the other being referred for a mental health and psychiatric assessment.

Aside from those with a history of mental health issues, a further five women were diagnosed with mental health problems either during or shortly after their release from detention. This included either a diagnosis or showing signs of one or more of the following: PTSD (3); depression/ major depressive episode (3); acute psychotic illness (1); and as well as anxiety (2).

There was evidence of detention worsening pre-existing mental health issues and/or triggering mental health problems as evidenced in the medical reports of six women in the sample.

For example, one woman who had disclosed a history of depression during her healthcare screening was found to have deteriorating mental health in detention by an independent doctor who visited her in detention. The doctor wrote:

> *'X has suffered a severe deterioration in her mental health following detention at Yarl's Wood. She clearly associates aspects of her detention with her detention in X. This*

*provoked distressing intrusive memories. (…) For the above reasons her continued detention presents a high risk of further deterioration in her mental state including increasing suicidal thoughts. (….)*

*At nearly 28 weeks gestation X's persistent low abdominal pain and the uncertainty about the diagnosis must be considered a contraindication to flying unless a specialist assessment can provide assurance that she is not at increased risk of premature labour.'*

In another case, a woman from sub Saharan Africa who claimed asylum on the basis of political persecution and disclosed her history of rape and torture that came as a result of her political activities, had been receiving rehabilitation treatment for two years prior to her detention. In detention, she reported a loss of appetite, low mood and insomnia. The independent doctor explained:

*'We believe that continued detention is proving detrimental to our client's wellbeing… We are concerned that continued detention is adversely affecting the chronic mental health conditions, post traumatic stress disorder and clinical depression, for which she has been receiving rehabilitation treatment … We are also concerned that interruption of this treatment will adversely affect the prognosis for her recovery.'*

In six cases, independent doctors stated that in their clinical opinion, women were not fit to be detained. In all cases, this was owing to deteriorating mental health and the need for specialist support and intervention in a therapeutic environment. For example, one doctor stated, *'Mrs X in my expert opinion is not fit to be in detention. She is acutely mentally unwell…'*

In another case, the doctor wrote:

*'Since her detention in Yarl's Wood, the stress of the situation along with her worries about the future, including her welfare and that of her unborn child, her anxiety symptoms have deteriorated.'*

In the majority of cases, the independent doctor following an assessment, found 13 of the women unfit to fly. Concern was also expressed in a further three women's cases that forced removal would worsen existing mental health conditions and/or create a suicide risk.

The reasons for women being not fit to fly, as noted by frequency of concern:

- ▷ Woman required a scan and/or specialist assessment (5)
- ▷ Malaria prophylaxis was contraindicated (8)
- ▷ Not enough time to establish tolerance to malaria prophylaxis (5)
- ▷ HIV (1) – (patient had not received 3 months' supply of ARVs or had blood tests to check her viral load)
- ▷ Other vaccines for safe return not administered as per guidance (1)

Thus, in most cases where there was a concern over fitness to fly, the concern related to anti-malarial medication. This was for one of two reasons. Chemoprophylaxis had not been prescribed within the requisite timeframe to allow the woman to develop tolerance prior to removal; or the prescribed medication was contraindicated either owing to mental health issues and/or the pregnancy being in the first trimester. As outlined in one letter of concern about a woman who was prescribed mefloquine: '*There appears to be no safe malaria prophylaxis for a depressed pregnant person considering flying to a chloroquine resistant area.*' In these cases, the doctors found that there was no safe way to return these women. The issue of malaria prophylaxis will be discussed in the following chapter.

In five cases, the independent doctor stressed that owing to issues relating to the women's pregnancy, they required specialist assessments and/or scans prior to removal to ensure the safety of the unborn child. The majority of these cases (4) were high risk pregnancies. This included twin pregnancies and histories of ectopic pregnancies and/or miscarriages.

Hypertension and diabetes are also conditions that make pregnancies high risk. For example, one Medical Justice doctor identified a high risk pregnancy and wrote:

*'…twin pregnancy, previous placental abruption, hyperthyroidism and hypertension are all risk factors for a further placental abruption, miscarriage, premature labour, pre-eclampsia and other complications. The additional stress caused by her detention is making it difficult for Ms X to follow her midwife's advice. She is yet to receive a specialist assessment to the effect that she is fit to fly. Unless a specialist obstetrician is able to provide assurance to the contrary, in view of her multiple risks of life-threatening complications it must be considered unsafe for her to fly.'*

In another case, the poor obstetric history of one woman provoked concern:

*'In view of X's history of ectopic pregnancy and miscarriage she cannot safely embark on a long flight until she has had a scan to confirm a normal intrauterine pregnancy.'*

In a final case, a woman reported to the independent doctor her history of miscarriages and bleeding during detention. The doctor wrote:

*'She tells me that she hasn't had a scan. A scan is needed to exclude an ectopic pregnancy and to establish the viability of the pregnancy before she can safely embark on a long flight particularly in view of the history she gives of two early miscarriages in the past.'*

Breaches of the British HIV Association (BHIVA) guidelines on the removal of individuals with HIV was noted in one case. The independent doctor concluded that the woman was not fit to fly on the basis that she had not received 3 months' supply of ARVs, and would also require blood

tests to check her viral load before removal. The doctor concluded that: *'It is vital that these checks are done to ensure that the baby does not become infected with the HIV virus.'*

Across the medical letters reviewed, a stark theme that emerged was that in the majority (18) of these cases, independent doctors expressed concern about the quality of healthcare the women had received. Whilst in some cases, as noted above, these concerns led to a conclusion that a woman was unfit for detention and/or unfit to fly, in others it simply highlighted areas of clinical concern and/ or mismanagement. The frequency of their concerns is noted in the table below:

| Concerns around quality of care | |
|---|---|
| **Inappropriate malaria prophylaxis prescription (contraindications)** | 8 |
| **Scans & specialist assessments needed, eg to investigate pain/ bleeding** | 7 |
| **Malaria prophylaxis prescribed too late to establish tolerance** | 5 |
| **Failure to do full STI screen, despite rape disclosure/ positive Hepatitis C test** | 4 |
| **Problems around information and consent** | 2 |
| **Inadequacies in mental health care** | 2 |
| **Record keeping/ handheld notes** | 2 |
| **Diet and nutrition** | 2 |
| **Other issues** | 5 |

Concerns over mental healthcare related to two women, one of whom had been diagnosed with PTSD and required specialist assessment, and the other who had been referred for counselling but had not yet received it. In a further two cases, the Medical Justice doctor highlighted the patients' concerns that they did not hold their handheld maternity notes.

Medical Justice doctors also commented on the absence of any discussion about informed consent and inadequate interpreting facilities. In one case involving a woman who suffered from depression and was prescribed mefloquine, the independent doctor wrote: '*There is no documentation of a careful discussion about the risk and benefits of Mefloquine treatment.*' Indeed, this is consistent with our data findings, as reported in the section on malaria prophylaxis.

In two cases, the doctor highlighted concerns around the diet in the detention centre. For example, one letter outlined:

> *'X is experiencing significant physical discomfort in the detention centre from inability to cook food she finds palatable while nauseous, discomfort in her clothes and back pain in the small detention centre bed.'*

Aside from malaria prophylaxis, two letters outlined that inappropriate drugs had been prescribed. For example: '*It is not clear why X has been given erythromycin as she has no known penicillin allergy*'; or in another case, '*Kalms is not in the British National Formulary. Boots pharmacy website advises 'Do not take if you are pregnant or breast-feeding'.*[99] *Valerian root, an active ingredient in Kalms, has not been approved for safety in pregnancy.*'

Other concerns noted included the following:

- Mismanagement of blood pressure
- Planned removal without 3 months' supply of ARVs
- Inadequate Rule 35 report and response
- Discontinuous care
- The threat of force being used

| | Reason for Detention | Frequency |
|---|---|---|
| **Main Reasons:** | Your removal from the United Kingdom is imminent | 16 |
| | You are likely to abscond if given temporary admission or release | 8 |
| **Sub Reasons:** | You have not produced satisfactory evidence of your identity, nationality or lawful basis to be in the UK | 11 |
| | You have previously failed or refused to leave the UK when required to do so | 9 |
| | You do not have enough close ties (eg family or friends) to make it likely that you will stay in one place | 8 |
| | You have previously failed to comply with conditions of your stay, temporary admission or release | 6 |
| | You have used, or attempted to use, deception in a way that leads us to consider you may continue to deceive | 6 |
| | You have previously absconded | 4 |
| | You have failed to give satisfactory or reliable answers to an Immigration Officer's enquiries | 4 |

## (d) Data from the immigration files

### Reasons for Detention

Researchers reviewed the reasons for the initial detention of pregnant women in the sample. When justifying detention, caseowners select from a checklist, the main and sub reasons applicable for any given individual. For the women in this sample, the following reasons were given.[100] (Only reasons with a frequency greater than two have been included in the table on the previous page).

In 16 cases, the main reason for women's detention was that "removal is imminent". However, only two women left the UK.

In one case, a woman was detained with the main reason being that her removal was imminent. She was held in detention for six weeks and released on temporary admission. She never received removal directions whilst held in detention. In another case where this was a primary reason for detention, the woman never received removal directions because her caseowner could not secure her a travel document.

In only three cases, "removal is imminent" was not cited as a reason for detention: in two of these cases, removal directions were never set and the third was a third country case where a removal was attempted and failed.

In eight cases, the lack of close ties was cited as a sub reason for detention. However, six of these women had the father of their babies in the UK. The remaining two women had ties in the form of friends or NGO support.

In nine Subject Access Request (SAR) files, IS91RA detention risk assessment forms were available. In four of these cases, the forms did not mention pregnancy – although in one case, the woman was not pregnant on entry into detention. In the remaining cases, the number of weeks of the pregnancy is noted together with any other associated risks, including bleeding, morning sickness, hospital appointments and being on 'raised awareness'.

The reasons why detention remained appropriate according to Home Office casowners were also investigated. The SAR files were often lacking this information altogether and in the majority of case files monthly detention reviews were not available. The researchers therefore additionally relied upon either the monthly progress reports to detainees and/or the caseowners' own notes for their weekly reviews, where available.

Pregnancy was found to be mentioned in the detention reviews or progress reports in only six cases. However, there appeared to be no factoring in of the pregnancy even if it was mentioned but merely stated the number of weeks pregnant the woman was and a statement such as removal was still imminent.

The failure to have detention reviews in the SAR files and the failure to mention pregnancy in those reviews that were available raise a concern about whether pregnancy is properly considered as part of the decision to maintain detention.

The reasons for maintaining detention instead remained standardised, ordinarily linked to the original reasons for detention. Additional reasons were also mentioned as time progressed and these included the following:

- Pending the outcome of appeal/ judicial review/ rule 35/ other immigration applications;
- To pursue Emergency Travel Document revalidation;
- Removal remained imminent and there were no barriers to effecting removal; and
- The woman remains fit for detention.

One woman who was detained when she was just over seven weeks pregnant and was held for three months in Yarl's Wood, ended up being released to go to Bedford Hospital Accident and Emergency, where she subsequently had a miscarriage. She had a poor obstetric history having suffered two miscarriages in the past. The main reasons for her detention was that her removal was imminent and that she was likely to abscond. On the first day of her detention an IS91RA risk assessment form was completed and stated, '*Sub claims to have had a miscarriage. Sub claims to be pregnant. Sub claims to be bleeding and is worried about this.*'

The internal detention reviews subsequently noted the following:

- 24 hour review: "7-8 wks pregnant, went to A & E with bleeding who stated she was fit to travel and required obstetric follow up. Her health concerns are not deemed an impediment to her removal."
- 7 day review: "8 wks pregnant, had bleeding, considered fit to fly, prescribed AMP. Continued detention appropriate to effect XX Removal and monitoring of Pregnancy"
- 14 day review: "Healthcare team at IRC are content for continued detention"
- 21 day review: "Maintain detention while injunction is considered".

Six days after the 21 day review she was rushed to hospital where she miscarried. The Home Office then granted her Temporary Admission (TA).

### Removals

16 of the 20 women in the sample received removal directions whilst held in detention. Two of these removals were successful: one woman was forcibly returned and the other flew under the Assisted Voluntary Return (AVR) scheme.

Thus, 14 women received removal directions but none of them were returned: of these women, 11 received multiple removal directions. One woman received a total of 8 removal directions, all of which were cancelled for a variety of reasons.

There were multiple reasons why removals were cancelled, some in advance, others on the day of the flight. As a result, a minimum of 39 flights were missed. Relying on the estimation of costs per flight of £900,[101] this amounts to a minimum of £35,000 wasted on the failed removals of the 14 women whose flights were booked but were never returned. For the women in this sample, it was common for them to be removed with four escorts and one medical escort accompanying them. This would undoubtedly push the costs up.

The table below outlines the reasons why removal directions were cancelled, as documented in the Subject Access Request file:

| Reason for failed removal | Frequency |
|---|---|
| **Judicial Review application lodged / pre-action letter sent** | 8 |
| **Woman refused to leave Yarl's Wood** | 7 |
| **Escorts refused to do the job** | 6 |
| **Woman found unfit to fly** | 5 |
| **Captain/airline manager refused to take lady** | 3 |
| **Woman taken to hospital en route** | 2 |
| **Asylum application made** | 2 |
| **Other[102]** | 5 |
| **Unknown** | 1 |

Whilst the most common reason for flights being stopped was a judicial review application, other frequent reasons were either the woman refusing to leave Yarl's Wood or the escorts refusing to do the job. In both instances, this often related to the use of force. Without authorisation to use force on pregnant women, it was documented that escort officers would abandon the job simply on the basis that the women was protesting about leaving or was complaining about abdominal pains. However, in one case, the use of force was authorised but the escorts still stopped the job. The following was documented in the Case Records Notes:

> *'As the subject was very disruptive during removal and even though the use of force was authorised, removal directions had to be cancelled as subject is heavily pregnant and* ***any further use of force would put the baby in further danger.'*** (Emphasis added)

The G4S escorts abandoned the job and took the woman to Bedford Hospital for a scan to check on the health of the baby.

In many cases a failed removal is justified on the basis that force could not be used. For example, this was commonly noted in the case records sheet: '*X refused to leave the IRC as she was pregnant and no authority for force had been granted, the job was aborted.*'

An analysis of the reasons given for cancelling removal directions shows the frequently used and incorrect terms of *"Subject became disruptive"* and *"Subject refused to leave Yarl's Wood"* (the word disruptive employed to describe a woman's refusal to be moved). These terms were often used to describe failed removals and to justify the future application for the authorisation of the use of force on pregnant women.

For example, in the case of one woman the following was noted in her immigration factual summary regarding one failed removal attempt: "*Subject refused to leave Yarl's Wood IRC*". However, the internal case records sheet note for the same failed flight documented a different reason: the woman suffered an anxiety attack, having witnessed a fellow deportee self-harming in the centre immediately prior to her removal, and the medic subsequently found her not fit to fly. The records state: "*the medic on the flight confirmed the subject was unfit to fly even though the subject had been seen by the GP and midwife at Yarl's Wood*". Following that incident, and relying on the incorrect reason that the woman refused to leave the IRC, the caseowner made and secured authorisation for the use of force on this woman for her next removal. In another case where this same reason was documented, closer investigation revealed it was because the woman was taken to hospital with abdominal pains.

Examples of incorrect and indeed dishonest reasons were further noted by the researchers. In one case, the SAR file showed an application and an approval for the use of force to be used on the woman. The case records sheets contained the following entry: *"We have now received an email from X advising on the authority to use minimal force"*. Women are usually informed when this authorisation has been successful and as a result this woman contacted her MP to ask him to intervene and stop the authorisation to use force on her. The MP wrote to the UKBA requesting this. An Assistant Director of UKBA cancelled the authorisation to use force and wrote back to the MP stating that no such authorisation had ever been given. He wrote: '*I have been assured that there has been no authorisation whatsoever, to use physical force or restraint on Ms X during her proposed removal.*' Details are shown in the scan on p33.

There were also three instances documented whereby the captain of the plane (2) and the airline manager (1) refused to let the pregnant woman on the flight. In one such case, the following was noted: "*Subject refused to leave G4S van to board flight. Airline flight manager witnessing this refused*

Submission for authority to use force on subject to remove updated and sent to RD [redacted] for comments and to forward to Alan Kittle , Director , Detention Services. Also copy of letter from Tom Blenkinsopp MP (Middlesbrough & East Cleveland) dated [redacted] received from OSCU. This was forwarded to Sharon Chambers to consider (She has already been in contact with the MP on [redacted] and resolved the barrier.) Copy on file

In addition we have now received an e-mail from [redacted] advising of authority to use minimal force (subject to various arrangement and processes being put in place. Copy on file.

Action: Liaise with Regional Director's Office / [redacted] office and start removal arrangements

[redacted] Unit:- *TEU/TEU* Date:- [redacted]

E-mail received from [redacted] She considers the MPs letters have been addressed and this has been resolved. (Copy of e-mail on file). She has spoken to the MP and confirmed a response to the letter of [redacted] was not required by the MP.

In the circumstances I consider that there are currently no legal barriers to removal. We have authority from [redacted] Director of Detention Services giving his authority for use of force. I have spoken to [redacted] of Regional Director's Office , Sheffield. She is aware of the situation regarding authority for use of force and resolution of the MPs barrier. She is haoppy for us to proceed with removal.

Mp wrote to MP Account Manager. See below.
I contacted [redacted] seeking a response. [redacted] confirmed by email that subject was presented with removal directions 18/10 and contents were explained, at no point during this time was she told that UK Border Agency had authorised for physical force or restrains be used for her removal from the UK.

See email reply to Tom Blenkinsops office below.

From: [redacted]
Sent: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted]

[redacted]

I have been assured that there has been no authorisation whatsoever, to use physical force or restraint on [redacted] during her proposed removal. I cannot comment on the article you attached as the UK Border Agency made a statement when it was published. Additionally I am unable to respond to the issues raised by [redacted] in his further email.
Kind regards,

[redacted]
Assistant Director|MP Account Manager|North East, Yorkshire & the Humber Region|UK Border

*to carry subject*". In another case where the captain refused to take the woman on board, this was on the basis that UKBA had provided incorrect information about the stage of the woman's pregnancy stating she was seven weeks pregnant (rather than 26 weeks pregnant) and because of the following documented reason:

> *"Medic stated that the captain of the plane refused to take her because of her complaints of not feeling well. Resident was reported to have L/O abdo pains, distress and anxiety. BP stared from 130/80 to 170/90 with racing pulse of about 124bpm".*

In total, the case records sheets show that in five of the 16 cases, an application for the use of force was made. The one and only successful forced removal involved the use of force.

## Julia

Julia had a history of ectopic pregnancy and a miscarriage. At 13 weeks, despite not having an initial scan to confirm a normal intrauterine pregnancy, she was removed. In addition, force was used in this removal. Upon return to her home country, she ended up having a stillbirth.

Julia had been warned that force was likely to be used on her to ensure she left the UK. An independent Medical Justice doctor wrote the following letter of concern, shortly before her upcoming flight:

> *'I am concerned that X believes that restraint and force may be used during removal and I would be grateful if UKBA could confirm to X that this is not the case, especially in view of the risk of injury and miscarriage which could result… In view of X's history of ectopic pregnancy and miscarriage she cannot safely embark on a long flight until she has had a scan to confirm a normal intrauterine pregnancy.'*

On the day of her removal, she was found naked on her bed, holding a tin lid threatening to self-harm. The healthcare notes state that she was given the opportunity to walk independently but was not compliant. The tin lid was subsequently removed and three officers attempted to restrain her; it is reported that she began kicking out so a forth officer came to further restrain her.

Julia was then handcuffed and transferred to a wheelchair to reception. She had self-harmed and a superficial cut to her wrist from the tin lid was noted. The medical escort was satisfied with all observations, finding her fit to fly. She was subsequently taken to the airport and forcibly removed to her home country where she later suffered a stillbirth.

During the case of *R on the application of Chen and Others v SSHD CO/1119/2013*, the Royal College of Midwives (RCM) submitted a statement, explaining the clinical reasons why UKBA must end the dangerous use of force:

> *'7. (…)*
>
> *(iii) Those who carry out restraint must have a thorough understanding of the changed physiology that impact on the physical changes and specific pregnancy related conditions such as, the softening of the ligaments and fragility of the musculo-skeletal system. Therefore, confining/placing the woman in a particular position can cause damage to any of her joints, spine due to over extension of ligaments, spinal injuries or fractures.*
>
> *(iv) Pressure on her chest /body could restrict her breathing as the growing uterus in the later pregnancy restricts the ability of the diaphragm to expand the lungs thus affecting oxygen supply to the fetus.*
>
> *(v) Compression on her abdomen can cause her to vomit and put her at high risk of aspiration of the stomach contents – induced Mendelsohn syndrome or aspiration pneumonia. A known cause of maternal death.*
>
> *(vi) Trauma to the abdomen can cause placental abruption – separation of the placenta which is a life threatening condition for both mother and fetus, where in some instances the bleeding is concealed. This imperils the lives of both mother and child.*
>
> *(vii) The practice of restraining pregnant women is stressful and can increase the blood pressure level in a pregnant woman. A raised blood pressure in pregnant women can induce fits. A known cause of maternal death.*
>
> *(viii) Pregnant women have a variety of vulnerabilities and restraining can lead to miscarriages, premature labours, still births or the onset of a serious illness.*
>
> *8. These factors have the potential to result in maternal and fetal mortality as well as poor pregnancy and neonatal outcomes (…)'*

Following the *Chen* case, UKBA re-published a policy prohibiting the use of force on pregnant women and children save for where it is absolutely necessary to prevent harm. Sadly, this was not the policy applied in the case of Julia.

## Fitness to Fly

Whereas the independent doctors found 13 women to be unfit to fly, in only three cases did an IRC doctor find a woman unfit to fly. In addition, some women were also found to be unfit to fly by doctors at Bedford Hospital (1) and also by medical escorts (2) during forced removals.

In one of the three cases where a woman was found to not be fit to fly by an IRC doctor, this was on the basis of having a history of two miscarriages in the past ten months. However, two days later, a different IRC doctor found this same woman to be fit to fly.

There were cases of conflicting assessments of a pregnant woman's fitness to fly. For example, one woman had a poor obstetric history, reported several gynaecological problems and had high blood pressure. The day before her planned removal, the case record sheet states:

> '*Healthcare has confirmed by telephone subject is fit to fly, does not have high blood pressure and the midwife considers her suitable not to be seen for another 4 weeks.*'

By comparison, on the day of the failed removal, the following is instead noted:

> *'G4S overseas contacted CCU at 22.10 to inform/update that the paramedic had deemed the subject unfit to fly. This is due to having high blood pressure when flying, pregnancy and previous medical history.'*

In cases where women were held late in their pregnancy, there was an emphasis in the case record sheet notes on the need for a speedy removal. For example, in one case, the following is noted: '*Call made to caseowners to advise that this female is currently 28 weeks pregnant. At this stage of pregnancy we would strongly recommend that RDs are set at the earliest opportunity.*'

A variety of airlines were planned to be used for the forced removal of pregnant women in the sample. Removal directions were booked on the following airlines – only those used on more than one occasion are listed:

| Airlines | Number of times documented as used |
|---|---|
| **Kenya Airways** | 5 |
| **Virgin** | 5 |
| **Charter flights** | 3 |
| **Ethiopian Air** | 2 |

Following a failed removal of one of the pregnant women in the sample, it was noted that the captain of the plane had refused to take the woman, as noted earlier. The caseowner made the following commentary: "*This is interesting as on a previous failed removal, it was requested a stronger airline be used, but ET were still used as the Port had insisted they had a good relationship with the airline and they did not see any problems in her travelling with them*". This text indicates that the Home Office/ UKBA have relationships with certain airlines to ensure the forced removal of people.

## Release from detention

18 of the 20 women were released back into the community with only one being forcibly removed and the other opting for Assisted Voluntary Return. Based on the data available and at the time of writing, all 18 still have their claims pending; none have committed a criminal offence following their release; and none have absconded.

Following release, ordinarily the women are subject to reporting restrictions. Typically, for women in the sample, this was either weekly or fortnightly reporting. At the point at which the women become heavily pregnant, reporting is paused until the birth of the child.

Most women who were released stayed in the address they were released to until after the birth of their child. However, there were some women who moved two to three times following their release, often because they were dispersed to hotel/ hostel temporary accommodation that was time limited.

# Chapter Seven – Malaria Prophylaxis

This section will begin by outlining background information and policy requirements regarding malaria prophylaxis. It will then go on to present that data on who in the sample required malaria prophylaxis; who was prescribed it; whether the medication was contraindicated, i.e. whether it indicated the inadvisability of such course of treatment; and whether informed consent around the choice of medication was documented.

## Background and Policy

During pregnancy, it is agreed by most reputable health organisations that all but essential travel to malarial areas should be avoided during pregnancy. For example, the Health Protection Agency notes:

> *'Pregnant women are advised to avoid travel to malarious areas…. Pregnant women have an increased risk of developing severe malaria and a higher risk of fatality compared to non-pregnant women.'*[103]

According to Home Office policy, pregnant women who are to be deported to countries where there is a risk of malaria should be given malaria prophylaxis. This is because people who have been away from their countries of origin may have suffered a decline in their immunity and so may be at risk of contracting a malarial infection upon return – pregnant women and small children are at greater risk of contracting the disease.

The Immigration Directorates' Instruction (IDI), Chapter 1, Section 8, outlines Home Office policy on malaria prophylaxis.[104] See the Annex for more information. The following are the key points:

- Pregnant women are at risk and require malaria prophylaxis (5.3)
- Patients should receive information and advice about malaria prophylaxis (5.6)
- Caseworkers should consult healthcare about malaria prophylaxis and its time lags prior to setting removal directions (RDs) (5.6)
- Malaria prophylaxis should be prescribed in time to establish tolerance (5.7)
- Specialist advice should be offered where there are contraindications (5.7)
- Removal need not be deferred where detainees decline anti-malarial medication (5.7)

The appendix of the IDI contains advice from the Advisory Committee on Malaria Prevention in UK travellers (ACMP). The important guidance around drug safety and timing for pregnant women are as follows:

- Doxycycline is not an appropriate prophylactic for pregnant women or children under 12 years.
- Following consultation with an expert, Mefloquine may be considered for use even in the first trimester of pregnancy.
- Chloroquine /Proguanil (C+P) is safe for use in the first trimester, however… it is now not appropriate in many areas of the world, particularly in sub-Saharan Africa.
- Mefloquine is probably safe to coadminister while the clinical significance of co-administering chloroquine/ proguanil with anti-retrovirals is unclear.
- Mefloquine is generally started with a 2-3 week window usually to determine tolerance if it has not been used before.
- Specialist advice should be provided for pregnant women and those with medical conditions. The Home Office may wish to contract out this advice and prescription to a single clinic/centre for consistent advice.

### Women's requirement for malaria prophylaxis

13 out of the 20 women required malaria prophylaxis but in total 15 were in fact prescribed it.[105] (In one case, healthcare realised in time and did not end up dispensing the drug). The remaining women did not require it and were not prescribed it.

### Choice of Malaria Prophylaxis for Pregnant Women

Recommended malaria prophylaxis is based on the following factors:

- the risk of contracting malaria in the destination country
- the principal species of malaria parasites in the area
- the level and spread of drug resistance reported in the country
- the possible risk of serious side-effects resulting from the use of various prophylactic drugs.

The chart overleaf is taken from the IDI Section 5.11 and lays out the different degrees of malaria risk and the suitable types of prevention.

All of the women who required prophylaxis (13) were from countries where there is a high risk of chloroquine-resistant Plasmodium falciparum malaria. Plasmodium falciparum accounts for the majority of malaria deaths worldwide.

Health Protection Agency (HPA) guidance stresses that pregnant women should avoid travel to such high risk areas:

## From the Home Office IDI Section 5.11

| | Malaria risk | Type of prevention |
|---|---|---|
| **Type I** | Very limited risk of malaria transmission | Mosquito bite prevention only |
| **Type II** | Risk of *P. vivax* malaria or fully chloroquine-sensitive *P. falciparum* only | Mosquito bite prevention plus chloroquine chemoprophylaxis |
| **Type III** | Risk of malaria transmission and emerging chloroquine resistance | Mosquito bite prevention plus chloroquine+proguanil chemoprophylaxis |
| **Type IV** | High risk of falciparum malaria plus drug resistance, or moderate/low risk falciparum malaria but high drug resistance | Mosquito bite prevention plus either mefloquine, doxycycline or atovaquone/proguanil (take one for which no resistance is reported in the specific areas to be visited) |

*'Pregnant women should be advised against travel to an area with malaria, particularly if there is chloroquine resistant Plasmodium falciparum.'*[106]

The only effective malarial prophylaxis for women returning to an area at high risk of chloroquine resistant falciparum malaria is Mefloquine (Larium), a drug produced by the company Roche. Its use in pregnancy is contentious. The Roche 2009 Patient Information Leaflet explicitly states that, '*Pregnant women should not normally take these tablets*.'

The National Travel Health Network and Centre (NaTHNaC) produced a Health Information Sheet in July 2009 on the use of mefloquine in pregnancy that reviewed the literature and guidance on its usage. It refers to the Summary of Product Characteristics (SPC) Lariam® (mefloquine) UK, and notes that:

*'Mefloquine use in pregnancy is unlicensed. The SPC for Lariam® states that 'there is too little clinical experience in humans to assess any possible damaging effects of Lariam during pregnancy'. It recommends that 'Lariam should be used in pregnancy only if there are compelling medical reasons. In the absence of clinical experience, prophylactic use during pregnancy should be avoided as a matter of principle'.*

In its conclusion it stresses the need for caution, seeking expert advice and securing informed consent:

*'Pregnant women planning to travel to areas with chloroquine resistant P. falciparum malaria should always be advised that such areas are not suitable destinations. (…)*

*The risk of adverse events of mefloquine use during pregnancy needs to be balanced against the risk of contracting malaria and the possible complications to both mother and foetus. The decision on whether or not to recommend mefloquine should be carefully discussed with the traveller. (…) Expert advice should be sought for pregnant women who have other medical contraindications to the use of mefloquine'.*

### Mefloquine in the first trimester of pregnancy

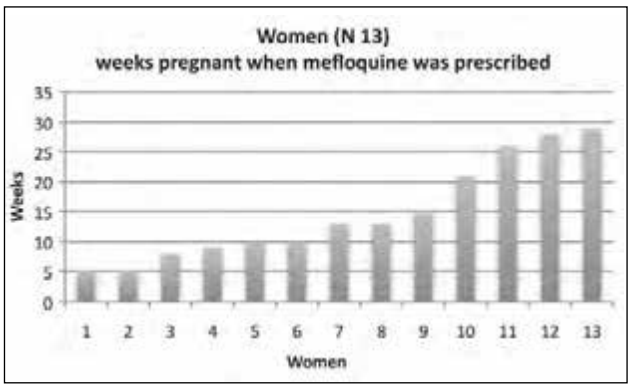
It is generally accepted that there is no strong association between mefloquine and miscarriage and stillbirth in the second and third trimesters; however, insufficient data on its use in the first trimester has encouraged caution.[107] The IDI lists *'early pregnancy'* as one of the main contraindications to the use of mefloquine.

The World Health Organisation (WHO) recommends that '*mefloquine prophylaxis may be given during the second and third trimesters but there is limited information on its safety during the first trimester.*'[108] NHS choices on malaria prophylaxis in pregnancy advise that '*Mefloquine should not be taken during your first trimester (the first 12 weeks of pregnancy)*.'[109]

The Health Information Sheet by NaTHNaC (2009) summarised the data around the use of mefloquine in the first trimester, still with an emphasis on the use of caution:

> *'Most experts recommend that mefloquine is avoided during the first trimester; but can be offered to women during the second and third trimesters. However, if travel during first trimester cannot be avoided, then mefloquine can be considered following expert consultation.*
>
> *The risk of adverse events of mefloquine use during pregnancy needs to be balanced against the risk of contracting malaria and the possible complications to both mother and foetus. The decision on whether or not to recommend mefloquine should be carefully discussed with the traveller'.* [110]

Despite this, six of the thirteen women requiring malarial prophylaxis were prescribed mefloquine in the first trimester. The chart below shows the gestation in weeks when the women who required malaria prophylaxis were prescribed them.




The IDI annex contains advice from the Advisory Committee on Malaria Prevention in UK travellers. Whilst mefloquine in the first trimester is not in general recommended, the Committee advises that, '*After expert consultation, Mefloquine may be considered for use even in the first trimester of pregnancy*'.

However, in no instances was there documentation of any form of expert consultation about this. In addition, as will be discussed later, there was almost no documentation relating to information given to patients or informed consent.

## Establishing a window of tolerance

For malarial propylaxis to work, it should be commenced prior to travel. Home Office policy as noted in the IDI states:

> *'5.7 (…)Any malaria prophylaxis recommended as appropriate by the removal centre medical staff for pregnant women and children under 5 should normally be provided and time allowed for it to take effect before removal.'*

There is widespread agreement amongst healthcare guidance sources that mefloquine treatment should be started two to three weeks prior to travel. For example:

- NaTHNaC: '*Mefloquine is ideally begun 2 - 3 weeks before departure to reach effective blood levels, and evaluate for adverse effects. This is particularly important for first time users*' [111]
- HPA: '*Weekly dosage, starting 2-3 weeks before entering a malarious area to assess tolerability*' [112]
- NHS: '*If you have not taken mefloquine before, it is recommended that you do a three-week trial before you travel to see whether you develop any side effects.*' [113]

Only the drug company itself, Roche, advise a smaller time lag:

> *'You should start taking the tablets at least 1 week and up to 2-3 weeks before departure'.* [114]

Home Office policy takes its lead from the Advisory Committee on Malaria Prevention in UK travellers (ACMP) and states in paragraph 5.8 of the IDI:

> *'It should be noted that para 4.8 of the ACMP advice states that "Mefloquine [also known as Larium] is generally started with a 2-3 week window usually to determine tolerance if it has not been used before".'*

The results of the data show that of all those who had required malaria prophylaxis (13), three in fact never even received removal directions. Of the remaining ten, none of them were given the medication in time to establish tolerance prior to their first set of removal directions. Of these:

- 4 did not receive any malaria prophylaxis prior to intended date of travel
- 2 received it only one and two days prior to intended date of travel
- 3 received it six to eight days prior to intended date of travel
- 1 received it twelve days prior to intended date of travel

In all of the cases there was therefore a policy breach in relation to establishing tolerance. Paragraph 5.6 of Section 8 of Chapter 1 of the IDI makes clear that '*removal directions may be set but should be dependent on any pre-departure element of such treatment being completed*'. Where anti malarials are considered to be required by healthcare staff, '*removal directions may be set but for a date after the treatment is completed.*'

The data shows that there was a lack of communication between Home Office caseowners and healthcare staff about requirements for malaria prophylaxis. This is why three people who had never been set removal directions were nonetheless prescribed mefloquine. In addition, it explains how in all the remaining case, healthcare staff did not prescribe mefloquine in the required timeframe in which to establish tolerance, prior to the caseowner setting of the first removal directions.

Paragraph 5.6 of the IDI states:

> *'Caseworkers and those responsible for setting removal directions should consult the health care professionals, via the IND team at the centre, on the appropriate minimum time lag between administering medication and removal taking place.'*
>
> *(…) Where removal centre medical staff consider that preventive treatment is necessary and can be completed (subject to para 5.7 below) without delay to planned removal, removal directions may be set but for a date after the treatment is completed.'*

However, in none of the cases, did this appear to have been done.

The failure to allow time to establish tolerance led independent doctors to find patients unfit to fly. For example, in one case the independent doctor points out that it is not safe to return the woman to her country of origin because not only is the malaria prophylaxis prescribed inappropriate (the lady was in her first trimester), but also it was not prescribed in the time necessary to allow for tolerance to be established. In addition, the doctor highlighted that this went against the Home Office's own guidance:

> *'Clearly there is considerable concern about the use of mefloquine in the first trimester. The IDI and HPA both recommend that it is avoided at this time. … mefloquine needs to be given 2 and a half weeks prior to travel to establish tolerance and to reach effective blood levels… The IDI states that 3 weeks should be allowed between starting the drug and removal….'*

## Mefloquine and neuropsychiatric disorders

Experts and Roche agree that mefloquine should be avoided in those with mental health disorders. For example, the HPA warns that:

> *'Mefloquine prophylaxis is contraindicated in those with a current or previous history of depression, neuropsychiatric disorders or epilepsy; or with hypersensitivity to quinine.'* [115]

The NHS stresses caution around any prescription to someone with psychiatric problems:

> *'Your prescriber may only prescribe this medicine with special care or may not prescribe it at all if you...have or have had psychiatric problems such as depression.'* [116]

Roche itself warns that it simply should not be taken in such scenarios:

> *'You should not take Larium (Mefloquine) if...you have a history of psychiatric illness, mental complaints or severe changes of mood (such as depression)….'* [117]

Despite this, eight out of the thirteen women requiring malarial prophylaxis had a history of and/or currently had mental health conditions.

## Mental Health of eight women prescribed mefloquine

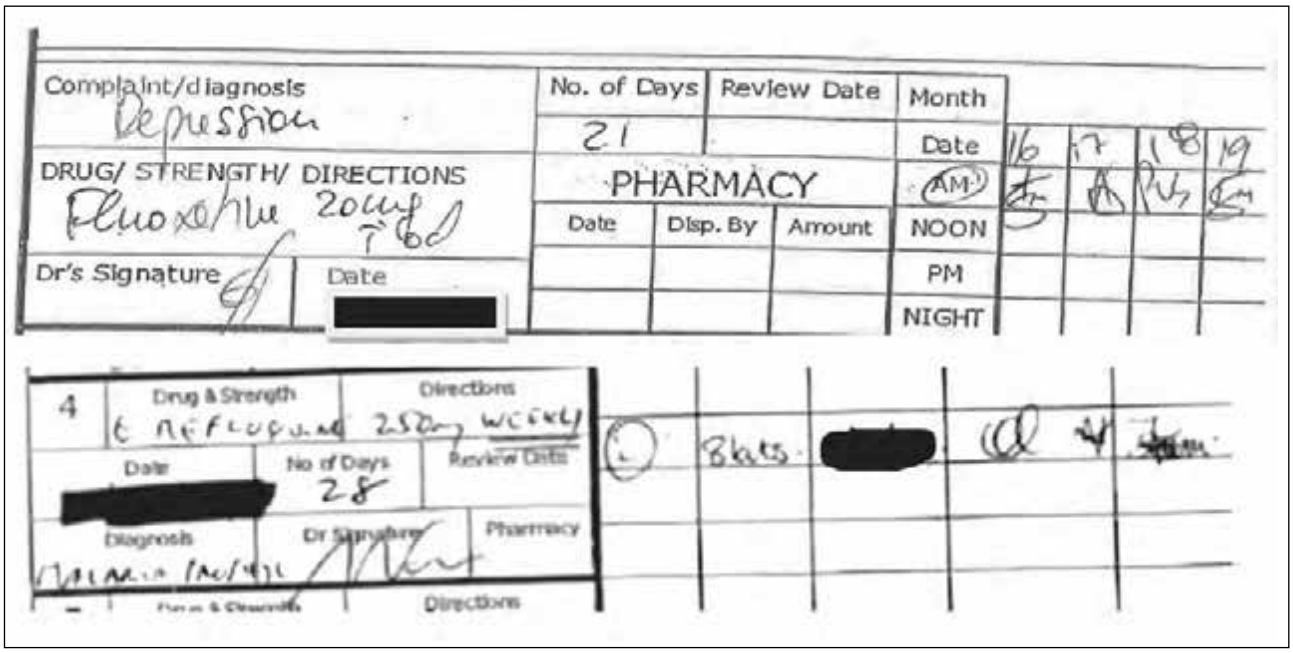
| | |
|---|---|
| 1. | Current: PTSD |
| 2. | History: PTSD, depression, suicide attempt<br>Current: Depression, on anti-depressants, on raised awareness |
| 3. | Current: Low mood, suicidal ideation, on ACDT |
| 4. | History: depression, on anti-depressants, counseling |
| 5. | Current: Moderate to severe depression |
| 6. | Current: Moderate to severe depression |
| 7. | History: depression, on anti-depressants<br>Current: 'low mood', 'self-harm and suicidal ideation', 'tearfulness', 'auditory hallucinations', persistent depression', on Raised Awareness, referred for counseling, started anti-depressants. |
| 8. | Current: On raised awareness and overdosed on Mefloquine |

A ninth woman who had experienced trauma during the previous five years, suffered an acute psychotic illness shortly after taking mefloquine. In the opinion of a Medical Justice independent consultant psychiatrist this case met '*the DSM IV Criteria for substance induced psychotic disorder, where medication is aetiologically related to the diagnosis'.* NaTHNaC in fact warns in its guidance that it, '*May cause neuro-psychiatric adverse events'.* [118] Refer to the case example of Aliya for further information.

Despite histories or current episodes of mental health disorders, mefloquine was regularly prescribed. In some cases, diagnoses of mental health problems were noted by the independent doctor but not by IRC staff. In such cases, a thorough examination should have been conducted prior to any prescription in order to appropriately prescribe (or not prescribe) a drug that would be contraindicated.

In one case, a woman with a known history of depression as well as repeated documentation about her current mental health, including self-harm and suicidal ideation, was prescribed mefloquine. The healthcare notes show that staff had a number of communications with her convincing her to take it but she refused. In one instance, the notes state: *'....fully aware of the benefits but declines to have it as feels it is unsafe for her pregnancy.'* The independent doctor who visited her in detention wrote in her report:

> *'I am very concerned that X has clearly documented previous depression which is ongoing with recent self harm. She is again on anti depressants for this. Mefloquine as detailed above is absolutely contraindicated in this situation because of the danger of exacerbation of her depression...'*




The scan above details a prescription chart for one lady with a history of and current depression. She had been prescribed fluoxetine, an anti-depressant, and just a week later, prescribed mefloquine.

In another case, a woman with documented mental health issues was found unfit to fly by an independent doctor because of her mental health status and because she was in the first trimester of her pregnancy:

> *'Mefloquine is contraindicated in people with a history of psychiatric disorders including depression so that X cannot use this drug. Mefloquine also needs special consideration in the first 3 months of pregnancy as it is in principle to be avoided in pregnancy according to the manufacturers.* ***In my opinion, X is not fit to fly as she will not be covered for malaria…'***

In addition, there is evidence that the stress of detention, the uncertainty about the future and possible return to situation from which they fled, makes detainees particularly vulnerable to mental health problems.[119] Contraindications with mental health disorders mean that healthcare staff responsible for prescribing malaria prophylaxis should conduct full mental health assessments of patients prior to prescribing.

## Informed consent to treatment with Mefloquine

In most expert guidance, informed consent is stressed as being integral to any prescription of malaria prophylaxis. For example, the HPA states:

> *'In the event that travel is unavoidable, the pregnant traveller must be informed of the risks which malaria presents and the risks and benefits of antimalarial chemoprophylaxis.'*[120]

Women were usually prescribed a malaria prophylaxis on reception following the GP Rule 34 report. These would normally be issued to her if she were approved to have certain medications in her possession. One woman who clearly did not understand the dosage took all four mefloquine tablets at once by mistake.

Three of the thirteen women who were prescribed mefloquine in the first trimester refused to take it. A fourth women declined after taking the first two tablets because she said they caused her to hear voices and made her feel unwell in her head.

The principle of consent to treatment is an important part of health professionals' ethical codes as well as international human rights law. For consent to be valid it must be voluntary, informed and the person must be capable of making the decision.[121]

The only evidence in healthcare records of any discussion about mefloquine appeared in the cases of those women who refused to take it. Examples are listed below:

> *'…fully aware of the benefits but declines to have it as feels it is unsafe for her pregnancy...'*
>
> *'…Reassured she could take it'*
>
> *'Advised that mefloquine is deemed safe in pregnancy by travel experts NaTHNaC and strongly advised to think about it and inform us if she changed her mind as it should be commenced now'*

This may not seem credible information to detainees who should be able to access sites such as the Health Protection Agency, NHS Choices, and even ROCHE online and see quite different advice about mefloquine prophylaxis in pregnancy.

One woman who was in her first trimester wrote a letter to her lawyer explaining her reason for not taking mefloquine:

*'I refused to take them because of the advice given on the drug label itself which clearly states not suitable if in the early term of pregnancy...I was not yet 12 weeks of pregnancy. Furthermore as to why I refused is because of the safety of my unborn baby who needs me as the life guard because he/she can not fight against anything on its behalf other than me as a mum.*

*...A specialist Registrar in the field has stated that no safe anti-malarial prophylaxis is available at this stage of my pregnancy...I conclude my reasons as to why I refuse because of the safety of the unborn baby. Otherwise I have no problem taking them if it is safe to do so.'*

If the aim is to assist a patient to weigh up the benefits and risks of a particular treatment, the standard of information giving here is poor. Rather than assisting the consent process, the meagre documentation of discussions about malaria prophylaxis appeared to be about applying pressure on those who declined treatment.

Whereas communication between Home Office caseowners and healthcare seemed to be absent around issues relating to whether malaria prophylaxis may be contraindicated or when would be a suitable time to set removal directions following completion of treatment, the only communications observed were to inform caseowners of when a patient refused malaria prophylaxis. For example, in a letter from healthcare to a caseowner, the staff member wrote: *"... I am writing to inform you that that above refused to accept anti malarial prophylaxis on the xx and again today".*

The IDI states that: *'Removal need not be deferred in any case where a detainee declines (on his or her own behalf or on behalf of a dependent child) to take malaria prophylaxis that has been provided on medical advice'.* Thus, there appears to be greater adherence to ensuring documentation around effecting removals is completed, than to whether it is indeed safe to remove patients from a clinical perspective.

### Problems around prescribing

In addition to having seemingly little regard for the principles of informed consent, healthcare staff at Yarl's Wood did not always demonstrate a clear understanding about which women required malaria prophylaxis and which medication to prescribe.

Two women who did not require anti-malarial medication were nonetheless prescribed it: they were a third country case or came from a region where the risk was variable and it was unnecessary.

In addition, in one case, malarone was prescribed, a drug that is considered to be unsuitable during pregnancy.[122] It appears from the notes that staff later realised their error. In one case, it is noted that, "*Asked resident to return prophylaxis, claims she threw it away*". In a second case, malarone was prescribed but never dispensed and the drug was crossed off the chart, presumably because the prescriber realised their error.

Finally, there was one woman in the sample who had been detained with her small child. The child was prescribed malarone, which was unsuitable given the child's body weight.

## Summary of findings

Experts agree that travel to areas with a risk of malaria should be avoided when pregnant. However, women due to be forcibly removed to their home countries are offered malaria prophylaxis prior to their intended removal date. Thirteen women in the sample required malaria prophylaxis but numerous problems were associated with their prescription:

| **Women who Required Anti-Malarial Medication** | 13 |
|---|---|
| Malaria prophylaxis contraindicated because women in first trimester | 6 |
| Malaria prophylaxis contraindicated because history/current mental health problems | 8 |
| Removal directions planned for a date prior to completion of treatment | 10 |
| Removal directions planned for a date prior to any prescription of anti-malarial medication | 3 |

In addition, a number of other problems were identified:

| **Other problems identified around prescriptions of anti-malarial medication** | |
|---|---|
| Malaria prophylaxis prescribed when not required | 2 |
| Malarone prescribed | 1 |

The results are damning and show that Home Office policy is routinely flouted. There is inadequate communication between healthcare staff and caseowners and there are major problems around providing detainees with information in order to secure informed consent. For the majority of women in this sample, the evidence is clear: there is simply no safe way to return them during their pregnancy.

# Chapter Eight – Case Studies[123]

## 1. Anna

Anna is a victim of torture, rape and trafficking. She managed to come to England where she claimed asylum on arrival and was then detained. She was 4-5 weeks pregnant as a result of rape. She was released after 12 weeks. This came after four letters from her legal representatives requesting Temporary Admission and two Judicial Review pre-action protocol letters.

In her time in detention, she suffered from depression, interpreting problems, poor nutritional intake and social isolation. A number of issues of concern arose in Anna's case, which draw attention to failings on the part of detention services and the IRC healthcare team. These issues include:

- Processing issues including transfers to IRCs and interpreting
- The treatment of torture claims
- Inadequate mental health services
- The decision to detain and continue to detain despite independent medical evidence in regard to scarring – and claim of trafficking

### Processing issues:

Having been picked up on arrival into the UK, she immediately had a screening interview, which is noted to have taken place at 21.59. From there, she was transported to Yarl's Wood IRC, and after a long journey, had a Full Admission Review (health screening) at 05.20 the following day.

The health screening recorded her level English to be "fair": Anna in fact spoke almost no English at all. Her isolation in detention was exacerbated and her healthcare continually disrupted by no one speaking her language and her speaking no English. LanguageLine was unable to provide an interpreter a number of times and on one occasion explained that the language 'did not exist'. Several appointments had to be rescheduled and a visit to the GUM clinic was wasted because they were not able to gain her consent for blood tests without an interpreter. When Anna was found crying and vomiting in her room and healthcare staff could not get an interpreter from LanguageLine they used Anna's roommate to interpret who spoke a totally different language.

With regard to the serious problems of communication, the volunteer doctor who visited Anna in detention noted that the lack of interpreting services meant that Yarl's Wood was not only unable to provide healthcare to NHS equivalent standards and also it was a risk to her pregnancy. In the MLR, the following was noted:

> *'The absence of adequate interpreting services is a risk to X's pregnancy and contravene IRC operating standards, current NHS guidelines for antenatal care, as well as the principle that detainees are entitled to care equivalent to that available in the wider community.*
>
> *The Detention Services Operating Standards Manual for IRCs states that the level of communication 'must be adequate to ensure correct clinical outcomes' (2011). Guidelines for the routine care of healthy pregnant women recommend that women receive information that is easily understood, enables informed decision making, and is evidence based (NICE 2008). Additional recommendations for care in pregnancy address the additional needs of vulnerable women who demonstrate poorer outcomes than the rest of the population. 'Recent arrival in the UK', 'asylum seeker or refugee status', 'difficulty speaking or understanding English' are examples of 'complex social factors' (NICE 2010).*
>
> *(…)The confusion caused to X by repeated poorly understood assessments in the absence of interpreting exacerbated her distress and anxiety, and sense of 'not knowing what is going on.'*

### Treatment of torture claims:

Upon arriving at Yarl's Wood, Anna disclosed a history of torture. On the day of arrival, a Rule 35 report was conducted with five areas of scars noted on the body map, sustained by bites, scalding and cigarette burns.

The Rule 35 response, which fell outside the prescribed timeframes for responding, concluded:

> *'Although I appreciate you have a few scars on one arm and one leg that may have occurred due to abuse, you have not stated in what way you suffered **real torture**. …. You were also asked if you had medical conditions and you said that you had no medical conditions. Again you made no mention of you being tortured.'*

The response fails to deal with the torture allegation or cause of scarring. Furthermore, as this was a third country case, she had not had the opportunity to have a full substantive asylum interview. She also had a second Rule 35 report in detention that detailed how her pregnancy was a result of her rape. This also failed to release her.

After a month in immigration detention, a Medical Justice independent doctor visited Anna in detention and wrote an MLR that detailed her scarring and mental state. Anna

reported a long history of physical, emotional and sexual abuse and multiple rapes. Her pregnancy duration was consistent with her account of rape. She presented with scars from cigarette burns, scars from a burning knife, and patchy hyperpigmentation caused by pouring hot water on her.

The doctor concluded, '*Considered in combination X's psychological and physical examination findings are typical of the history of emotional, physical and sexual abuse and exploitation described.*'

The report provided independent evidence of torture, yet the caseowner failed to review Anna's detention in light of this new evidence. She remained in detention for another six weeks after that.

### Inadequate mental healthcare:

Soon after reception, Anna was brought to healthcare very tearful, stating that people were *'coming to harm her and that they are choking her...she said that she might do something to herself but does not know what.'*

She was referred for counselling and a mental health assessment and put on ACDT (a self-harm reduction strategy). Discovering that she was pregnant as a result of rape increased her distress and she considered having a termination of pregnancy for a while. She was assessed as having moderately severe depression on a patient health questionnaire and was recommended for further assessment for PTSD. However, this assessment was never undertaken. The Medical Justice volunteer doctor also noted that that her history and current symptoms corresponded to diagnostic criteria for PTSD.

Anna presented to healthcare on several occasions raising issues such as low mood, poor sleep and bad dreams. The notes suggest she had been vomiting and unable to eat. At one point, Anna had not been able to keep fluids or food down for some days whilst held in detention. The notes record: *'Resident was advised and encouraged to try to eat and drink as much as possible to improve dietary and fluid intake'.* Such is the default advice from staff when a detainee is unable to eat or drink, for whatever reason. Her nausea and vomiting continued.

Following a visit, assessment and written report from the Medical Justice independent doctor, healthcare at Yarl's Wood then decided to monitor her weight. By the time Anna was released, after spending 12 weeks in detention, she had lost 4.5 kgs from admission. This weight loss was a clear indication of inadequate nutritional intake.

The NICE guidelines note that:

> *'Mental disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members.'* [124]

### The decision to detain and continue to detain despite medical evidence and claim of trafficking:

Anna was detained on arrival with no history of absconding or criminal conviction. She was pregnant, had mental health issues and claimed to be a victim of torture and trafficking. After a month in detention, she had independent evidence of the torture and trafficking she claimed. Her lawyers persistently wrote to the Home Office asking them to release her but this was to no avail. Finally, after 12 weeks, she was released. Her immigration case remains pending.

## 2. Mariam

Mariam is seeking asylum on the basis of her claimed history of domestic servitude, abuse and trafficking. Mariam was detained when she was 7-8 weeks pregnant. She subsequently spent 3 months in immigration detention before suffering a late miscarriage. She had a history of two miscarriages previously: the most recent was six months prior to detention.

On admission to Yarl's Wood, the history of miscarriages and pink discharge per vaginam (PV) within the previous week were noted. Despite this, and in the absence of an ultrasound scan (USS) her removal from the UK was attempted one week later. An ultrasound scan and assessment were carried out a week after this and a live fetus was confirmed.

Immigration detainees have numerous problems and complex health needs. In Mariam's case, she was seen in healthcare for numerous complaints including diarrhoea, vomiting, boils, dental problems, hay fever, leg pains, dizziness, urinary incontinence, symptoms of urinary tract infection, itching all over, runny nose and sore throat, nose bleeds, and pulling away the fingernails on her right hand. The latter was not documented as self-harm.

At around 17 weeks she reported lower abdominal pain to healthcare staff. No response to this is recorded in her records, nor was a referral made to see a doctor. At 19+ weeks she complained to healthcare staff of sporadic pelvic pain and feeling unwell. Again she was not referred to a doctor. The notes state:

> *'Reassured it's probably ligament stretching pain only. Advised to rest when it happens and take paracetamol'*

Two days later, officers brought her to healthcare with abdominal pain radiating to the back and spotting blood PV.

> *'Explained to the patient that on current observations there was no reason to get worried. Resident calmed down especially after listening to the fetal heartbeat.... Advised to take paracetamol for pain...and to inform healthcare if any further signs of bleeding.'*

Six hours later she returned to healthcare with painful contractions, bleeding and passing clots. Staff called the local hospital delivery suite who advised a blue light ambulance transfer to their A & E.

In hospital an USS showed that a miscarriage was inevitable. Mariam delivered the following day. She required a manual removal of the placenta in theatre and in total her blood loss was over 1.5 litres. Guards, including at least two males guards, were present throughout this traumatic train of events.

Following delivery Mariam attempted suicide several times and hit out at staff when restrained. She was transferred to the acute mental health assessment wing and treated with antipsychotic medication. Mariam had never had mental health problems before. The psychiatrist on call wrote:

> '*Acute grief reaction with significant suicide risk. Risk to others + (tried hitting/biting staff in the morning when restrained. Self neglect risk ++'*

He recommended Mariam be detained under Section 2 of the Mental Health Act and for her to have high level one to one observation, to manage her risk.

Over the next six days in hospital her condition improved and the Home Office arranged a taxi to transport her back to her pre-detention address. She had not had a period (as of June 2012) since the loss of her baby and has been investigated for recurrent miscarriages. She has also been treated for depression since her release.

Mariam described the quality of healthcare as being "really bad" and "really awful". She stated:

> *'They did nothing for me – except giving me folic acid and anti malarial medication – so they could send me back. They said there was nothing wrong with me, that it was just normal. I didn't have access to the care I should have had. On the nights I had very bad backache, I went to healthcare and the man I saw was very stupid. He said I can't lose the baby as it was 20 weeks. He wanted me to wipe myself with a tissue to show the blood. When I showed him: he said it was nothing serious and told me to take paracetamol. I knew there was something wrong with me and it couldn't be solved with paracetamol. I needed to go to hospital. Something was wrong with my baby. At about 5am, the bleeding was getting very serious. The woman I shared a room with got help. When they came they saw I was very weak and took me downstairs. … I couldn't go for breakfast …. At around 9am… the officer said I couldn't take my phone with me… That's when they called the ambulance.'*

Looking back at her time in detention, Mariam reported:

> *'I still feel empty and depressed. It's just really awful. I feel empty, defeated, lonely and overpowered. Every day it's in my head. It wears me down. It doesn't allow me to do the things I want to do or concentrate. It's just everything together. They knew my history but they still didn't do anything. The only thing I regret is that if I were outside this would not have happened. At night I dream about it – it's more like a flashback of the time – a reminder of three months of my pregnancy in the detention centre with the guards. It depresses me.'*

## 3. Lily

Lily came to the UK in 2006 to seek asylum, having been persecuted as a result of her political activities. She was imprisoned by government forces where she was tortured and suffered rape at the hands of five different men. She was tied up, deprived of food and water, beaten, whipped with belts and given electric shocks. She was able to escape and used an agent to get to the UK. After a long determination process, she finally received indefinite leave to remain in 2011.

Having been detained in early 2009 for one week, and despite reporting consistently (and remaining in touch with the Home Office), she was re-detained later that year. Lily was three weeks pregnant when she was detained. She was released after almost 10 weeks. Upon entering detention, a pregnancy test was negative at reception but positive three weeks later. Small intra- mural fibroids ('for follow up') were identified on her dating scan at 12 weeks.

Lily, like many other immigration detainees, had multiple health needs. She had a history of one miscarriage, hypertension, asthma, depression, self-harm and attempted suicide. She had been receiving treatment from the Medical Foundation for the Care of Victims of Torture (now Freedom from Torture) for depression and PTSD over the previous two years.

This case illustrates the poor quality level of healthcare delivered to immigration detainees: there was a failure to adequately manage her hypertension and an inappropriate prescription of mefloquine, given her long-standing mental illness. It also highlights how immigration detention can interrupt patients' care plans and have a negative impact on their mental well-being.

### Management of her blood pressure:

On reception, according to the medical notes: *'several attempts to obtain her blood pressure (BP) were unsuccessful as BP machine kept reading error'*. When a reading was obtained the following day it suggested 'severe hypertension' requiring admission to hospital. The doctor recorded it soon afterwards and it was reduced to being 'moderate hypertension'.[125] He wrote her up for antihypertensive therapy and follow up blood pressure monitoring.

Lily presented with raised BP requiring treatment. Even with the prescribed antihypertensive her BP was difficult to manage. Although prescribed an antihypertensive

the day after she was detained and despite the doctor ordering a follow up check in three days, her blood pressure was not taken again for three weeks when it was still unacceptably high. The midwife wrote *'she refuses to take medication'*. Although there is no discussion about why she refused to do so or the possible consequences of this, the midwife has added that Lily *'will need to see a consultant'*. There was no evidence in Lily's records that this ever happened. After an independent Medical Justice doctor's visit, a Yarl's Wood doctor referred Lily for specialist opinion by a Bedford obstetrician. Her medication was also changed and her blood pressure settled to within acceptable levels.

In her recommendation that Lily was not fit to fly, the Medical Justice independent doctor wrote:

> *'Her blood pressure has been extremely high throughout this pregnancy, looking at her notes some of her readings would indicate that she should have been admitted for bed rest and drug treatment … [Her BP] is still unacceptably high… She is at risk of having a seizure or a stroke if she flies.'*

Despite this, the IRC healthcare doctors considered her fit to fly. However, the removal did not go ahead because the G4S escorts refused to do the job, as she was pregnant.

Poor compliance is implied a number of times in Lily's medical records, presumably as an explanation for her uncontrolled hypertension. It is apparent that she did not come to healthcare for her medication on a number of occasions. These episodes coincided with a period where she was seen three times in healthcare about other matters. During that time there is no evidence that any discussion about her medication or the importance of compliance ever took place, or that her blood pressure was even measured. When she did see the doctor her medication was changed and the she was advised about compliance. Since that time compliance was good. This is a further example of pregnancy care being seen as someone else's responsibility to the extent that other health problems are the primary focus for healthcare in Yarl's Wood.

### Malaria Prophylaxis and history of mental illness:

The poor quality care is also highlighted by the fact that Lily was prescribed mefloquine malaria prophylaxis despite her long history of mental illness and self-harm.

On admission to Yarl's Wood, the GP notes in her Rule 34 screening assessment that Lily had a history of depression and "was keen" to start on anti-depressants. She was referred for counselling, prescribed an anti-depressant, and placed on Raised Awareness Level 6 (high). The doctor also signed her off as fit to fly. A nurse wrote in the notes: *'seen in reception...no issues stated and nil PMH (past medical history) of serious illness'.*

Despite her known history of mental illness and use of anti-depressants (which she stopped upon receiving a positive pregnancy test), Lily was prescribed mefloquine in anticipation of her upcoming removal and signed off as fit to fly.

An independent Medical Justice doctor who visited her in detention and wrote a report, highlighted her history of depression and concluded that:

> *'She will not be able to take mefloquine as it is contra-indicated in depression and other psychiatric disorders. It is also contra indicated in pregnancy. Malaria in Sub Saharan Africa is chloroquine resistant, and therefore use of that drug is inappropriate. Doxycycline is contra indicated in pregnancy also.* ***There appears to be no safe malaria prophylaxis for a depressed pregnant person considering flying to a chloroquine resistant area****.'*

Her upcoming removal was cancelled as "*G4S refused the job due to the subject being confirmed as being 3 months pregnant".* (Case Record Sheet).

### Detention adversely affecting mental health:

Lily had been receiving treatment for her mental health for years prior to being detained. Whilst held at Yarl's Wood, she reported several times to healthcare with loss of appetite, insomnia and low mood.

After a month in detention, an independent doctor from the Medical Foundation (now Freedom from Torture) wrote:

> *'Although she has been able to access limited relevant medical services regarding immediate symptoms at Yarl's Wood Immigration Removal Centre we are concerned that continued detention is adversely affecting the chronic mental health conditions, post traumatic stress disorder and clinical depression, for which she has been receiving rehabilitation treatment at MF since 2007. We are also concerned that interruption of this treatment will adversely affect the prognosis for her recovery.'*

Despite this clinical warning, Lily was not released until over a month later.

## 4. Emma

Emma was persecuted, tortured and arrested in her home country on the basis of her political opinion. Two policemen raped her and threatened to kill her and her husband was murdered in front of her.

Emma was five weeks pregnant when she was detained in Yarl's Wood and released 10 weeks later. A few months after being released, when she was five months pregnant, she suffered a miscarriage. She attributed the late miscarriage of her baby to the stress she suffered in detention.

Emma came to the UK in 2008 with an agent and worked illegally. She was arrested two months later attempting to leave the UK on false documents. She was seven months pregnant at the time and gave birth in prison in the UK. After serving an eight month prison term she was released with reporting restrictions. She was required to report fortnightly and did so without missing a single reporting event over the following six months but was detained again.

## Experience of being detained:

Whilst reporting at her local police station, she was detained for immigration purposes and separated from her child. She was held at the station overnight where she had two pregnancy tests (both positive), before being transferred to Yarl's Wood the following day.

> *'It was very difficult at the police station. No food, no water…They didn't allow me to call my lawyer. Nobody gave me a phone.… The way they treat people, it's a really shameful thing. I never expected this to happen. You can't say anything because it's not your country. That's the way I look at it.'*

Her child was nine months old at the time and was still breastfeeding. Immigration officers located the child and brought her to Yarl's Wood two days later. She arrived wet, having not had her nappy changed during the long journey to the detention centre.

In detention, Emma was unable to breastfeed but had previously been doing so. Her child became ill in detention, including having a chest infection, temperature and experiencing weight loss. Emma reported:

> *'When she came in she was about 15lb. When leaving that place, she was down to 9lb. It was really hard, it was really difficult.'*

Emma explained how the whole process of being detained was a traumatic experience and stressed that prison is a far more welcoming environment. She stated:

> *'Prison was like being in your home compared to detention. Yarl's Wood is the worst place you've ever seen in your entire life. Because they don't care there. You're better off in prison. When you're in prison, they give you sheets to make your bed, you can go for a walk, meet friends. They give you things to do, there are activities. You feel at home. At Yarl's Wood, you're trapped – you don't even have fresh air to breathe… It's better to stay in prison, I can't lie to you. The way it is at Yarl's Wood is really, really bad. They don't care. (…) Here in the Western world, they shouldn't treat people like that, like we are animals or something.'*

Emma felt that the quality of healthcare and the staff were deplorable:

> *'Care in detention was the worst ever in your life. … There's no healthcare there. They don't do anything. For example, they gave me medication, which was out of date. They don't know what they're doing. They'll give you medication that could kill you.'*

Unlike in prison, she felt she had no privacy and felt male officers did not respect her privacy:

> *'When you're sleeping at night, a man will just burst into your room and open the door. It was really difficult. In prison it was different: women staff are the people who go into women's rooms and male staff go into men's areas. In Yarl's Wood, they just don't care.'*

Other problems specific to immigration detention at Yarl's Wood related to allowance, food and mattresses, all of which are common complaints.

Upon her release from detention, she was housed in a hostel for two weeks. Following that, she was dispersed to permanent accommodation. However, at 5 months, she miscarried.

## Management of Mental health in detention:

The full medical review on reception at Yarl's Wood recorded her history of depression as well as a nondisclosure Rule 35 form as she was *'too upset to complete at the moment'*. The doctor who conducted the Rule 34 exam also noted the depression, Hepatitis C positive status and wrote the following about her mental health: *'...tearful, low, attempted self-harm yesterday. Still actively considering self-harm.'*

Prior to her detention, she had been taking anti-depressants, receiving fortnightly counselling sessions and had been on the anti-depressant citalopram for three years. Emma was placed on ACDT raised awareness (8/10) and referred for counselling. In addition, she also had a mental health assessment and was seen by a visiting psychiatrist.

The nurse conducting the mental health assessment, over three weeks after she was detained, noted that Emma still had self-harming thoughts but would no longer act on them because of her children. Emma had become friendly with some other detainees, but after their removals became very isolated. She had auditory hallucinations. The notes report: *'She hears a man saying 'I am going to kill you'. She cannot recognise or identify the man but thinks it's the voice of the people who killed her husband'.*

The records of her anti-depressant treatment in Yarl's Wood are incomplete but it is clear that the medication prescribed made little difference to her mood.

## Inappropriate prescription of malaria prophylaxis:

While still in the first trimester she was prescribed and advised to take mefloquine several times. Each time she declined. According to the doctor's notes, Emma was: *'.... fully aware of the benefits but declines to have it as feels it is unsafe for her pregnancy.'*

Her history of depression and anti depressant treatment was noted when Emma was detained. In spite of this and repeated documentation of her current mental health, such as 'low mood', 'self-harm and suicidal ideation', 'tearfulness', 'auditory hallucinations', 'persistent depression', and wanting to restart anti-depressants, she was prescribed mefloquine.

As noted by an independent Medical Justice doctor with a specialism in malaria: *'Mefloquine is contraindicated in women with mental health problems including depression due to the significant risk of severe, acute neuro-psychiatric side effects.'*

Emma reported that no information or explanation about the medication was offered to her at the point when it was initially prescribed. The issues related to malaria prophylaxis contributed to Emma's mistrust of healthcare staff. She stated:

> *'When they prescribed it for me, they didn't tell me what it was about. I didn't know anything and I said I'm not taking any medication if I'm not getting any information. They won't give you an explanation, they just give you the medication to take. They are not interested in anything. They just want you to go: they don't want you there. They won't explain anything to you.'*

Emma was subjected to repeated 'discussions' about the importance of her taking mefloquine. Her refusal to take it was documented each time, presumably for the purposes of an evidentiary basis for the Home Office in line with the IDI guidance:

> *'Removal need not be deferred in any case where a detainee declines (on his or her own behalf or on behalf of a dependent child) to take malaria prophylaxis that has been provided on medical advice.'*

## Impact of detention on mental health:

During her interview, Emma revealed how the stress of detention had a negative impact on her mental health:

> *'I was already about 3 months pregnant when I was there [in detention]. I came out and was too stressed out. It felt so bad looking at my daughter: I found it stressful. And then when I was let out, I was worried – Where were we going to live? My elder daughter in Africa, I don't even know where she is. It was really difficult for me and it was all so stressful. It really made me feel like I was going mad. I had to take anti depressant medication because it wasn't easy for me. It's really bad, especially for families to be living in the detention centre.*
>
> *When we came out after that, the stress was just too much. I can't believe I was in that state of mind. And when I came out, I ended up losing that baby. I didn't have that baby. I lost the baby. It was so sad…. Coming out from detention, I lost everything. It was so stressful. We had not house, nothing. We were living in a hotel for three weeks and from there I went to my friend's.'*

## Psychiatric assessment:

After her release from detention, she saw a psychiatrist who assessed her and wrote a report. The psychiatrist found that the experience of being detained had traumatised her.

> *'She had been pregnant with her boyfriend's child at the time of arrest and miscarried this pregnancy, she feels as a result of her detention experience. …She found her experience of arrest and immigration detention particularly traumatic. She felt that this experience accounted for what she called '95%' of her current difficulties. She felt detention was much worse than prison and she has struggled to cope with its aftermath.'*

The doctor diagnosed her with suffering from a depressive episode of moderate severity. The doctor found the trauma of her reported rape to be consistent with her description of nightmares.

The doctor found that following her release from prison, she became more depressed- this may have been linked to her diagnosis of hepatitis, linked to her rape, but also could be attributed in part to her detention.

> *'It follows from the above that Ms X was depressed at the time of her arrest and detention. It appears from the available records that this condition deteriorated during her detention. This was predictable due to the following: a) the counselling which she had been receiving and which she had found helpful was discontinued and never resumed b) her medication also appears to have been discontinued initially which would have led to a possible deterioration as a result c) when her medication was resumed it was at a lower dose than previously; it is often the case that doses have to be increased to gain a therapeutic response and that this was at the lower dose.'*

The doctor continued:

> *'It is also the case that the experience of arrest and detention is itself associated with the development of mental health problems, even in an individual who is otherwise psychologically healthy. In particular, the unexpected nature of arrest, the unknown reasons, duration and outcome of the detention would be significant stressors themselves…*
>
> *…The ongoing difficulties experienced in caring for the baby were also significant factors in leading to deterioration in her mental state.'*

The doctor goes on to note that counselling was neither discussed nor offered to her in detention and stated that there had been a 'limited examination of the mental state and limited reasons for reaching this mental diagnosis' [depression].

## Dispersal:

Upon release from detention, she lived in temporary accommodation for three weeks in a hotel, after which she

moved to a permanent address. During her course of her five month pregnancy, she lived at three addresses (one of which was a hotel), spent one night in a police station and 10 weeks in a detention centre. She was moved a total of five times.

Her immigration file reveals that for the past 12 months, she has been required to report either weekly or fortnightly. In a year, she has only ever failed to report twice. She states: '*I'm reporting week in, week out. I don't know what they want.*'

## 5. Salma

Salma was detained when she was 10 weeks pregnant and was released after five weeks. The Home Office caseowner knew she was pregnant when they detained her and did so when she was reporting and complying with restrictions. Salma came to the UK on a spouse visa and had been married to her husband who is a British citizen for almost five years at the point at which she was detained. Three months after her release from detention, she was granted Indefinite Leave to Remain under Article 8 at her appeal.

Whilst held in detention, her removal was attempted on three occasions. All removal attempts failed as she refused to leave Yarl's Wood. After the third failed attempt, the Home Office caseowner requested information "*in order to obtain information to use restraints/force*" on her. However, she was released shortly after on Temporary Admission.

### Screening clinical conditions:

Her full medical admission review noted that she was married and that her husband lived in the UK. The doctor's subsequent Rule 34 report recorded *'twin pregnancy at present'*. (She told healthcare staff that she had already had a scan with the British Pregnancy Advisory Service showing a twin pregnancy.) Whilst the full admission review and Rule 34 did not identify any mental health issues, the independent doctor who visited her later in detention diagnosed her with moderately severe depression.

### Unprovoked bleeding and pain – delayed investigation and inadequate advice:

Salma reported to healthcare with per vagina (PV) bleeding three times and lower abdominal pain six times. On one occasion, as recorded in her records:

> *'She was advised that this is bound to happen and that she must continue taking her pregnacare.'*

A midwife from Bedford Hospital noted the recurrent bleeding and that a routine ultrasound appointment was not due for another three weeks. She referred Salma to the GP for an earlier appointment 'if needed'. Her ultrasound scan appointment was brought forward by a week. In his referral letter to Bedford the doctor wrote: *'...possible twins, c/o episodes of PV bleeding and lower abdominal pain on & off 2 weeks'.*

Salma finally had a scan almost a month after she first reported PV bleeding to healthcare. This showed an intrauterine pregnancy and only one fetus was seen. Salma believed that she lost one twin because of the history of bleeding in detention. Had she been receiving routine NHS care Salma would have had a scan after her first episode of bleeding and abdominal pain.

### Fitness to fly & malaria prophylaxis:

Two independent doctors either spoke with or visited Salma while she was in detention. They both wrote letters on her behalf stating that she was not fit to fly for a number of reasons: this was despite the IRC healthcare doctor finding her fit to fly on more than one occasion. For example, because she had not had a scan to explore the unprovoked bleeding. All of these indicate shortcomings in her healthcare in detention. An independent doctor wrote:

> *'She is at high risk of miscarriage because of the twin pregnancy, the loss of PV blood and the abdominal pains, all of which can presage an early miscarriage. She is not fit to fly at present.'*

On page 88 of the HPA guidance, it is noted that: *'Most experts recommend that mefloquine is avoided during the first trimester.... The risk of adverse effects of mefloquine use in pregnancy should be balanced against the risk of contracting malaria and the complications that can result. The decision on whether to recommend mefloquine should be carefully discussed with the traveller.'*

As in all the other cases reviewed in this study there is no evidence that any such discussion ever took place.

The doctor who visited Salma wrote that she met the criteria for depression (rating moderately depressed). She noted that mefloquine should be avoided if there is a history of psychiatric disorders. However, even if she were not depressed, treatment would need to begin two and a half weeks before travelling.

The independent doctor concluded that Salma was not fit to travel:

> *'She is also not fit to fly as she has a high risk pregnancy due to having a twin pregnancy. We do not know the location of the placenta: she may have placenta previa which puts her at high risk of bleeding. We do not know the cause of this unprovoked recurrent vaginal bleeding. She needs a ultrasound scan and antenatal care as per NICE guidelines.'*

Salma now has leave to remain in the UK and is pursuing an unlawful detention claim.

# Chapter Nine – Discussion

The results of the data indicate that the current policy of detaining pregnant women is flawed. This is for three main reasons, each of which will be discussed, followed by an analysis of some of the underlying factors that contribute to the flawed policy.

### a. Ineffective

Existing policy is not being implemented in practice: pregnant women are not being detained in only very exceptional circumstances. Rather, their detention is commonplace. Pregnant women in detention are typically not removed. In addition, IRC doctors often find women fit to fly in conflict with other clinicians' opinions.

### b. Unworkable

The current system is unworkable because the policy on protection against malaria does not account for the health issues that typically afflict pregnant detainees. The majority of pregnant women held in detention are from countries where there is a high risk of malaria. Whilst there is a policy instruction that states that pregnant women should be protected on return through malaria prophylaxis, in many cases (where there is a history of mental health problems and/or the woman is in the first trimester), the only prophylaxis which would work is contraindicated or to be used only with caution following consultation with an expert. Thus, for these women (who constitute the majority), there is no safe way for them to return to their country of origin.

### c. Damaging

The data results show that the healthcare pregnant women receive is inadequate. There is evidence that the level of care falls short of NHS equivalence and breaches of NICE guidelines were identified. Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy.

## a. The current policy is ineffective

The policy outlining the detention of pregnant women states:

> *'Pregnant women should not normally be detained. The exceptions to this general rule are where removal is imminent and medical advice does not suggest confinement before the due removal date.'* [126]

This section will examine why this policy is failing and analyse the underlying reasons as to why the process is not working:

i. Imminent removal
ii. Use of force
iii. Fitness to fly & fitness for detention

### i. Imminent Removal:

In the majority of cases, 16 out of 20, the main reason for detention was that "your removal from the United Kingdom is imminent". However, only two women were actually removed. One woman in the sample was forcibly returned and another opted for Assisted Voluntary Return (AVR). The remainder were released into the community either through Temporary Admission (TA) or bail.

The Secretary of State is obliged to conduct a monthly review of detention for each detainee. As noted in the results, a woman's pregnancy was only mentioned in six detention reviews and/or progress reports. In these cases, there was a failure to engage with the details of the pregnancy or any ongoing health problems and accordingly failed to adequately consider whether a woman's profiles may make them unsuitable for detention.

There is little evidence of caseowners reviewing the detention of pregnant women upon receipt of a Pregnant Lady Notification (PLN) form. In the experience of Medical Justice, the lack of any formal mechanism to ensure the review of detention following receipt of a PLN form means that a review is rarely done. Furthermore, no Rule 35 reports, which should alert caseowners to anyone whose health may deteriorate in detention, was completed on account of a woman's pregnancy.

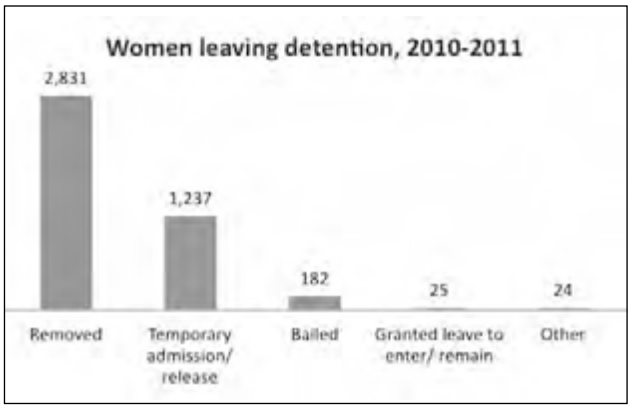
Given that the Home Office does not hold information centrally and the Secretary of State has consistently been unable to disclose how many pregnant women are held in immigration detention at any given time, it appears that there is a black hole in terms of how to implement its own policy of detaining pregnant women only in very exceptional circumstances. Indeed, in HMIP's recent inspection of Yarl's Wood IRC, they found seven pregnant women detained: 'Seven pregnant women were being held at the centre at the time of the inspection, something that should be exceptional.' [127]

Without knowing or recording how many pregnant women there are, it is difficult to see how the Home Office is able to implement its own policy. The failure to factor in pregnancy in the majority of decisions to detain and maintain detention supports this. For example, see the case study of Anna on p42.

The results support the findings of the previous Medical Justice audit that women are highly unlikely to be

removed to their countries of origin and are instead ordinarily released into the community. In this research sample, only one successful forced removal took place out of a total of 40 attempted removals, which shows the problems associated with safely removing pregnant women.

This proportion of removals is not in line with the general trend for women held in detention. The table below[128] shows the number of women leaving detention in 2010-2011. The chart shows that of the total 4300 female detainees, the majority (66%) are removed.




The main reason for pregnant women not being removed is because they cannot be safely returned to their countries of origin. Indeed, the results show that in the majority of cases, independent doctors found the women to be unfit to fly and that the majority of removals were stopped because judicial review applications were lodged.

The second main reason for removals being stopped was because the women or the escorts refused. One woman in her interview recalled her three failed removal attempts:

> *'I fought with escorts when they took me to a plane. The doctor said I was fit to fly but I said I was not fit to fly. It happened to me three times. One time, they spent two hours arguing with me. There were seven of the escorts talking to me. I was having lower abdominal pains and I was bleeding and they tried to force me to fly. I told them I'm not going anyway. We argued for over two hours. The way they are bullying pregnant people, handcuffing people, injecting people on the way to the airport – it is very serious.'*

## ii. Use of force:

An analysis of the SAR files shows that the Home Office/ UKBA often resort to the use force in order to effect the removal of pregnant women. UKBA have been adamant about their need to use force. However, in the recent *Chen* case,[129] UKBA conceded the need for a policy on the use of force against pregnant women and children in the context of removals and this has brought about the end of the use of force on pregnant women, save to prevent harm.[130]

HMIP inspected Yarl's Wood in 2011 and Cedars pre-departure accommodation in 2012 and recommended that force should never be used on pregnant women, stating that there is no safe way of protecting the unborn child. UKBA rejected this recommendation. In the Cedars inspection, HMIP recommended:

> *'Force should never be used to effect the removal of pregnant women or of children. It should only ever be used in relation to such vulnerable groups in order to prevent harm.' (HE.40)*[131]

UKBA rejected this in their Service Improvement Plan, instead stating:

> *'…. If we were to rule out physical intervention in all circumstances as a matter of policy, there would be a strong incentive for pregnant women to refuse to comply, or for women to claim to be pregnant, with the result that removals would not take place until after the baby had been born. This could mean a delay of many months, during which the family (including any older siblings) would strengthen their ties to the UK, making the eventual removal more difficult and more distressing to the children.'*[132]

In an email exchange with the Head of Operational Practice and Inspection of Detention Operations on 28 November 2012, the process for the use of force was outlined:

> *'Escort officers must seek prior approval from the Returns Director (or his nominated deputy) before using physical intervention techniques for the purpose of ensuring women who are believed to be, or are, pregnant are removed from the UK.*
>
> *Physical intervention must only be used when it is:*
>
> — *Honestly perceived that the use of force is necessary in the circumstances;*
>
> — *The degree of force used is reasonable; and*
>
> — *The force used is proportionate to the seriousness of the circumstances.'*

However, this was never outlined in published policy. In fact, prior to the *Chen* case, there was no policy on the use of force on pregnant women. On March 1 2011, a new family returns policy was established with the new guidance incorporated into a revised Chapter 45 of the Enforcement Instructions and Guidance (EIG). The new Chapter made provisions for enforcement action against adults but there was no guidance regarding the use of force pregnant women: the policy on the use of force on pregnant women that had previously existed in the earlier EIG was repealed.

In the previous version of the EIG, the following guidance was offered, which has now been reinstated:

> *'Force should only be used on a pregnant woman to prevent her from harming herself, any member of her family or any member of staff. Any force used must be appropriate, justified and proportionate. Staff will need to be able to justify the use of force, note the reasons in writing for doing so and complete the use of force form.'*[133]

However, this sample contains cases where the old policy of using force only to prevent harm was in existence. The results show that the use of force was routinely applied for, with no adequate justification and was approved without questioning. Even in cases where force had been approved at Director level, outsourced escorts in some cases refused to do it, while in another case, subjected the woman to such great force that the team leader stopped the action and took her to hospital.

The fact that the *Chen* case has now forced the UKBA to concede that force can only be used in cases to prevent harm firstly highlights the brutal nature of immigration policy but also raises some further concerns. The use of force previously was not a rare occurrence so concerns persist around the use of force under the revised policy. Medical Justice knows of one case where a pregnant woman who was due to be removed following this High Court case, where escorts physically assaulted her causing bruising.

UKBA strongly argued that the use of force was essential to execute removals: now that that has been removed (except to prevent harm), it must be questioned whether it is now appropriate to continue detaining women when it is clear that removing them remains problematic.

## iii. Fitness to Fly and Fitness for Detention:

An additional reason as to why the current policy is ineffective is because it relies on clear, timely and transparent communications channels between Home Office caseowners and the healthcare teams. However, there are two problems that prevent this process working optimally. Firstly, IRC doctors regularly find women fit to fly, often in conflict with other clinicians' opinions. Secondly, even in cases where IRC doctors find detainees to be unfit for detention, they are not necessarily released.

Rule 35 is a safeguarding tool, which instructs medical practitioners to alert Home Office caseowners of detainees whose health is deteriorating in detention, has suicidal intentions or may have been a victim of torture. An analysis of the Rule 35 mechanism, conducted by Medical Justice a year ago, showed the major deficiencies in the communication loop between Home Office caseowners and healthcare staff. This is characterized by administrative failures, bureaucratic mismanagement, dual loyalties and a lack of political will to resolve failing process.[134]

Reports continue to show that Rule 35 does not work.[135] A recent report from the IMB in Harmondsworth was critical of UKBA regarding this point. They found that GPs working in IRCs identified 125 detainees who were unfit for detention. However, only 12 of these were released, leading the IMB to conclude: "We are amazed that a doctor's judgement is overruled by case owners in 9 cases out of 10."[136]

In none of the cases in this sample were women released from detention on the grounds that detention may be injurious to their health. This is despite six women having had Rule 35 reports completed for them during this spell in detention; two had non disclosure forms; and three had Rule 35 reports in earlier spells in detention which were paid reference to in this set of medical notes. Amongst these women, six of them were on 'raised awareness', ACDT and/or had counselling.

In one case, a woman who claimed to be a victim of torture and trafficking had two Rule 35 reports completed in detention that did not lead to her release. The case example illustrates the failure amongst healthcare staff to identify women who are unfit for detention and to notify caseowners with clinical reasons that explain why detention may be harmful. See the case of Anna on p42 for further details.

In addition, case file analysis identified blind spots in communication between escorts and healthcare staff. As noted in the results, this is evidenced in conflicting determinations of whether women are assessed to be fit to fly. However, it also is made clear in the case example of one woman who had removal directions and was taken by escorts from Yarl's Wood to the airport. On the way to the airport, the van crashed. The woman was taken to hospital and returned to Yarl's Wood that evening. No information was handed to staff at Yarl's Wood about the incident. Indeed, on her return from the crash that day, late that night, the following entry is made in her healthcare notes:

> *"…resident observed to be lying on floor in her room and appeared distressed – she was complaining of pain in lower abdominal area. Cause unknown- BP 13/70 and pulse 80. Decision made to send resident to Bedford Hospital for further examination."*

She stayed overnight in the hospital and the gynaecologist there found her "*not fit to fly as treated for possible UTI*". Healthcare staff at Yarl's Wood only realised she had been in a road accident two days later: *"Informed by operational staff that X was involved in an RTA [road traffic accident] following removal attempt on X. …. This information was not handed over by G4S at the time*." See the case example of Sarah that follows.

Another example of poor communication channels between Home Office caseowners and healthcare is highlighted in the prescription of malaria prophylaxis and the failure to communicate with healthcare about the appropriate minimum time lag between administering medication and removal taking place in order to establish tolerance. In addition, in some cases, it seems there was confusion over whether a woman needs the prophylaxis as healthcare were unsure where the woman is being returned to. For example, Anna was a third country case with removal directions to a European country and thereon did not require malaria prophylaxis.

The lack of clear and transparent communication between the different bodies involved, namely immigration caseowners, healthcare providers and escorts provokes a

dangerous disconnect. If healthcare needs are not identified and/or communicated to Home Office caseowners, then people can languish in detention or be forcibly removed when they are not fit for either. Background health information was rarely available for detainees when they arrived in detention. Information about the health status of individuals and their medication lists may have been fragmented between GP records, records held in NHS trusts, records from other IRCs, or the detainee may have no records. If healthcare records are incomplete and/or not transferred to and between detention centres, both those delivering care services and those making decisions are relying on inadequate information.

## Case Study of Sarah: Use of Force in Removals & Ineffective Policy

Sarah is an asylum seeker from sub Saharan Africa. She was detained under immigration powers for 27 weeks. Sarah was pregnant during this entire time: she was just over two weeks pregnant upon entering detention and 29 weeks when she was released. A pregnancy test was positive one week after her arrival when she reported missing a period and having nausea and vomiting. (A Pregnant Lady Notification Form was not however completed until her tenth week of pregnancy). During her time in detention, she had a series of failed removal directions, some of which involved the use of force.

The first set of removal directions were cancelled because no travel document had been issued. The next set did not go ahead owing to "disruptive" behaviour. The case record sheet states: 'RDs failed as sub became disruptive. Escorts required for subsequent removal.' The case records sheet notes: '… escorts refused to take subject to the airport as she stated she may be disruptive. Escorts stated as subject is pregnant they won't be able to restrain her.'

Following these two failed removals, an application to use force was submitted to the Director of Detention Services. The case note states, 'draft submission to use force on subject as she is pregnant and has been disruptive'. This was approved and removal directions were re-set. However, the flight did not go ahead because '… escorts were not willing to use force as the subject is 19 weeks pregnant' (fax from Enforcement unit to OSCU). Thus, despite having UKBA Director-level support to use force, the escorts chose not to deploy it.

Sarah then had further removal directions set for a month later. The day before, notes from a conference call stated: 'Subject has been informed that use of force has been cautioned…If non compliant tomorrow, there is a 3 man team on standby to move her or deal with any disturbance that may arise on the Unit'. In our experience at Medical Justice, it is common for detainees to report that they are informed beforehand that force is likely to be used on them to remove them – this, no doubt, adds to the stress and terror of any forced removal. In the end, the removal 'failed as airline refused to carry subject when she became distressed': the captain refused to have her on the flight.

A week later, she was again taken to the airport on further removal directions. However, en route the van crashed and she had to be taken to hospital for a check-up examination: the flight did not take place.

The next set of removal directions were cancelled owing to bad weather. The final set of removal directions again had approval for the use of force. The case record notes state the following about this final attempt: 'happy to carry forward use of force authority….X will ensure escorts have a certain amount of cash to offer subject on removal'. This entry raises questions as to why the escorts would be offering detainees cash to the very people they are attempting to remove.

This removal also failed. The case record sheet states: 'As the subject was very disruptive during removal and even though the use of force was authorised, removal directions had to be cancelled as subject is heavily pregnant and **any further use of force would put the baby in further danger**'. The G4S incident note records the following: '**Even though we had permission to use force, the job was stopped as Team Leader was very concerned for the safety of her unborn child**'.

Following this, she was taken to Hillingdon Hospital for a scan and returned to Yarl's Wood that evening. The next day, she was released.

This case study shows how abusive immigration policies can be. This woman was held for 27 weeks in detention and was pregnant the entire time. Not only was the use of force authorized but she was also warned that they would be using it on her. Furthermore, whilst the Director of Detention Services may have thought it was appropriate to use force on pregnant women, this example shows that escorting staff and plane captains sometimes do not.

In February 2013, a High Court case *Chen and Others v SSHD CO/1119/2013*, led to a reinstatement of the old policy whereby force is only used on pregnant women (and children) in very exceptional circumstances where it is absolutely necessary to prevent harm. Sadly, this was not the case for Sarah who had the misfortune to experience the brutality of state sponsored use of force on pregnant women.

## b. The current policy is unworkable

### i. Malaria prophylaxis:

The results of the data on the prescription of malaria prophylaxis were damning. They reveal that both Home Office policy is breached and prescribing runs counter to leading healthcare advisory services.

All of the women who had been prescribed and taken malaria prophylaxis had taken it unnecessarily because none of them ended up being removed. This includes three women who were prescribed mefloquine when removal directions were not set at any point during their detention. For detention to be lawful, detention should be for the purposes of removal and the period of detention must be reasonable: if there is no prospect of removal within a reasonable time, then detention can be unlawful. In some cases, this can conflict with the requirement to prescribe malaria prophylaxis, where they will be contraindicated.

The evidence shows that in several cases there were contraindications: as a result, for the majority of the women there was no safe way of removing them. Malaria prophylaxis were contraindicated either because of mental health problems (8) and/or because the woman was in the first trimester (6) of her pregnancy; or because women were set their first set of removal directions with either no malaria prophylaxis prescription or within a timeframe when they had not yet established tolerance (13). The problems around prescriptions of anti-malarial medication seemed to be owing to poor communication with Home Office caseowners regarding time lags, deficient knowledge about mefloquine prophylaxis and its contraindications and poor detection of mental illness.

There was also an absence of any evidence of informed consent in the healthcare notes in almost all cases and this was substantiated by the interviews. One woman overdosed on mefloquine and reported to healthcare staff afterwards that she did not speak or read English so did not understand how to take the medication. In another case, a woman even stated that it was forced on her. She stated:

> *'They just said to travel to Africa, you need it. I had to take it in front of them. It was forced on me. If it was up to me, I would not have taken it because I don't think it is safe.'*

In some of the cases examined, there was evidence in the healthcare notes of IRC staff repeatedly recommending women take mefloquine, even where there were known contraindications. This is consistent with the evidence from interviews, where some women felt they were pushed into taking it, raising the question as to whether staff have their patients' best interests at heart.

One of the key issues that make the current policy unworkable is the contraindication with mental health problems. Eight of the women who were given mefloquine had a history or current indicators of mental illness.

In one case, a woman whose history of depression and previous suicide attempt had been documented by the healthcare team at Yarl's Wood was prescribed two different types of inappropriate malaria prophylaxis. The independent doctor who assessed her, wrote:

> *'Initially she was prescribed proguanil – which is totally inadequate as an antimalarial in sub-Saharan Africa. Then on X [date], she was prescribed mefloquine. This is absolutely contraindicated in someone who has a history of mental health problems including depression. It is fortunate that she did not consent to take it as the side effects of mefloquine include severe depression and anxiety, hallucinations and psychotic behaviour.'*

The side effects of mefloquine include severe depression and anxiety, hallucinations and psychotic behaviour. These side effects are much more likely in someone with a history of mental illness including depression, which is why it is contraindicated. However, effects can also occur in cases where no history is known. Indeed, the case study that follows shows how Aliya, after being prescribed mefloquine, began experiencing mental health problems and was then diagnosed with and treated for acute psychosis.

Similar cases have been examined by others. Nevin, a public health physician and epidemiologist from the United States has written extensively on the use of mefloquine. In one article he argues that 'the pathophysiological mechanisms underlying mefloquine's neuropsychiatric and physical side effects and the clinical significance of the drug's neurotoxicity have remained poorly understood'. He finds that an adverse reaction to mefloquine is characterized by 'symptoms of anxiety with subsequent development of psychosis, short-term memory impairment, confusion and personality change ….'. He concludes by stating that such a reaction could even be induced in patients without contraindication and after only a single 250 mg tablet. He thereon warns of the need for caution in its administration.[137]

Given the contraindications and the possible side-effects of mefloquine, it is extremely important that healthcare staff screen patients well in order to identify a history of or current mental problems.

In June 2012, Heidi Alexander MP asked the then Secretary of State about the removal of pregnant women to high risk malaria areas:[138]

> ***Heidi Alexander:*** *To ask the Secretary of State for the Home Department (1) whether health advice is provided to pregnant women in immigration detention whom the UK Border Agency plans to remove to sub-Saharan African countries where there is high risk of chloroquine resistant malaria, and who have contra-indications to other anti-malarials due to early pregnancy or mental ill health;*
>
> *(2) what steps the UK Border Agency is taking to monitor*

*whether appropriate advice is given by its contractors to pregnant women in immigration detention who are to be removed to sub-Saharan African countries where there is high risk of chloroquine resistant malaria, and who have contra-indications to other anti-malarials due to early pregnancy or mental ill health;*

*(3) what her Department's policy is on the immigration detention and removal of pregnant women to sub-Saharan African countries where there is high risk of chloroquine resistant malaria in cases where appropriate anti-malarials cannot be administered due to contra-indications with early pregnancy or mental ill health.*

***Damian Green** [holding answer 19 June 2012]:* (…) *The level and type of advice provided to pregnant women or those suffering from a mental illness in detention will depend on the clinical judgment of the health care professionals in the immigration removal centres in which they are detained, taking into account the circumstances of the person concerned and their proposed destination country. In addition, pregnant women or those suffering from mental health issues who are leaving the United Kingdom under an assisted voluntary returns scheme would be able to discuss protection against malaria and other risks with the independent Choices service. This provides confidential and impartial advice to help asylum seekers and irregular migrants decide and plan their return home. Pregnant women in families being removed under the family returns process would have their health and vaccination needs considered by the Family Returns Panel as part of the panel's consideration of the proposed removal plan before entering the pre-departure accommodation.*

*Further advice and information, including a newly produced Health Protection Agency leaflet on prevention of malaria is provided by the health care team at the accommodation.*

*Pregnant women who are considered to be 'at risk' of malaria are routinely provided with mosquito nets free of charge on removal and provided with the appropriate course of anti-malaria medication.*

*The delivery and quality of health care arrangements, including medical advice for those who are pregnant or suffering from a mental illness, at immigration removal centres and short-term holding facilities is monitored through the UK Border Agency's compliance monitoring arrangements and through independent inspection by Her Majesty's inspectorate of prisons.*

The then Secretary of State answers with regards to people who are pregnant *or* have mental health problems. However, this avoids the crux of the problem: that pregnant women *with* mental health problems or in the early stages of pregnancy coming from chloroquine resistant areas cannot take malaria prophylaxis safely because it is contraindicated. The Secretary of State has no policy to deal with this category of persons and it seems, has not adequately considered the issue before.

## Aliya Case Example: Mefloquine and Mental Health

Aliya was detained when she was 12 weeks pregnant under the detained fast track process at Yarl's Wood IRC. She spent five and a half weeks in detention before being released on medical grounds.

On reception Aliya was noted to have blood stained sputum and recent weight loss. Whether or not she had night sweats was not documented. Apart from this she was noted to be 'physically well and emotionally stable' with no history of mental health problems. She was issued with pregnacare supplements and mefloquine in anticipation of her forced removal to Nigeria.

Within one to two weeks of taking mefloquine, Aliya began to develop psychotic symptoms. After three weeks of taking it, she reported to healthcare her symptoms, which included that she was feeling confused, hearing voices, memory loss, agitation and experiencing hallucinations. Aliya was subsequently diagnosed with acute psychotic illness. The nurse advised Aliya to return the remaining tablets to healthcare.

Three days later an independent Medical Justice mental health consultant doctor visited and assessed Aliya over a period of two hours. The doctor found that:

> *'X is suffering from an acute psychotic illness and fits the DSM IV Criteria for substance induced psychotic disorder, where medication is etiologically related to the diagnosis. Whilst it is possible that she had a mental illness prior to taking mefloquine, the ingestion of these tablets has undoubtedly exacerbated her problems…. 'She may have been particularly vulnerable to the risk of psychosis because of high levels of stress and anxiety related to the events she reports brought her to this country and the events that have befallen her since…'*

The doctor concluded:

> *'Mrs X in my expert opinion is not fit to be in detention. She is acutely mentally unwell with a psychotic illness of at least three weeks duration. This requires treatment with antipsychotic medication. The onset of her illness coincided in time with the first dose of mefloquine (Lariam). Mefloquine is known to cause a psychotic-like illness in which the mental state deteriorates a short time after ingesting the drug and can deteriorate dramatically despite the cessation of the drug. It is not clear if she had the capacity to consent to treatment with mefloquine on the 21st of June when it was first commenced.'*

The doctor recommended release from detention and admission into an acute mental healthcare unit for treatment. A week later she was released.

### Poor management of mental health issues:

There was a delay in the identification of Aliya's mental illness. After reporting her symptoms to healthcare, a referral was made for a mental health assessment. The assessment by Yarl's Wood staff (a nurse) took place almost one week after a referral had been made. In his summary he wrote:

> *'Appears to be in an acute stage of psychoses receiving commands that are upsetting her from TV/reports hallucination hearing, visual context. X needs further assessment my psychiatrist to establish medical treatment plan ASAP, I would also not rule out further assessment in more appropriate environment such as hospital to establish her additional needs.'*

Aliya was subsequently prescribed Risperidone, an anti-psychotic and referred to a psychiatrist, which took another week: it was almost 2 weeks after Aliya reported to healthcare that she was hearing voices that a psychiatrist assessed her.

> *'Presentation is of an acute psychosis possibly related to mefloquine...is starting to develop paranoid beliefs about her roommate and about staff and she makes angry threatening statements of her intention to kill staff before she leaves, and if they put handcuffs on her... May need in-patient assessment in view of the risks to her health and safety of others.'*

Following a threat to kill herself Aliya was moved to a single room and the next day she was released.

### Capacity Issues and Consent:

At least three Yarl's Wood healthcare professionals noted the possible association between mefloquine and Aliya's deteriorating mental health in detention. Yet in the healthcare records, there is no evidence that the risks and benefits of mefloquine were ever discussed with Aliya.

The independent Medical Justice psychiatrist who visited Aliya in detention raised concerns not solely about whether there had been informed consent about taking mefloquine but also about Aliya's capacity to have an asylum interview. In the MLR, the following is noted:

> *'In my view she did not have capacity to give an asylum interview …with deteriorating mental state at the time. The fact that she is three to four months pregnant, unable to adequately care for herself and her unborn child, unable to eat and drink and that this has gone undocumented within the IRC Healthcare Records is a matter of grave concern. The health of X and her unborn child remain greatly at risk while she remains in detention.'*

### Post release:

Upon leaving detention, a multidisciplinary team in an NHS Trust closely monitored her pregnancy and mental health. Her GP renewed her anti-psychotic prescription and made an emergency referral to the perinatal psychiatry team.

Aliya delivered a healthy baby girl. Following the birth of her baby, she remained under the care of the perinatal psychiatry team, where she was seen weekly.

Some weeks after the birth, UKBA attempted to disperse her to a location, away from her social network. Perinatal Community Services wrote letters of concern warning UKBA of the disruption of care and impact on her wellbeing and ability to care for her child. Her lawyers successfully challenged the decision to disperse her arguing that such action contravened the Secretary of State's safeguarding and equalities duties.

Aliya's case is pending. Meanwhile, she continues to present with severe mental health problems. It is possible that she will make a full recovery but, as the independent psychiatrist wrote:

> *'Her prognosis is guarded. Patients can recover well from Lariam induced psychosis although in other reports patients are reported to have gone on to develop a chronic psychosis, following acute psychosis triggered by mefloquine.'*

## ii. Mental Health in Immigration Detention:

Upon arrival at all IRCs, detainees are screened by a health professional, (usually a nurse) within two hours of arrival and by a doctor within 24 hours (Rule 34). However, the screenings have been shown not to be optimal, with full mental health assessments rarely taking place.[139] Diagnoses of mental health illness can be specifically challenging within a population from a wide range of countries and cultures, for there may be more somatic presentation of psychological problems among asylum-seekers and refugees.[140] In addition, some detainees may not disclose all their details at this initial stage. If mental health problems are not documented at the initial stage, in some cases they are only identified following a full assessment by a visiting independent doctor. However, only a small minority of detainees get the chance to see a Medical Justice independent doctor and there is much unmet need.

There is consistent evidence to suggest that asylum seekers and refugees have higher rates of mental health difficulties than are found within the general population. In a meta-analysis of worldwide studies investigating the mental health of refugees (including asylum seekers and displaced persons), Porter and Haslam found high rates of psychopathological disorder among refugees worldwide compared with non-refugee control groups.[141] However,

in the UK, the true number of those with mental health conditions in IRCs is unknown because the data is not collected.[142]

The Department of Health has identified PTSD as the most common problem amongst asylum seekers and refugees and has also observed that because of these mental health issues the risk of suicide amongst asylum seekers and refugees is raised in the long term.[143]

The effects of detention on detainees' mental health can be significant. It is well documented that asylum seekers have a higher prevalence of mental health problems than other groups.[144] In addition, there is a growing body of literature that highlights the correlation between immigration detention and mental illness as well as between the process of seeking asylum and mental illness.[145] For those with such illnesses, health can deteriorate in detention with lasting damage as a result.

A large Australian study (based on 241 participants) considered the impact of immigration detention on the mental health of refugees and demonstrated that past detention contributed independently to the risk of ongoing PTSD, depression and mental health-related disability.[146]

A systematic review by Robjant et al identified ten studies (from removal centres in Australia, the UK or the USA) that reported high levels of mental health problems in detainees. There was evidence to suggest an independent adverse effect of detention on mental health and that time in detention was positively associated with severity of distress.[147] A study by Cohen in 2008 examining the incidence of suicide and self-harm in asylum seekers in the UK, showed high levels of self-harm and suicide for detained asylum seekers as compared with the United Kingdom prison population 12.97% vs. 5-10%. It was suggested that this could be attributed to routine failure to observe and mitigate risk factors within immigration detention.[148]

Pre-existing mental health disorders are thought to be adversely affected by the detention process itself and the IRC environment. Specific stressors such as loss of liberty, uncertainty regarding return to country of origin, social isolation, abuse from staff, riots, forced removal, hunger strikes and self-harm are particularly relevant within the detained population.[149]

With a vulnerable population and a stressful environment, full mental health assessments are essential. In addition, taking into account the research evidence that shows that the length of time is a variable in deteriorating mental health, such assessments should be conducted regularly.

The relationship between stress and poor maternal outcomes, including preterm birth and low birth weight has been explored but remains unclear. This has been partly attributed to inconsistency in the methodology designs, definitions and measurements of stress.[150]

However, it is becoming increasingly apparent that antenatal maternal mood can have lasting effects on the psychological development of the child.[151] According to Diego et al:

> 'Women with prenatal depression, anxiety, and/or stress show higher rates of spontaneous abortion and preeclampsia. These women are also more likely to deliver premature and low-birthweight/small-for-gestational- age infants who may exhibit growth retardation across the first year of life.'[152]

In addition, their study finds that women exhibiting psychological distress during pregnancy exhibit elevated cortisol levels during midgestation that are in turn related to lower fetal weight.

As noted in a recent submission to the Canadian Parliament,[153] concern about the detention of pregnant women was raised on the basis of the potentially negative impact of maternal depression on the child's physical and mental health.[154] The briefing, in particular noted that:

> *'…detaining pregnant women puts them at risk of depression which can have serious negative consequences for their baby'.*[155]

Indeed, the stress of detention, the uncertainty about the future and possible return to situation from which they fled, makes detainees particularly vulnerable to and mental health problems.[156] Pourgourides in her study on the mental health implications for detainees in UK IRCs noted that:

> *'We found that detainees are rendered hopeless and powerless in detention….*
>
> *The unpredictable outcome of detention, in particular fear of deportation is a constant source of stress…The responses to detention, including despondency, demotivation, anxiety and depression are understandable responses to an abnormal situation. They can manifest in constellations of symptoms consistent with diagnoses of post-traumatic stress disorder, depression, anxiety and psychosis…they are not always identified by medical staff'.*[157]

Our own study had similar findings. Independent doctors found six women's mental health was deteriorating in detention. In the interviews, women also emphasised the stress, trauma and disempowerment of being detained. For example, one woman stated:

> *'It's no good to put pregnant women in detention. It's too much stress for pregnant women. I lost my memory there. I always thought about my life in detention. Every day I wanted to kill myself there…too much stress.'*

There is evidence that time in detention is linked to negative mental health outcomes. It is therefore incomprehensible why vulnerable pregnant women, who often have complex health needs, should be held in immigration detention purely for administrative convenience. This is particularly when it is difficult to remove them because there is often no safe way to do so.

## Zara Case Example: Mental health deteriorating in detention

Zara fled to the UK with her husband. On arrival, they claimed asylum but were immediately detained and prosecuted for possession of false documents to enter the country. They received a 12 month prison sentence having entered the UK on false documents, of which they served six months. Following that they were transferred to an immigration removal centre (IRC) together: 12 weeks after her arrival at the IRC, she got pregnant. This was her first pregnancy. She was released at 31 weeks gestation.

During her entire time in detention, no mention of her pregnancy was made in any of her six monthly progress reports. In addition, she never had removal directions set whilst in detention.

Apart from dental problems, no health issues were noted in her reception full medical review or her Rule 34 GP assessment. She had multiple health problems while in detention including urinary tract infection, lower abdominal pain and bleeding, anaemia, constipation, alopecia, heartburn, thrush, and trouble eating the detention centre diet. For example, in her medical notes, the following entry was made:

> *'Husband came to nurse triage on behalf of wife saying she was always hungry and could not get enough to eat. Her portions were limited and although she has extra milk and fruit now she says she doesn't like milk. Suggested extra items could be purchased from shop but the family feel pregnancy should entitle them to extra portions. It was agreed I could make X an appt to see the midwife.'*

However, detainees get a daily allowance of 71pence, which would not suffice. Weight loss was also documented in her notes. Zara had difficulty sleeping as well as having nightmares, was tearful, anxious, stressed and depressed. She started treatment for depression early in her stay and was referred to a counsellor for suicidal ideation. When she found out she was pregnant, on the advice of a locum GP in Yarl's Wood, she stopped taking antidepressants.

An independent doctor volunteer visited Zara twice during her period of detention in Yarl's Wood. And wrote about Zara's inability to sleep and having nightmares:

> *'.... nightmares of something coming out of the wall and strangling her, problems concentrating with interruptions with bad intrusive thoughts, fears of inability to attach to and care for her baby and to be a good mother, fears that her baby will have a disability, and episodes of numbness of the body all point to significant depression with features of post traumatic stress disorder, the latter possibly resulting from reported frightening experiences in the past and the fear of possible stoning if returned as mentioned in X's witness statement.'*

The doctor drew attention in her report to the NICE guidelines for antenatal and postnatal mental health that state that mental disorders during pregnancy can have serious consequences: after identifying a possible mental disorder, further assessment should be conducted. The doctor thereon wrote:

> *'I am concerned about X's pessimistic thoughts about the outcome of the pregnancy and her ability to care for the child and to feel attached to the baby. She needs an assessment by a perinatal psychiatric service.'*

Soon after, Zara was seen by an obstetric consultant from Bedford who also recommended that Zara be referred to the mental health clinic for assessment and appropriate medication. This never happened.

Prior to being released from detention, Zara wrote the following in support of her bail application:

> *'I am now about 8 months pregnant. Detention is adversely affecting my health. I have been feeling hopeless and down a lot and I am having problems coping with the fact that I am pregnant. (…) I am due to give birth to my first child. I will need time to prepare myself and the accommodation where I will be staying for having a baby. I believe that it would not be good just to keep me in detention until just before giving birth. (…) I and my husband have been detained together for 8 month. This is a very long time to spend in detention especially for a pregnant woman.'*

Shortly thereafter, Zara was released.

## c. The current policy is damaging

There is broad consensus that wherever possible mothers with children should, in the first instance, be kept out of custody.[158] Rule 64 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) states:

> *'Non-custodial sentences for pregnant women and women with dependent children shall be preferred where possible and appropriate, with custodial sentences being considered when the offence is serious or violent or the woman represents a continuing danger, and after taking into account the best interests of the child or children, while ensuring that appropriate provision has been made for the care of such children.'* [159]

The World Health Organisation outlines that:

> *'The imprisonment of pregnant women and women with young children should be reduced to a minimum and only considered when all other alternatives are found to be unavailable or are unsuitable'.* [160]

Given that leading experts in the field advocate that incarceration of pregnant women should be avoided, the current policy of detaining pregnant women for immigration purposes needs urgently reviewing.

The results of the data show that the healthcare that pregnant women receive in Yarl's Wood is inadequate. There is evidence that the level of care is not always of NHS equivalent standard and breaches of NICE antenatal guidelines were identified. Women held in immigration detention receive discontinuous care and the stress of detention can impact on their mental health and in turn the health of their unborn babies.

Three main themes emerge from the data results that make the current policy of detaining women for immigration purposes damaging. These are:

i. Inadequate healthcare
ii. Lack of information and informed consent
iii. Inadequate access, choice and continuity of care

## i) Inadequate healthcare:

In 18 of the medical letters and MLRs reviewed, concerns around the quality of care patients were receiving in Yarl's Wood were highlighted. The majority of these concerns related to inappropriate prescriptions of anti-malarial medication but concerns also included a failure to do scans or send patients for specialist assessments.

As noted earlier in this report, newly arrived migrants, asylum seekers and refuges are particularly vulnerable groups and have poorer maternal outcomes than the general population.[161] As a result, specific guidance around maternity care has been developed in order to address the disparity of outcomes.

The majority of the women who were detained in this sample not only had poor obstetric histories but also had multiple health needs. These health needs were not just physical, (for example HIV, hypertension, hyperthyroidism and hepatitis C), but also mental. Six of the women had pre-existing mental health problems and an additional five suffered mental health problems either in Yarl's Wood or immediately following their release. Furthermore, there was evidence that six women's mental health problems deteriorated in detention.

In total seven women in the sample had suffered a history of miscarriages and two had previous ectopic pregnancies. On reception, six women reported additional histories of gynaecological problems and three women had STIs. Despite disclosures of rape and/or torture, STI testing was not automatically offered and in some cases, only took place at the request of external doctors.

For women with such complex needs, the data showed that healthcare was not geared up to meet their requirements. Some pregnant women in Holloway prisons end up with more visits than is required in routine antenatal care because they are recognized as a vulnerable population. However, this same standard of care was not observed in Yarl's Wood IRC. For example, one woman with a history of rape had a pregnancy complicated by urinary tract infection (UTI), vaginal discharge (Group B Streptococcus), depression and gestational diabetes. She had two visits from a midwife. A healthy low risk woman receiving routine antenatal care would have had four visits over a similar period of her pregnancy.

Interviews with women who were pregnant in detention did not feel that they had a good standard of healthcare at all and did not see midwives enough. One woman stated that: *'I only saw a midwife once. Most of the time, they were saying a midwife would come. But the midwife didn't come – they said they needed more people to be seen.'* This opinion was echoed by others. In one case, an appointment was cancelled because the midwife was sick, yet no cover was provided. It is likely that because there are no specific contractual obligations in place, issues such as ensuring sick cover had not yet been addressed.

The NICE guidelines on Antenatal Care CG 62[162] outline the need for women to have the opportunity to have screening for Down's syndrome and scans. In general, scans were completed if the woman remained in detention but in many cases, women would have either had them prior to detention and/or be released before having them. Thus, her maternity care would be interrupted with different midwives and hospitals responsible at different times. In addition, in nine cases, there was no evidence that the Down's syndrome screening had been done, despite all of these women being eligible for the early or later screening test during the period of their detention.

The results show that there were failures to identify and deal with high risk pregnancies. There appeared to be no appreciation that even without complications, this is a group of vulnerable women who need to be managed according to the NICE Pregnancy and Complex social factors pathway. A number of women had concomitant factors that put them at increased risk. These included: psychiatric disorders requiring medication, endocrine disorders, HIV as well as a previous caesarean section, history of severe preeclampsia or stillbirth.[163] In addition, some women were hypertensive and currently had multiple pregnancies.

In addition, the level of mental healthcare provided, in some cases, did not meet NICE antenatal and postnatal mental health CG45 guidance, particularly with regards to the delay in identification of illness and referrals for assessments. In part, as explained earlier, this was owing to inadequate screening on reception but also there were delays in management. Often temporary measures such as placing a detainee on ACDT or raised awareness following reports of suicidal ideation were implemented but there was little effort to address the roots causes or develop care plans for such illnesses. Management was often delayed until after an independent Medical Justice doctor

had seen a woman and written recommendations in the healthcare notes and/or a medical report.

## Hana : Failure to identify and manage a high risk pregnancy

Hana was detained when she was just over 13 weeks pregnant with twins. She spent five weeks in detention under the detained fast track process before being released.

Hana had a complex obstetric history and multiple health needs, which raised concerns over her fitness to fly when pregnant. She had a history of one normal delivery, one miscarriage and a placental abruption at 28 weeks with delivery by C section of a baby that had died in utero. In addition, she was being treated for essential hypertension and hyperthyroidism.

Hana had numerous health problems and visits to healthcare while in detention: severe itching, swelling in lower eyelid, suspected urinary tract infection, labile blood pressure, difficulty breathing associated with longstanding nasal infection and bleeding following bowel movement.

The doctor who carried out the medical assessment within 24 hours of her arrival noted her medical conditions and a partial obstetric history. He made a referral to Bedford Hospital requesting consultant led care in view of her twin pregnancy, hypertension, hyperthyroidism and previous C section. However, on the same day, he signed her off as being 'fit to fly'.

By contrast, an independent doctor who held a telephone consultation with Hana found that it was unsafe to fly.

> *'Ms X's twin pregnancy, previous placental abruption, hyperthyroidism and hypertension are all risk factors for a further placental abruption, miscarriage, premature labour, pre-eclampsia and other complications..... Unless a specialist obstetrician is able to provide assurance to the contrary, in view of her multiple risks of life-threatening complications it must be considered unsafe for her to fly.'*

Hana was subsequently referred to Bedford Hospital for such an assessment by an obstetrician. She was released on temporary admission before this took place.

### Care and Advice received in detention:

The stress Hana experienced during her detention is documented a number of times in her records, as is the advice she was given. On one occasion, when she was crying and her blood pressure was raised, she was reassured that:

> *'She has many doctors and nurses here to make sure that her and her baby are looked after and to keep relaxed she must try to do relaxation. Suggested deep breathing, music, or to try the internet to find something else that she may prefer.'*

In our interview with Hana she was still agitated recalling the effect such fatuous advice had on her state of mind. She complained bitterly about the lack of concern on the part of health care staff in Yarl's Wood and described some as "cruel".

> *'When you complain they don't care. Whatever you say is happening to you they say 'is normal'. Even when someone is dying they would say 'it's normal'. . .They shouldn't use the word normal because they don't know what is happening inside you. . . Apart from saying everything is normal in pregnancy there is also a lot of "Go to the office and take paracetamol. You'll be OK"".*

Indeed, there was no real evidence in the notes that any healthcare staff appreciated how much risk was associated with Hana's pregnancy. Furthermore, there was no evidence of a discussion or informed consent about her anti-malarial prescription.

When interviewed, Hana complained that the food was of poor quality and inappropriate, and that the beds were too narrow and uncomfortable for pregnant women. For example, she stated: *'They don't have good food for pregnant women. . . They don't ask you about what you're eating. They don't care if you don't eat'.* She also spoke of the discomfort of having to share a room and reported that at one point had to sleep in the corridor.

Hana became tearful and angry when she spoke about her experiences of detention. She is convinced that the stress of detention affected her health in pregnancy.

> *'From my own experience I don't want this to happen to other women. . . The place is no good for pregnant women. They're taking a risk with pregnant women.'*

Hana spent 13 weeks in detention before being released. Following her twin girls' births, Hana was temporarily housed in a hostel with no financial support. Since being moved to National Asylum Support Service (NASS) accommodation in East London she has no cash but survives on government support in the form of a voucher card that can be used for designated purchases in specified shops.

## Faith: Gaps in Antenatal Care

Faith was just over five weeks pregnant when she was detained for immigration purposes. She was released after 20 weeks in detention when she was around six months pregnant.

Faith had a poor obstetric history yet the quality of healthcare in detention did not attend to the nature of her pregnancy. Following sexual abuse by her father, she had a history of a forced abortion in a non-clinical setting in her country when she was young and years later, had an abortion in the UK. She had suffered two miscarriages in the previous year (the first at nine weeks and the second at 17 weeks). She had a hysteroscopy, was found to have fibroids, had a laparoscopic drainage of an ovarian cyst, mild endometriosis and a history of bacterial vaginosis.

Faith had numerous gynaecological problems that could have medical implications for her pregnancy. Her most persistent problem while in detention was abdominal pain which she reported on 11 occasions over a four and a half month period. Despite her recent history of two miscarriages, on all but one occasion, the only treatment she received was paracetamol and advice on the pain she was experiencing such as, *'symptoms are normal in pregnancy and to take paracetamol if pain prolongs' or changes in body due to hormone 'changes'.*

For any pregnant woman receiving NHS care these explanations would be inadequate. For a vulnerable woman who had suffered two recent miscarriages and had significant gynaecological problems documented in her records, these explanations are incompetent and unprofessional.

It seems that it was up to Faith to make the links for medical staff between her medical history and current symptoms. On one occasion when she said the pain was exactly like that she felt before her previous miscarriages, she was immediately referred to a doctor who had her transferred to the Labour Ward in Bedford Hospital. On examination there were no evidence that she was miscarrying.

The Medical Justice independent doctor who visited Faith in detention wrote a report detailing her numerous gynaecological problems and identified gaps in her antenatal care. The doctor wrote:

> *'This is a high risk pregnancy and she needs an early scan to confirm an intrauterine pregnancy [and to exclude an ectopic pregnancy] given the risk of pelvic infection with the history of abortion in a non clinical setting , recent evidence of endometriosis and abdominal pain in this pregnancy. She needs an early referral to an obstetrician to assess the cervix in view of the history of a late miscarriage and a late abortion in a non clinical setting. She also needs genital swabs.'*

### ii) Lack of information and informed consent:

Many of the standards produced by NICE regarding antenatal care revolve around information and record-keeping. The role of the woman is deemed to be central to good practice in maternity care. Reviews of maternal death found women who did not speak English were at increased risk and the use of professional interpreting services continues to be a top recommendation.[164] As a result, interpreting and ensuring women receive information in a language they understand are crucial standards.

The Detention Services Operating Standards Manual for IRCs states that the level of communication 'must be adequate to ensure correct clinical outcomes'. Guidelines for the routine care of healthy pregnant women recommend that women receive information that is easily understood, enables informed decision making, and is evidence based. Additional recommendations for care in pregnancy address the additional needs of vulnerable women who demonstrate poorer outcomes than the rest of the population. 'Recent arrival in the UK', 'asylum seeker or refugee status', 'difficulty speaking or understanding English' are examples of 'complex social factors'.[165]

The results of the data indicate several breaches of NICE guidance relating to information provision. A review of the medical notes revealed an absence of documentation around patient information. It was documented that a woman had received information on appropriate food in only three cases and that she had received her blood test results in eight cases. In only three cases was it documented that there had been a discussion with the patient on anti-malarials and as noted earlier in this report, informed consent was a rarity.

Healthcare notes were sometimes incomplete with forms, such as the Pregnant Lady notification form, the Maternity Log, or the Special Diet Requests forms not always located in the patients' files.

NICE guidance on antenatal care stresses that:

- women have the opportunity to make informed decisions about their care in partnership with their healthcare professionals
- good communication should be evidence based accessible information tailored to the woman's needs[166]

For women with complex social factors and in particular recent migrants, asylum seekers, refugees, or have difficulty reading or speaking English, NICE guidance highlights the importance of professional interpreting services, and information being in a variety of languages and formats e.g. leaflets, posters, DVDs, notices.[167]

Although English was the second language for most of the women, two of the 20 women had very little or no English and required an interpreter. In one such case, the woman could barely say a word in English yet on her initial health screening form, it is documented that her English was "fair".

Yarl's Wood attempted to use LanguageLine where required but the service was less than satisfactory. In one case, appointments at Bedford were missed and tests could not be undertaken because an interpreter was not available. Relatives or other detainees were used to interpret in some instances. There are a number of well-known disadvantages to using untrained interpreters, such as inaccuracy of interpretation; lack of completeness; lack of confidentiality; lack of impartiality or conflict of interest; advice giving or advocacy.

On two occasions staff at Bedford hospital indicated that the lack of appropriate interpreting made gaining consent impossible. In one of these the ultrasonographer noted on the scan result:

> *'…patient unable to understand information regarding Down's screening. Yarl's Wood officer will arrange translation so quadruple test may be performed when patient returns.'*

This detainee's English was noted to be 'excellent' on her reception at Yarl's Wood. Whether or not she ever had Down's screening before her release is not documented in her healthcare notes.

In another case a woman could not be tested for sexually transmitted diseases at the GUM clinic because there was no interpreter and her English was inadequate for valid consent.

Both cases highlight however that information had not been made accessible for women who do not speak English; there was not ready access to professional interpreting services; communication was not supported by evidence based written information in her preferred language; and provision had not been made for information in a variety of formats and language. This goes against the NICE guidance Antenatal Care CG62 and NICE Guidance Pregnancy and complex social factors CG110.

One woman held in detention had a long history of rape and abuse. She arrived in detention speaking barely any English at all and there was a frequent lack of interpretation. An independent Medical Justice doctor who visited her in detention wrote in an MLR with concern about this. (See case study of Anna above (p42) for further information):

> *'Arranging for adequate interpreting services is a challenge for healthcare in Yarl's Wood and appears to be nearly impossible for X's language. This is evident in many instances as reported by X and as recorded in her records. At the point that the subject of mefloquine was raised there is no evidence that a discussion outlining the risks and benefits of use in the first trimester took place. The prescription of Kalms was issued without any documented discussion about its use in pregnancy. In the absence of an interpreter the GUM clinic could not do an exam or take bloods, both essential to the effective management of sexually transmitted diseases in pregnancy. A critical second discussion about termination of pregnancy was impossible due to lack of interpreting.*
>
> ***The absence of adequate interpreting services is a risk to X's pregnancy in detention and contravenes IRC operating standards**, current NHS guidelines for antenatal care, as well as the principle that detainees are entitled to care equivalent to that available in the wider community.'*

Without evidence based information and support in a language that they understand, women are unable to make informed choices about their care. Furthermore, as shown in the case above, it can even be a risk to a woman's pregnancy and her own mental health.

## Reem: Poor record-keeping

Reem was 25 weeks pregnant when she was detained at Yarl's Wood and released after five and a half weeks.

Throughout her detention Reem suffered with severe headaches, pelvic pain and generalised itching all over her body. The headaches and lower abdominal pain were unresponsive to paracetamol and aqueous cream did not help the itching that caused her to have insomnia. Obstetric cholestasis is associated with stillbirth and premature delivery. According to NHS Choices:

> *'The main symptom is severe generalised itching (all over your body) usually without a rash, most commonly in the last four months of pregnancy. Some women get itching and a severe rash. For some women with OC, the itching is non-stop or unbearable, and can be worse at night.'*

The healthcare team at Yarl's Wood was sufficiently concerned to order liver function tests (LFTs) on Reem:

> *'Obstetric cholestasis is diagnosed when otherwise unexplained pruritus occurs in pregnancy and abnormal liver function tests (LFTs) and/or raised bile acids occur in the pregnant woman and both resolve after delivery.'* [168]

There is no result or reference to a result for the LFTs in Reem's medical records. This shows that even though they were sufficiently concerned to order the tests, they then failed to follow up and/or document the results.

At 29 weeks the community midwife referred Reem to the Bedford Hospital Day Assessment Unit because of reduced fetal movements. The hospital complained that she did not have her maternity notes with her. Handheld maternity records are a basic principle of antenatal care in the UK. According to NICE:

> *'Maternity records should be structured, standardised, national maternity records, held by the woman.'* [169]

Had they seen her records the staff at Bedford may have learned of Reem's pruritus and followed up on her LFT result. In any event her reporting reduced fetal

movements would be assessed in the knowledge that she might have obstetric cholestasis.

Reem was released a few days later following a letter on her behalf from Medical Justice, which highlighted that removal was not imminent, she had an appeal pending and Reem was at this stage very late in her pregnancy. Since her release, Reem has had her baby. Her immigration case is pending and she continues to report fortnightly.

## iii) Inadequate access, choice and continuity of care:

One of the principles outlined in the NICE guidance on Antenatal Care CG 62[170] is whether the woman has had easy access, choice and continuity in her antenatal care. Women who are placed in immigration detention have no choice over where they access their antenatal care or who their midwife might be. Their antenatal care will necessarily be interrupted by being detained and they will normally receive their care from a different provider either before and/or certainly after their release.

Data from the interviews highlighted that women felt they did not have choices around their antenatal care. One woman stated:

> *'I was not asked to sign anything by the doctors. I was not able to make any decisions, I was taken from place to place.'*

Many of the complaints that women had related to healthcare, their own welfare, and fears over the welfare of their unborn child. For example:

> *'I wasn't the only pregnant woman in detention. Most of us had a similar experience. When they say you can't go home, it's like a panic attack. It's very bad for your health. Even for people who aren't pregnant, it's bad. They make people really weak. The food in detention is really bad. If you're pregnant you don't feel like eating what everyone else is eating. Being there is very bad for your health and for pregnant women, the treatment is really awful. ….Pregnant women should not be detained. Children should not be detained.'*

Lord West of Spithead on behalf of the Home Office stated the following with regards to the nutrition provided to pregnant detainees:

> *'All women who are intending to get pregnant or are less than 12 weeks gestation are offered folic acid supplements. All pregnant women at any stage of the pregnancy, or who are breast feeding, are routinely offered Vitamin D and also receive extra fruit and an additional fresh milk allowance.'* [171]

Detainees can access 250mls of milk 3 times a day and one extra piece of fruit 3 times a day.[172] However, according to the women we interviewed, this was inadequate. The food in detention and mealtimes were a repeated concern amongst interviewees. Numerous entries were documented in healthcare notes of women reporting that they were hungry. In addition, there was little documentation around diet, even for a woman with documented hyperemesis (pregnancy condition characterised by intractable nausea and vomiting) and weight loss. The woman was simply told to eat and drink.

Another pressing issue is that detention invariably disrupts continuity of care. Of the 20 women in the sample, nine were released to different addresses, prior to being detained. (Although three were detained on arrival into the UK; one was removed; and one voluntarily returned to her home country). The impact of interrupted antenatal care was identified in one of the MLRs where the doctor wrote:

> *'She has been parted from her previous midwife with whom she had a helpful and supportive relationship and received confusing contradictory advice about the treatment of her streptococcal infection.'*

In addition, the majority of the women had close ties in their local community and 13 had fathers of their babies in the UK.

Upon leaving detention, some women were left to travel alone great distances. One woman in interview recalled the trauma of having to make her way from Bedford to Middlesbrough.

> *'When I left the detention centre, I was with all my luggage and they left me at the train station. I had to carry all my luggage with me and had to go all the way to Middlesbrough. I was 7 months pregnant and it was hard. I did not ask anyone to help me because I was so scared. It was very sad.'*

Most women who were released stayed in the address they were released to until after the birth of their child. However, there were some women who moved two to three times following their release, often because they were dispersed to hotel/ hostel temporary accommodation that was time limited. For example, in one case, the Refugee Council telephoned the relevant Home Office caseowner, expressing concern over a woman who had been told to leave her temporary accommodation at 28 weeks pregnant after just one day, allegedly because her appeal rights were exhausted and had no entitlements.

The impact of interrupted care can be disastrous. As noted by a recent report by Maternity Action and the Refugee Council:

> *'Dispersal and relocation of pregnant women seeking asylum has a serious impact on their physical and mental health, and negatively affects the maternal care they receive.'* [173]

This has been attributed to a number of reasons, including the separation from family and a move away from their midwives and/or GPs.

Most of the women in the sample who left detention were either given Section 4 or Section 95 support.[174] This entitles them to less than 70% of Income Support, which some interviewees reported to be inadequate. Those on Section 4 had no cash at all (except £3 a week if they completed the relevant UKBA maternity forms). One woman explained in her interview the frustration she felt, having to use a voucher card in specific shops rather than having access to cash. This added to the feelings of stress and disempowerment.

A recent parliamentary question showed that the Secretary of State has had no discussions at Ministerial level with the Secretary of State for Health on the policy of the dispersal of pregnant women seeking asylum, despite continuous lobbying efforts by NGOs.[175]

## d. Factors contributing to an ineffective, unworkable and damaging policy

Given the transient nature of the detainee population, healthcare provision is not designed to cater for long-term patient care. In addition, detainees tend to have multiple healthcare needs and as this sample shows, obstetric vulnerabilities. Given that the detainee population are "temporary", there is a focus on managing acute risk in IRCs rather than addressing the root causes.[176]

International codes of healthcare ethics generally mandate complete loyalty to patients: the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. The Declaration of Geneva states that: 'The health of my patient will be my first consideration'.

"Dual loyalties", or "dual obligations", refer to the conflicting demands placed on doctors who have direct obligations to their patients as well as to a third party.[177] Literature on medical ethics discusses the conflicting interests that may arise amongst healthcare professionals. Settings in which loyalties may be challenged include: prisons, immigration detention centres, the military and in forensic evaluations.[178]

A recent report on the doctor- patient relationship within IRCs in the United States highlighted that 'conflicts arise when health professionals are torn between their duties to their patients and their obligations to an employer, government, insurer, or the military'. The report stated that this was a common problem in immigration detention centres, prisons, and other secure environments. The report found 'consequences of dual loyalties can be devastating for patients'.[179] Doctors in UK detention centres are likely to face similar challenges, seeing themselves as part of the "system".

In July 2010 in an interview with *The Independent*, Anne Owers, then the Chief Inspector of Prisons, suggested that that there was a "conflict" between forced removal of non-citizens and the appropriate treatment of detainees, suggesting that the roles should be separated to allow healthcare staff to maintain clinical independence.[180, 181] Commentators have noted that a "culture of disbelief" exists amongst IRC healthcare staff.[182] Detention staff may become cynical when faced with reported health concerns that they may perceive to be attempts to frustrate removals.

Recent correspondence between two clinical staff employed in detention centres in the UK (a nurse at Yarl's Wood and a doctor at Harmondsworth) expose the dual loyalties that exist. The GP, employed at Harmondsworth, wrote the following, advising against such any change of policy which would see the end of the detention of pregnant women: '*…my IRC colleagues and I believe that standards should be raised and no changes made to the system otherwise women may become pregnant to avoid detention*'.

In a separate email, he stated:

> *'In my opinion there are other issues that need to be considered before …giving approval to changes in the current system. Other than clinical, there are ethical, political and judicial issues (…)* ***I strongly feel that such a knee jerk response could be inappropriate and damaging to the system we are there to support****. (…) there is a very real risk of females becoming pregnant just to avoid detention. This may sound unlikely but* ***I have extensive experience of detainees (understandably) trying anything to avoid detention****.'*

In a third email from the same IRC GP, he admits that '*healthcare standards have been unacceptable*'; that '*there is no formal evidence*' for his assumption that women will get pregnant; but still concludes that: '*I think a policy change could do more harm than good*'.

In this regard, it is important to be cognizant of the interest private healthcare providers may have in people being detained. Whilst the Home Office seeks to increase the numbers of people detained and removed, the private companies have a commercial interest in winning contracts, executing successful removals, cutting expenditure and maximising the number of bed spaces and usage of their facilities.

The Refugee Studies Centre wrote with concern about the relationship between government policy and private contractors:

> *'It is not only formidable government policies and legislation which construct barriers to reform, but also a large, politically and economically powerful private industry which relies on the continued profits and consequently the continued incarceration of a growing number of asylum seekers. (…) as long as there is excess capacity in the detention estate, there will be pressure to fill the empty spaces. This means there will be a continued commercial interest in the continuation of a 'get tough'*

*attitude towards asylum; maintaining detention as an integral part of the asylum regime; and encouraging the prevailing view that asylum seekers are compromising the interests of the state.'* [183]

Such allegations have also been made with regards to the prison estate. The Prison Reform Trust argue that with profit as a driving motive, vested interests could create pressure to grow the market and further inflate prison numbers. They note a multitude of problems associated from the privatisation of prisons. For example, poor pay and conditions, high staff turnover, low staffing levels, inexperienced staff and concerns over assaults and safety.[184]

In addition, with the devolution of responsibilities, it is often unclear where responsibility or culpability falls, which can thereon create a vacuum for accountability.[185] Outsourcing can encourage a closed culture with a lack of transparency. As part of this research, Medical Justice repeatedly asked to consult healthcare staff at Yarl's Wood and for a guided tour of the healthcare centre. This was declined by the Yarl's Wood healthcare manager, who stated: '*MJ have stated that they would like to consult with Healthcare staff at YW and NHS Bedfordshire. I am opposed to this* (…)'. Medical Justice escalated the request but this too was declined by the Deputy Director of Detention Operations, the Director of the Returns Directorate and the Minister of Immigration.

The mistrust identified on the part of healthcare staff was also identified on the patient side of the relationship, some of whom even highlighted what they perceived to be "dual loyalties". For example, one woman stated:

*'When you go to healthcare and you feel pains, they don't write it down in the notes. Because they don't want it on paper, they don't want a record of it. From my experience, I think they are trained to help the UK Border Agency.'*

The lack of trust in healthcare is reflected in the numbers of appointments that are booked for the women but they do not attend. In total, ten appointments with midwives were missed because the patient did not attend. Another relevant factor identified was in relation to anti-malarial prophylaxis. For those who refused to take it, there was an accompanying feeling that the staff prescribing it to them did not have their interests at heart.

When a detainee arrives in detention, it may not be immediately apparent to the detainee that the healthcare professional performing the health screening is not employed by immigration services, but to provide them with healthcare. They may see healthcare screening as an interrogation rather than safe confidential place for advice and support. Furthermore, when being offered medication for the purposes of assisting the Home Office to remove them, particularly when there are known contraindications, the independence of the clinician may become compromised in the eyes of the patient.

Poor communication channels, a lack of monitoring and dual loyalties encourage the failure to identify and release pregnant women who are unfit for detention or unfit for removal. Pregnant women are not alone here. Indeed, there is a wealth of literature highlighting concern of the treatment of other vulnerable groups, notably torture survivors and the mentally ill. With both of these groups, it has been exposed that UKBA are unable to implement their own rules and detain them in only very exceptional circumstances.[186] In cases where such individuals may be detained and their health is deteriorating in detention, the safeguarding policy that should identify and release them has been shown to be ineffective.

# Chapter Ten – Conclusion

This report shows how a belligerent immigration policy can negatively impact upon one of the most vulnerable groups in our society. Pregnant asylum seekers have multiple health needs, as well as poorer maternal outcomes and a higher prevalence of mental health problems than the general population. Yet, they are detained for immigration purposes.

The current policy on detaining pregnant women for immigration purposes is flawed. The primary purpose of detention is removal, yet this research and a previous audit show that only around 5% of pregnant women are successfully removed.[187] This is because, in the majority of cases, there is no safe way to return them.

Detaining pregnant women is therefore not only ineffective but it is also damaging. The data results show that the healthcare pregnant women receive is inadequate. There is evidence that the level of care falls short of NHS equivalence and breaches of NICE guidelines and national guidance on malaria prevention were identified. Immigration detention introduces discontinuity in women's care and the stress of detention can impact on their mental health and their pregnancy.

The National Institute of Health and Care Excellence (NICE) states that:

> *'The 'Changing childbirth' report (Department of Health 1993) and 'Maternity matters' (Department of Health 2007) explicitly confirmed that women should be the focus of maternity care, with an emphasis on providing choice, easy access and continuity of care.'* [188]

Immigration detention negates these principles of maternity care. Women have no choice over where they access care, when they see a midwife or which midwife they see. In addition, pregnant women are subject to interrupted care: the antithesis of what is central to recommended practice.

With so few pregnant women detained and limited prospects for the removal of this group, the government should seriously question why they are detaining them – and not merely on an ethical level. Detention is not serving any purpose: the costs are great and the damage to women's health can be dramatic.

# Chapter Eleven – Recommendations

**Our primary recommendation is to end the practice of detaining pregnant women. This requires a simple administrative re-wording of policy, which can be implemented immediately. In the meantime, a number of emergency interim recommendations are proposed below:**

## 1. Pregnant women should not be detained for immigration purposes:

This recommendation is in line with Asylum Aid's Charter of Rights of Women Seeking Asylum that is supported by 337 organisations.[189] The Charter contains the provision:

> *'4. Women seeking asylum have the right to be treated with dignity in a way that is appropriate to their needs as women and that ensures their safety if in detention or during removal.*
>
> *To realise this right, the UKBA should:*
>
> *(…) d. not detain women who are breastfeeding or at any stage of pregnancy'*

## 2. Existing policy must be implemented in practice:

While the practice of detaining pregnant women continues, at a minimum the government should ensure that the existing policies pertaining to pregnant women are properly implemented. This includes that they should only be detained in very exceptional circumstances; that Immigration Directorates' Instructions on malaria prophylaxis are always implemented; and that the use of force is only used to prevent harm. Healthcare should also be of NHS equivalent standard.

## 3. Address the existing policy contradiction:

For women from high risk malarial areas, who are either in their first trimester of pregnancy and/or either have a history of or current mental health problems, there is no safe way to return them. The current policy is unworkable for this group. Given that removal is unsafe, people that fall in to this category must not be detained.

## 3. Detention Reviews:

Detention reviews should always be held in the Subject Access Request file. The Pregnant Lady Notification form should trigger an immediate detention review. This needs to be formalised in policy guidance.

## 4. NICE guidance should be followed:

The Home Office should recognise that pregnant asylum seeking women have complex needs and ensure that the healthcare professionals they contract are aware of and implement the following NICE guidance: NICE Antenatal Guidelines CG 62; NICE Pregnancy and complex social factors CG 110; and NICE Antenatal and postnatal mental health CG 45.

## 5. Monitoring of all pregnant women entering detention:

Statistics must be collected on the number of pregnant women entering immigration detention. There should be external monitoring of whether policies are implemented in practice and whether NICE guidance is being followed. This information should be made publicly available.

## 6. Malaria Advice:

All women must be provided with information about the benefits and risks of taking malaria prophylaxis in a language they understand in order to give informed consent. This should be provided orally and in written format.

The Home Office should follow the recommendation from the Advisory Committee on Malaria Prevention in UK travellers: 'Specialist advice should be provided for pregnant women and those with medical conditions. The Home Office may wish to contract out this advice and prescription to a single clinic/centre for consistent advice.' In addition, any prescription of mefloquine must only be done following a full mental health assessment.

## 7. Improved record-keeping:

Record keeping should be electronic and centralised. If midwives do not write their observations in the healthcare notes a photocopy of women's antenatal records should be incorporated into the women's IRC healthcare notes.

## 8. Rule 35 forms should be completed for every pregnant woman:

This is in order to alert the caseowner of the woman's pregnancy and should encourage the caseowner to review the detention in light of this (new) information. Rule 35 forms should include information on any complications of the pregnancy and implications for the likelihood of removal taking place.

## 9. The basic needs of pregnant women should be met:

This should include: specific rooms for pregnant women with alternate mattresses and pillows; supplementary clothing for pregnant detainees; greater cash allowance; increased opportunity to use the cultural kitchen; more generous nutrition and diet allowance. In addition, pregnant women should not be subject to health screenings in the middle of the night or long journeys to IRCs.

## 10. Training for healthcare staff:

This should address, in particular: cultural competency issues; how to impart evidence based information and gain informed consent from patients; how to recognise and manage vulnerable groups; how to take full histories during health screenings; and how to identify and fulfil interpreting requirements.

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# Annex

## The National Institute for Health and Care Excellence (NICE) Guidance

NICE guidelines provide standards, which can be used to assess whether the care that pregnant women receive in Yarl's Wood is equivalent to that received in the broader community. Relevant standards are included below.

### 1. Antenatal care CG 62[190]

- Does she hold her own maternity record?
- Is communication by healthcare professionals supported by evidence based written information in her preferred language?
- Is information accessible for women who do not speak English?
- Is she offered evidence based information as well as support to make informed choices about her care?
- Does she have the opportunity to have screening for Down's syndrome either between 11 weeks and 13 weeks + 6 days or between 15 weeks and 20 weeks?
- Does she have the opportunity to have a dating scan?
- Does she have the opportunity to have a scan for structural anomalies usually between 18 weeks and 20 weeks +6 days?
- Has she been screened to determine whether she will need extra care in the current pregnancy?
- Does she have the opportunity to review and discuss the results of tests undertaken?
- Has she had easy access, choice and continuity in her antenatal care?

### 2. Pregnancy and complex social factors CG 110[191]

- Are her handheld notes and relevant health record complete and contain the results of all antenatal tests? (Because of the likelihood of release/ resettlement or dispersal and the possibility of removal she will need a clear record of her care to date to ensure continuity.)
- Is there ready access to professional interpreting services?
- Has provision been made for information in a variety of formats and languages?

### 3. Antenatal and postnatal mental health CG45[192]

- Have health care professionals asked her about past or present mental illness, treatment for mental illness or a family history of mental illness?
- In her contact with primary care and at booking was she screened to identify possible depression?
- After identifying a possible mental disorder has referral been made for further assessment
- Where treatment is being considered has a healthcare professional discussed the risks of treating and not treating the mental disorder in pregnancy?

## The Immigration Directorates' Instruction (IDI), Chapter 1, Section 8, outlines UKBA policy on malaria prophlyaxis.[193]

The following key extracts are of relevance:

### Pregnant women are at risk and require malaria prophylaxis:

5.3 (…) example pregnant women and children under 5, may be particularly vulnerable to infection and therefore may need inoculation or other prophylaxis in preparation for their return.

### Patients should receive information and advice about malaria prophylaxis:

5.6 (…) Where removal centre medical staff consider that preventive treatment should be given, removal directions may be set but should be dependent on any pre-departure element of such treatment being completed. Medical advice on preventive measures, including advice leaflets, should be made available to detainees as soon as possible, and should if possible be given as appropriate in the initial medical examination or screening which all detainees receive within 24 hours of detention, and in any case when removal directions are set.

### Removal Directions (RDs) should be set for a date after treatment is completed where preventative treatment is necessary:

5.6 (…) Where removal centre medical staff consider that preventive treatment is necessary and can be completed (subject to para 5.7 below) without delay to planned removal, removal directions may be set but for a date after the treatment is completed.

### Caseworkers should consult healthcare about medication prior to setting Removal Directions:

5.6 (…)Caseworkers and those responsible for setting removal directions should consult the health care professionals, via the IND team at the centre, on the appropriate minimum time lag between administering medication and removal taking place. Caseworkers, those responsible for setting removal directions and IND teams at removal centres should document case histories as thoroughly as possible. This is because, if a JR is commenced, access to a claimant's medical records cannot be guaranteed. Therefore, if staff have carefully minuted, for example, any refusal of malarial prophylaxis after it has been offered, then that may make it easier to keep RDs in place, respond to any further representations on the point and/or defend any JR claim. These points should if possible be minuted directly on CID.

### Malaria prophylaxis should be prescribed in time to establish tolerance:

5.7 (…)Any malaria prophylaxis recommended as appropriate by the removal centre medical staff for pregnant women and children under 5 should normally be provided and time allowed for it to take effect before removal. The guidance by the Advisory Committee on Malaria Prevention (at Appendix, together with a supplementary letter) should be followed and copies of it should be given to the detainees concerned. Specialist advice (according to the relevant condition or age of the detainee), which can be obtained from a helpline, should be provided for pregnant women, children under 5 and those with medical conditions which might contra-indicate the prophylaxis. In the event of adverse side-effects, time should also be allowed to obtain and follow further medical advice.

### Removal need not be deferred where detainees decline malaria prophylaxis:

5.7 (…) Removal need not be deferred in any case where a detainee declines (on his or her own behalf or on behalf of a dependent child) to take malaria prophylaxis that has been provided on medical advice.

## IDI appendix:
## The Advisory Committee on Malaria Prevention in UK travellers (ACMP): advice when deporting individuals at risk from malaria

### 1. Risk

1.1 Persons returning to their original homes in malarious regions may have suffered a decline in the partial immunity to malaria that develops during childhood and is maintained by repeated exposure while living in endemic regions; they may therefore be at increased risk of suffering an acute attack of malaria after returning home.

1.2 Pregnant women and small children are at higher risk than others of suffering severe disease.

### Drug options and safety

4.4 Doxycycline is not an appropriate prophylactic for pregnant women or children under 12 years. Mefloquine would be a better option. After expert consultation, Mefloquine may be considered for use even in the first trimester of pregnancy.

4.5 For pregnant women, Chloroquine /Proguanil (C+P) is safe for use in the first trimester, however, its effectiveness is declining significantly in most areas, and it is now not appropriate in many areas of the world, particularly in sub-Saharan Africa.

4.6 Note that there is little evidence on safety of co-administering anti-malarials and anti-retrovirals during pregnancy. Mefloquine is probably safe to coadminister while the clinical significance of co-administering chloroquine/proguanil with anti-retrovirals is unclear.

4.7 Prophylaxis should not be relied on by itself and other protective antimosquito measures should also be used.

### Timing of start of use

4.8 Malaria chemoprophylaxis (for the two high risk groups stated above) may be started shortly before departure and in general should not be a barrier to returning persons to their home country. Mefloquine is generally started with a 2- 3 week window usually to determine tolerance if it has not been used before. If deportation is delayed, stopping and restarting the prophylactic regime should not be a problem.

### Proposed Assessment and Advice

(…)
E) Specialist advice should be provided for pregnant women and those with medical conditions. The Home Office may wish to contract out this advice and prescription to a single clinic/centre for consistent advice.

# The rights of women seeking asylum: a charter


## endorsements

**The organisations below have endorsed this Charter of rights of women seeking asylum and are committed to promoting these rights.**

1. Account3
2. Advance Advocacy Project
3. AdviceUK
4. Africa Educational Trust
5. African Voices Forum
6. African Women's Care
7. Afro-Asian Advisory Service
8. Afruca
9. Agency for Culture and Change Management
10. Al-aman, Domestic Violence Prevention Project
11. Akina Mama wa Afrika
12. Amnesty International UK
13. ARKH (Asylum seekers and Refugees of Kingston upon Hull)
14. Asian Women's Resource Centre
15. Ashiana Sheffield Ltd.
16. ASLEF Women's Committee
17. Association of Jewish Women's Organisations in the UK
18. Association of Visitors to Immigration Detainees (AVID)
19. Asylum Aid
20. Asylum and Refugee Women's Project- Mewn Cymru
21. Asylum Research Consultancy
22. Asylum Rights Campaign
23. Asylum Support and Immigration Resource Team (Birmingham)
24. Asylum Support Appeals Project
25. Asylum Welcome
26. Anti-Trafficking Legal Project
27. Aurora New Dawn Ltd
28. Avon & Bristol Law Centre
29. Back 2 Basic Creates
30. Bail Circle
31. Bail for Immigration Detainees
32. The Baptist Union of Great Britain
33. BARAC (Black Activists Rising Against Cuts)
34. Barnet Refugee Service
35. BEMIS – Black and Ethnic Minority Infrastructure in Scotland
36. BIHR – British Institute of Human Rights
37. Birnberg Peirce and Partners
38. Birth Companions
39. Boaz Trust
40. BRASS (Bedfordshire Refugee & Asylum Seeker Support)
41. Bradford Refugees and Asylum Seekers Stories (BRASS)
42. Bridge + Tunnel Voices
43. Brighton Housing Trust
44. Brighton Voices In Exile
45. Bristol Detainee Support Group
46. British Association of Social Workers
47. British Black Anti-Poverty Network
48. British Red Cross
49. Bradford African Women Empowerment Forum
50. Bury Law Centre
51. Butterfly Migrant Women's Project
52. CAADA (Co-ordinated Action Against Domestic Abuse)
53. Campaign Against Criminalising Communities (CAMPACC)
54. CARE (Christian Action Research and Education)
55. Centre for Armenian Information & Advice
56. Centre for Equality and Diversity
57. The Centre for Law, Gender and Sexuality at Westminster
58. Centre for Trauma, Asylum and Refugees – Essex University
59. Child and Woman Abuse Studies Unit – London Metropolitan University
60. Children's Rights Alliance of England – CRAE
61. Chinese Information and Advice Centre
62. The Children's Society
63. Churches Refugee Network
64. Churches Together in Britain and Ireland
65. Citizen's Organising Foundation
66. Community Law Clinic (CLC Solicitors)
67. Compass
68. Council for Assisting Refugee Academics (CARA)
69. The Coventry Refugee Centre
70. Crisis
71. Crossing Borders (Medsin-UK)
72. CWSG Cardiff
73. DASH - Destitute Asylum Seekers Huddersfield
74. Deighton Guedalla Solicitors
75. developing partners
76. Devon & Cornwall Refugee Support
77. DEWA Project
78. Diapalante
79. Displaced People In Action
80. Domestic Violence and Sexual Abuse Counselling Service
81. Doughty Street Chambers - The Immigration Team
82. Dover Detainee Visitor Group
83. Ealing Equality Council
84. Eaves Housing for Women Ltd – The Poppy Project
85. ECPAT UK
86. Employability Forum
87. End Violence Against Women Coalition
88. Engender
89. The Equal Rights Trust
90. Equality Now
91. Equality South West
92. The European Women's Lobby (EWL)
93. The Evelyn Oldfield Unit
94. Fair Play South West
95. Fawcett Society
96. Forward
97. Freedom from Torture
98. FAWA (French African Welfare Association)
99. Gatwick Detainees Welfare Group
100. Gender and Participation (GAP) Unit, Manchester Metropolitan University
101. Genesis
102. George House Trust
103. GMB
104. Gloucestershire Action for Refugees and Asylum Seekers
105. Govan and Craigton Integration Network
106. Greater London Domestic Violence Project
107. Greater Manchester Immigration Aid Unit
108. Greater Pollok Integration Network
109. The Green Party
110. Hackney Refugee and Migrant Support Group
111. Hackney Women's Forum
112. Hammersmith and Fulham Refugee Forum
113. Havelock Family Centre
114. Health Advocacy Project
115. Helen Bamber Foundation
116. Hibiscus
117. Hillingdon Women's Centre
118. The Housing Associations' Charitable Trust
119. Housing for Women
120. Immigration Advisory Service
121. Immigration Law Practitioners' Association
122. Immigration Support Calderdale

123. IMECE Turkish Speaking Women's Group
124. Imkaan
125. Independent Academic Research Studies (IARS)
126. International Care Network
127. International Centre for Eritrean Asylum Seekers and Refugees
128. International Coalition Against Violence in Iran
129. International Council of Jewish Women
130. International Solidarity Network, Women Living Under Muslim Laws (WLUML)
131. Iranian and Kurdish Women's Rights Organisation
132. Iraq Body Count
133. Iraqi Association
134. Islington Refugee Forum
135. James and Co Solicitors
136. Jesuit Refugee Services UK
137. Jewish Community Centre for London
138. Jewish Council for Racial Equality
139. Joint Council for the Welfare of Immigrants
140. Justice For Domestic Workers
141. Justice for Women
142. Kalayaan
143. Kingdom Love Christian Centre
144. Kirklees Law Centre
145. Knowsley Domestic Violence Support Services
146. Kurdish & Middle Eastern Women's Organisation Ltd.
147. Latin American Women's Aid
148. Latin American Women's Rights Service
149. Latitude Law
150. LASA Charity UK
151. Law Centres Federation
152. Law Centre (Northern Ireland)
153. Lawrence Lupin Solicitors
154. Leeds Asylum Seekers' Support Network
155. Leeds Women's Aid
156. Lewes Group in Support of Refugees and Asylum Seekers
157. Lewisham Churches for Asylum Seekers
158. Lewisham Refugee Network
159. LGBT Youth Scotland
160. Liberty
161. Liverpool Prisons Visitors Group
162. London Detainee Support Group
163. London Feminist Network
164. London South Bank University Refugee Studies
165. London Voluntary Service Council
166. MA Refugee Studies programme, University of East London
167. Manchester Refugee Support Network
168. Maternity Action
169. Medact
170. Medical Justice
171. Merseyside Asylum Seeker Health
172. The Methodist Church in Britain
173. Migrant Helpline
174. Migrants' Law Project
175. Migrants Resource Centre
176. Migrants' Rights Network
177. Minority Rights Group International
178. Multilingual Community Rights Shop
179. Multilingual Wellbeing Service
180. Musicians' Union
181. NASUWT, The Teachers' Union
182. National Alliance of Women's Organisations
183. NAPO
184. National AIDS Trust
185. National Board of Catholic Women
186. National Coalition of Anti-Deportation Campaigns
187. The National Council of Women of Great Britain
188. National Union of Students
189. National Union of Teachers
190. Newcastle Law Centre
191. Newham Asian Women's Project
192. nia
193. No Recourse to Public Funds (NRPF) Network
194. North of England Refugee Service
195. Northern Ireland Community of Refugees and Asylum Seekers
196. Northern Refugee Centre
197. Notre Dame Refugee Centre
198. Nottingham and Nottinghamshire Refugee Forum
199. Nour – Domestic Violence
200. OBJECT
201. Ogunte
202. Older Feminist Network
203. One Parent Families Scotland
204. ORA UK (Oromo Relief Association UK)
205. Oxfam
206. Paragon Law
207. Public and Commerical Services Union (PCS) Women's Forum
208. Peace in Kurdistan Campaign
209. Platform 51
210. Positive Action for Refugees and Asylum Seekers
211. Positively UK
212. PozFem UK
213. Praxis Community Projects
214. Prospect
215. Quaker Peace and Social Witness
216. Quilliam
217. Race On The Agenda
218. Rape and Sexual Abuse Support Centre (Rape Crisis South London)
219. Rape Crisis
220. Rape Crisis Scotland
221. REACH Domestic Abuse Project
222. Reading Refugee Support Group
223. REDRESS
224. Refugee Action
225. Refugee Action Group
226. Refugee and Asylum Seekers Participatory Action Research – RAPAR
227. Refugee & Migrant Forum of east London – RAMFEL
228. Refugee & Migrant Justice
229. Refugee Assessment and Guidance Unit
230. Refugee Council
231. Refugee Forum Calderdale
232. The Refugee Mentoring Project at Terence Higgins Trust
233. Refugee Network Sutton
234. Refugee Resource
235. Refugee Therapy Centre
236. Refugee Women's Association
237. Refugee Women's Strategy Group
238. Refugees in Effective and Active Partnership (REAP)
239. RenéCassin
240. Respect (Association for domestic violence perpetrator programmes)
241. Rights of Women
242. Rochdale Law Centre
243. Roehampton University
244. Roj Women's Association
245. Rosa – the UK fund for women and girls
246. The Royal College of Midwives
247. Ruth McNeil and Associates
248. St. Augustine's Centre, Halifax
249. St Mary Magdalene Centre
250. Sahan Society Centre
251. Sahir House
252. Santé Refugee Mental Health Access Project
253. SARSVL (Support After Rape and Sexual Violence Leeds)
254. Scottish Detainee Visitors
255. Scottish Refugee Council
256. Scottish Refugee Policy Forum
257. Scottish Women's Aid
258. School of Oriental and African Studies
259. Sheffield Women's Counselling and Therapy Service
260. Sion Centre for Dialogue and Encounter
261. Solace
262. Solace Women's Aid
263. Solidarity
264. Soroptomist International Loughborough
265. South Yorkshire Migration and Asylum Action Group
266. Southall Black Sisters
267. South London Fawcett Group
268. South London Refugee Association
269. Southwark Day Centre for Asylum Seekers
270. Southwark Law Centre
271. Standing Together
272. STOP UK
273. Student Action for Refugees
274. Sufficient Grace For Women
275. Swansea Bay Asylum Seekers Support Group
276. Swansea Women's Asylum Support Group
277. Talk Visa LLP
278. Tamil Information Centre
279. Tamil Relief Centre
280. Tamil Women's Development Forum
281. Tender Education & Arts
282. The Angelou Centre
283. The Eagles Wing
284. The Harbour Project
285. The Testimony Project
286. The Women's Aid Group, Bury
287. Trinity Church United Reformed and Methodist Church Harrow,
288. TUC
289. UK Black Pride
290. UK Coalition Against Poverty
291. UK Feminista
292. UK Lesbian and Gay Immigration Group
293. UNDUGU – African Swahili Community Project
294. United Reformed Church

295. Unity Centre, Glasgow
296. Urban Partnership Group
297. Umoja Inc
298. Voluntary Action Calderdale
299. Wales Women's National Coalition
300. Warrington Domestic Abuse Advocacy
301. Wearside Women in Need
302. WECARe+ (Women in Europe and Central Asia Regions)
303. Welsh Refugee Council
304. Welsh Women's Aid
305. Welwitschia Legal Advice Centre
306. Wesley Gryk Solicitors
307. West London Refugee Women's Forum
308. Westminster Justice and Peace Commission
309. Westminster Women's Forum
310. White Ribbon Campaign
311. Why Refugee Women
312. Widows for Peace Through Democracy
313. WOMANKIND Worldwide
314. Women @ the Well
315. Women and Girls Network
316. Women Asylum Seekers Together – London
317. Women Asylum Seekers Together – Manchester
318. WomenCentre
319. Women for Refugee Women
320. Women in Prison
321. Women Seeking Sanctuary Advocacy Group Wales (WSSAG Wales)
322. Women's Association for African Networking and Development
323. Women's Aid Federation of England
324. Women's Aid Federation Northern Ireland
325. Women for Women International
326. Women's Health and Equality Consortium
327. Women's Health and Family Services
328. Women's Health Matters
329. Women's International League for Peace and Freedom
330. Women's National Commission
331. Women's Resource Centre
332. Women's Support Project
333. Yarl's Wood Befrienders
334. Zero Tolerance
335. Zimbabwe Association
336. 1 Pump Court
337. 28 Too Many

# Endnotes

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2 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 55.10 http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary

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4 G. Lewis (ed.) (2004) *Why Mothers Die 2000-2002, The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*, London, CEMACH 2007 http://www.hqip.org.uk/assets/NCAPOP-Library/CMACE-Reports/33.-2004-Why-Mothers-Die-2000-2002-The-Sixth-Report-of-the-Confidential-Enquiries-into-Maternal-Deaths-in-the-UK.pdf G. Lewis (ed.) (2007) *Saving mothers' lives: reviewing maternal deaths to make motherhood safer – 2003–2005, Seventh Confidential Enquiry into Maternal and Child Health* http://www.publichealth.hscni.net/sites/default/files/Saving%20Mothers'%20Lives%202003-05%20.pdf

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6 The total had been 22 but two were excluded from the sample. In one case, the woman had only been detained for a day and the second woman miscarried a few days after being detained but it was unclear at what point she had miscarried; it may have been just prior to being detained.

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9 The Migration Observatory (2011) The University of Oxford, *Briefing: Immigration Detention in the UK,* 08/03/11 http://migrationobservatory.ox.ac.uk/sites/files/migobs/Immigration%20Detention%20Briefing.pdf

10 http://www.indymedia.org.uk/en/2008/05/399156.html

11 UKBA, *Immigration Statistics: April-June 2012* http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/immigration-asylum-research/immigration-tabs-q2-2012/detention-q2-2012-tabs

12 As of January 2011, there were 907 FNPs detained in IRCs and 760 in the prison estate. Independent Chief Inspector of the UK Border Agency (2011) *A thematic inspection of how the UK Border Agency manages foreign national prisoners,* February-May 2011. http://icinspector.independent.gov.uk/wp-content/uploads/2011/02/Thematic-inspection-report-of-how-the-Agency-manages-Foreign-National-Prisoners.pdf In addition, there were 3,444 detainees held in prisons under immigration powers during 2011. http://www.whatdotheyknow.com/request/108414/response/270191/attach/3/FOI%2021945%20response.pdf

13 UKBA Detention Data tables: Immigration Statistics July to September 2012, published 29 November 2012 https://www.gov.uk/government/publications/detention-data-tables-immigration-statistics-july-to-september-2012

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15 Aspden, J. (2008), *Evaluation of the Solihull Pilot for the UKBA and LSC*, p6. http://www.asylumaid.org.uk/data/files/publications/137/Solihull_Pilot.pdf

16 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 45 http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/oemsectione/chapter45?view=Binary

17 Detention services order 03/2012, *Pregnant women in detention* http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/detention-services-orders/pregnant-detention?view=Binary

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19 The Detention Centre Rules 2001 http://www.legislation.gov.uk/uksi/2001/238/pdfs/uksi_20010238_en.pdf

20 Email, 13 Jun 2012, from Emma Ross, Head of Operational Policy – Detention Operations.

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22 NHS Bedfordshire (2011), *A Refresh Health Needs Assessment of Adults Detained in Yarl's Wood Immigration Removal Centre (IRC),* June 2011.

23 Email correspondence with Patricia O'Brien, Detention Operations, Enforcement and Crime Group

24 Minutes of a meeting held on 16/2/12 with Lesley Quinn (Serco Health Contract Manager, Yarl's Wood), Ali McGinley (AVID) and Adeline Trude (BID).

25 For example, in response to a parliamentary question, Damian Green stated: "*… The UK Border Agency does not hold such information centrally".* Hansard, 25 Oct 2011 : Column 148W http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111025/text/111025w0002.htm

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30 R (on the application of HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 (Admin ) http://www.bailii.org/ew/cases/EWHC/Admin/2012/979.html

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32 Hansard, 25 Oct 2011 : Column 148W http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111025/text/111025w0002.htm

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38 NHS Bedfordshire (2011)

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40 Meeting with NHS Bedfordshire commissioners

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42 *Ibid.*

43 NHS Bedfordshire (2011)

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46 *Ibid.*

47 IMB (2011)

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58 Paragraph 3.21 notes that of the 7 women detained, HMIP reviewed the files of 5 of them and found that: "Only one of the monthly review letters mentioned pregnancy, and even that one suggested that the pregnancy was disputed, although it had been confirmed for some time". At paragraph 3.15 noted that most monthly reviews were served on time but some were late or missing completely. UKBA had no adequate system for monitoring monthly reviews.

59 The 2005 and 2008 HMIP inspections did not make comments on pregnant women aside from noting that a midwife provided routine care for pregnant women, who attended the local hospital for their scans (2008 report, 5.26) and that a midwife from Bedford Hospital visited the centre each week and saw pregnant women, who could attend the hospital for relevant scans and other appointments (2005 report, 6.26).

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63 Asylum Aid, *The rights of women seeking asylum: a charter.* http://www.asylumaid.org.uk/data/files/Endorsements.pdf

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65 Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services: Standard 11 Maternity Services*, London, Department of Health.

66 Department of Health (2010) *Maternity and Early Years – Making a good start to family life* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114023 ; Marmot, M. (2010) *Fair Society, Healthy Lives: The Marmot Review – Strategic Review of Health Inequalities in England Post-2010* http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

67 Lewis, G. (2004); Lewis, G. (2007); BJOG (2011) *BJOG: An International Journal of Obstetrics and Gynaecology (2011) Special Issue: Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006–2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom,* March 2011, Volume 118, Issue Supplement s1 Pages 1–203 http://onlinelibrary.wiley.com/doi/10.1111/bjo.2011.118.issue-s1/issuetoc

68 Lewis (2004), p 26

69 *Ibid.,* p 26

70 BJOG (2011), pp. 47 & 50.

71 Lewis (2007)

72 Lewis (2004) p 23

73 BJOG (2011)

74 NICE (2010) *Antenatal Care: NICE Clinical Guideline CG 62*

75 NICE (2012) *Antenatal Care: Quality Standards QS22,* September 2012 http://guidance.nice.org.uk/QS22

76 NICE (2013) *NICE Quality Standards,* http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp?p=off

77 NICE (2010) *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors CG 110* http://www.nice.org.uk/CG110

78 NICE (2007) *Antenatal and Postnatal Mental Health: clinical management and service guidance CH 45* http://guidance.nice.org.uk/CG45

79 However, of these, three had been detained (either in an IRC or HMP establishment) on arrival and two were removed to their countries of origin.

80 UNHCR (2012) *UNHCR raises key concerns with the Detained Fast Track,* 23 February, 2012 http://www.unhcr.org.uk/fileadmin/user_upload/pdf/DFT_PressRelease.pdf

81 Independent Chief Inspector of the UK Border Agency (2012) *Asylum: A thematic inspection of the Detained Fast Track* http://icinspector.independent.gov.uk/wp-content/uploads/2012/02/Asylum_A-thematic-inspection-of-Detained-Fast-Track.pdf

82 Human Rights Watch (2010) *Fast-Tracked Unfairness: Detention and Denial of Women Asylum Seekers in the UK* http://www.hrw.org/reports/2010/02/24/fast-tracked-unfairness-0

83 UK Border Agency, *Detained fast Track Processes,* 29/3/12 http://www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/detention/guidance/detained_fast_processes?view=Binary

84 Note some women suffered multiple vulnerabilities so, for example, may be a victim of domestic violence *and* trafficking.

85 Medical Justice (2012) *The Second Torture: the immigration detention of torture survivors* http://www.medicaljustice.org.uk/mj-reports,-submissions,-etc./reports/1953-qthe-second-tortureq-the-immigration-detention-of-torture-survivors-220512.html

86 UK Border Agency, *Detention Service Order 06/2008, Assessment Care in Detention and Teamwork* http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/detention-services-orders/assessment-care-in-detention.pdf?view=Binary

87 A placental abruption is the partial or complete separation of the placenta from the uterine wall.

88 NICE (2010) *Antenatal Care: NICE Clinical Guideline CG 62*

89 NICE (2010) *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors CG 110*

90 CSIP (2008); HMIP (2011)

91 UK Border Agency (2005) *Detention Services Operating Standards manual for Immigration Service Removal Centres,* January 2005

92 NICE (2010) *Antenatal Care: NICE Clinical Guideline CG 62,* p 12

93 Hansard, Written Answers, 28 Jun 2012 : Column 345W http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120628/text/120628w0001.htm

94 http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11947

95 Domestic abuse: An incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. It can also include forced marriage, female genital mutilation and 'honour violence'. Recent migrants: Women who moved to the UK within the previous 12 months. See: NICE (2010) Pregnancy and complex social factors overview http://pathways.nice.org.uk/pathways/pregnancy-and-complex-social-factors/pregnancy-and-complex-social-factors-overview

96 This and any subsequent reference to antenatal care in Holloway Prison resulted from interview with the team leader for midwives providing care for pregnant women in Holloway.

97 Bedford Maternity *A Guide to Antenatal Tests* http://www.bedfordhospital.nhs.uk/upload_folder/patient%20information/a%20guide%20to%20antenatal%20tests.pdf (NICE say normally 18 - 20 weeks plus 6 days).

98 Assessment Care in Detention and Teamwork (ACDT) is the process used when an individual has been identified as being at risk. It involves an initial risk assessment and assessment interview. A specific care plan should be in place to ensure provision of multi-disciplinary support, including input from healthcare professionals and staff at the centre.

99 Boots, *Kalms-200tablets* http://www.boots.com/en/Kalms-200-Tablets_2275/

100 One woman's SAR file was incomplete and so the results are based on 19 of the 20 women.

101 Migration Observatory (2011)

102 This category comprises the following: medical escort not available; "administrative issue"; bad weather; flight was overbooked; no emergency travel document was secured.

103 Health Protection Agency (HPA) (2007) *Guidelines for Malaria Prevention in Travellers from the United Kingdom,* January 2007, Chapter 6.2 http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1206520188365

104 UK Border Agency, *Immigration Directorates' Instruction, Chapter 1 Section 8, Medical,* February 2007 http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/IDIs/idischapter1/section8/section8.pdf?view=Binary

105 One of the detainees in the sample had a small child who also needed malaria prophylaxis if removed. Note that the HPA guidance states: *Children are at particular risk of severe and fatal malaria; therefore, parents are advised against taking infants and young children to malarious areas.* Health Protection Agency (2007), Chapter 7.1 Children

106 HPA (2008) *Frequently Asked Questions on Malaria Prevention* www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1203496943523

107 HPA (2007) Chapter 4.2.4

108 WHO (2009) *International travel and health*. http://www.who.int/ith/ITH_2009.pdf

109 NHS Choices, *Can I take malaria tablets if I'm pregnant?* http://www.nhs.uk/chq/Pages/2475.aspx?CategoryID=54

110 National Travel Health Network and Guidance (2009) *Use of mefloquine in pregnancy*, July 2009 http://www.nathnac.org/pro/factsheets/documents/mefloquinepregnancy.pdf

111 National Travel Health Network and Guidance (2012) Malaria chemoprophylaxis, October 2012 http://www.nathnac.org/pro/factsheets/malariaproph.htm

112 HPA (2007)

113 NHS Choices, *Can I take malaria tablets if I'm pregnant?* http://www.nhs.uk/chq/Pages/2475.aspx?CategoryID=54

114 Roche (2009) *Mefloquine patient information leaflet*

115 HPA @007) Chapter 4.2.4

116 NHS Choices *Lariam (Lariam 250mg tablets)* http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Malaria&medicine=Lariam&preparation=Lariam%20250mg%20tablets

117 Roche (2009) *Patient Information Leaflet*

118 NaTHNaC (2012)

119 See for example: Robjant, K. et al (2009), 'Psychological Distress amongst Immigration Detainees: A cross sectional questionnaire study', *British Journal of Psychology 48:275-86*; Medical Justice, (2010), *State Sponsored Cruelty: Children in Immigration Detention*; London Detainee Support Group (2009) *Detained Lives: the real cost of indefinite detention*; Bail for Immigration Detainees (2009) *Out of sight, out of mind: experiences of immigration detention in the UK*; Pourgourides, C. (1997) 'The mental health implications of detention of asylum seekers in the UK'. Psychiatric Bulletin 21:673- 674.

120 HPA (2007) Chapter 4.2.4

121 NHS Choices *Consent to treatment* http://www.nhs.uk/conditions/consent-to-treatment/Pages/Introduction.aspx

122 NaTHNaC (2011) *Use of Malarone in Pregnancy*, April 2011 http://www.nathnac.org/pro/misc/malaronepregnancy_Toxbase.pdf.pdf

123 All names have been changed and any identifiable features have been removed in order to protect the identity of those involved. The histories given rely upon the accounts of (ex)-detainees. All supporting evidence has been found in the SARs, healthcare records and legal documentation.

124 NICE (2012) Antenatal and postnatal mental health: NICE guideline CG45

125 NICE (2010) *Hypertension in pregnancy, The management of hypertensive disorders during pregnancy, CG 107*

126 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 55.10

127 HMIP (2011) para. 3.21

128 Hansard, Damian Green MP, 25 Oct 2011 : Column 150W http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111025/text/111025w0002.htm

129 *Chen and others v Secretary of State for the Home Department* CO/1119/2013

130 See also: Bhatt Murphy, "Victory for Claimants in Children and Pregnant Women Use of Force Challenge" (22 February 2013), available at: http://www.bhattmurphy.co.uk/media/files/Press_Release_Chen_22_02_13.pdf

131 HMIP (2012) *Report on an announced inspection of Cedars pre-departure accommodation, 30 April – 25 May 2012.*

132 UKBA Service Improvement Plan (2012) *Cedars pre-departure accommodation – Announced Inspection, 30 April – 25 May 2012,* Section 5.1

133 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 45, August 17, 2010 http://webarchive.nationalarchives.gov.uk/20100817085141/http://ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/oemsectione/chapter45?view=Binary

134 Medical Justice (2012)

135 See for example: House of Commons Home Affairs Committee (2013) *The work of the UK Border Agency (July – September 2012): Fourteenth Report of Session 2012-13.* http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/792/792.pdf

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137 Nevin, R. (2012) 'Limbic encephalopathy and central vestibulopathy caused by mefloquine: A case report', *Travel Medicine and Infectious Disease (*2012) 10, 144e151

138 Hansard, 25 Jun 2012 : Column 32W http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120625/text/120625w0001.htm#120625w0001.htm_spnew82

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142 Hansard, 2 December 2010: Column 972W http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101202/text/101202w0002.htm

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168 Royal College of Obstetricians and Gynaecologists (2011) *Obstetric Cholestasis, Green Top Guideline no 43*, April 2011. http://www.rcog.org.uk/womens-health/clinical-guidance/obstetric-cholestasis-green-top-43

169 NICE CG62 Quick Reference Guide p 12

170 NICE (2010) *Antenatal Care: NICE Clinical Guideline CG 62*

171 Lord West of Spithead, 03/11/09 http://www.theyworkforyou.com/wrans/?id=2009-11-03a.48.3

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174 The Immigration and Asylum Act 1999 makes provisions for support. Asylum seekers who are destitute, or likely to become destitute within 14 days are entitled to apply for Section 95 support. The support is either 'subsistence only' or subsistence and accommodation. Subsistence is paid in cash. Section 4 support is for asylum seekers whose claims have been refused, are destitute, or likely to be destitute in 14 days and are able to meet one of the following conditions: taking reasonable steps to leave the UK; cannot leave the UK owing to a physical impediment or medical reason; have no viable route of return; have permission to judicially review their claim; or because accommodation provision is necessary to avoid a breach of their human rights. See Maternity Action and Refugee Council (2013), Chapter 1

175 Hansard, 16 April 2013: Column 302W http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130416/text/130416w0001.htm#1304171000070

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177 British Medical Association (2012) *Ethical decision-making for doctors in the armed forces: a tool kit: Guidance from the MA Medical Ethics Committee and Armed Forces Committee* http://bma.org.uk/practical-support-at-work/ethics/armed-forces-ethical-decision-making-toolkit/managing-dual-loyalties

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181 Alistair Burt MP stated the following in an adjournment debate on Yarl's Wood on 10th Feb 2010: "The contractors—either Group 4 or Serco—have the responsibility to commission the health care, but I think that is wrong because the independence of the health care is inevitably compromised. … If there is an issue about fitness to travel and the decision is made by a contracted company inside Yarl's Wood, what chance is there of having confidence that it has not been influenced by the contract given to the contractors to get people out of the country?.... A degree of independence in respect of the health care provided at Yarl's Wood is now necessary. That would happen if the contract were not given to Serco, but to the NHS and the local primary care trust." http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm100210/debtext/100210-0020.htm

182 Siva, N. (2011)

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184 Prison Reform Trust (2005) *Private Punishment: Who Profits?* http://www.prisonreformtrust.org.uk/Portals/0/Documents/private%20punishment%20who%20profits.pdf

185 RSC (2005)

186 See for example: Medical Justice (2012); IMB (2013). Also refer to the cases of Article 3 breaches: R (S) v Secretary of State of State for the Home Department [2011] EWHC 2120 (Admin); R (BA) v Secretary of State of State for the Home Department [2011] EWHC 2748 (Admin); R (HA) v Secretary of State of State for the Home Department [2012] EWHC 979 (Admin); R (D) v Secretary of State of State for the Home Department (2012) EWHC 2501 (Admin).

187 With the reinstated policy of only using force to prevent harm, it is expected that numbers of "successful" removals of pregnant women will now fall.

188 NICE (2010) *Antenatal Care: NICE Clinical Guideline CG 62*

189 Asylum Aid, *The rights of women seeking asylum: a charter.* http://www.asylumaid.org.uk/data/files/Endorsements.pdf

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192 NICE (2007) *Antenatal and Postnatal Mental Health: clinical management and service guidance CG 45*

193 The Immigration Directorates' Instruction (IDI), Chapter 1, Section 8. http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/IDIs/idischapter1/section8/section8.pdf?view=Binary

NAPO NATIONAL AIDS TRUST NATIONAL BOARD OF CATHOLIC WOMEN NATIONAL COALITION OF ANTI-DEPORTATION CAMPAIGNS THE NATIONAL COUNCIL OF WOMEN OF GREAT BRITAIN NATIONAL UNION OF STUDENTS NATIONAL UNION OF TEACHERS NEWCASTLE LAW CENTRE NEWHAM ASIAN WOMEN'S PROJECT NIA NO RECOURSE TO PUBLIC FUNDS (NRPF) NETWORK NORTH OF ENGLAND REFUGEE SERVICE NORTHERN IRELAND COMMUNITY OF REFUGEES AND ASYLUM SEEKERS NORTHERN REFUGEE CENTRE NOTRE DAME REFUGEE CENTRE NOTTINGHAM AND NOTTINGHAMSHIRE REFUGEE FORUM NOUR – DOMESTIC VIOLENCE OBJECT OGUNTE OLDER FEMINIST NETWORK ONE PARENT FAMILIES SCOTLAND ORA UK (OROMO RELIEF ASSOCIATION UK) OXFAM PARAGON LAW PUBLIC AND COMMERICAL SERVICES UNION (PCS) WOMEN'S FORUM PEACE IN KURDISTAN CAMPAIGN PLATFORM 51 POSITIVE ACTION FOR REFUGEES AND ASYLUM SEEKERS POSITIVELY UK POZFEM UK PRAXIS COMMUNITY PROJECTS PROSPECT QUAKER PEACE AND SOCIAL WITNESS QUILLIAM RACE ON THE AGENDA RAPE AND SEXUAL ABUSE SUPPORT CENTRE (RAPE CRISIS SOUTH LONDON) RAPE CRISIS RAPE CRISIS SCOTLAND REACH DOMESTIC ABUSE PROJECT READING REFUGEE SUPPORT GROUP REDRESS REFUGEE ACTION REFUGEE ACTION GROUP REFUGEE AND ASYLUM SEEKERS PARTICIPATORY ACTION RESEARCH – RAPAR REFUGEE & MIGRANT FORUM OF EAST LONDON – RAMFEL REFUGEE & MIGRANT JUSTICE REFUGEE ASSESSMENT AND GUIDANCE UNIT REFUGEE COUNCIL REFUGEE FORUM CALDERDALE THE REFUGEE MENTORING PROJECT AT TERENCE HIGGINS TRUST REFUGEE NETWORK SUTTON REFUGEE RESOURCE REFUGEE THERAPY CENTRE REFUGEE WOMEN'S ASSOCIATION REFUGEE WOMEN'S STRATEGY GROUP REFUGEES IN EFFECTIVE AND ACTIVE PARTNERSHIP (REAP) RENÉCASSIN RESPECT (ASSOCIATION FOR DOMESTIC VIOLENCE PERPETRATOR PROGRAMMES) RIGHTS OF WOMEN ROCHDALE LAW CENTRE ROEHAMPTON UNIVERSITY ROJ WOMEN'S ASSOCIATION ROSA – THE UK FUND FOR WOMEN AND GIRLS THE ROYAL COLLEGE OF MIDWIVES RUTH MCNEIL AND ASSOCIATES ST. AUGUSTINE'S CENTRE, HALIFAX ST MARY MAGDALENE CENTRE SAHAN SOCIETY CENTRE SAHIR HOUSE SANTÉ REFUGEE MENTAL HEALTH ACCESS PROJECT SARSVL (SUPPORT AFTER RAPE AND SEXUAL VIOLENCE LEEDS) SCOTTISH DETAINEE VISITORS SCOTTISH REFUGEE COUNCIL SCOTTISH REFUGEE POLICY FORUM SCOTTISH WOMEN'S AID SCHOOL OF ORIENTAL AND AFRICAN STUDIES SHEFFIELD WOMEN'S COUNSELLING AND THERAPY SERVICE SION CENTRE FOR DIALOGUE AND ENCOUNTER SOLACE SOLACE WOMEN'S AID SOLIDARITY SOROPTOMIST INTERNATIONAL LOUGHBOROUGH SOUTH YORKSHIRE MIGRATION AND ASYLUM ACTION GROUP SOUTHALL BLACK SISTERS SOUTH LONDON FAWCETT GROUP SOUTH LONDON REFUGEE ASSOCIATION SOUTHWARK DAY CENTRE FOR ASYLUM SEEKERS SOUTHWARK LAW CENTRE STANDING TOGETHER STOP UK STUDENT ACTION FOR REFUGEES SUFFICIENT GRACE FOR WOMEN SWANSEA BAY ASYLUM SEEKERS SUPPORT GROUP SWANSEA WOMEN'S ASYLUM SUPPORT GROUP TALK VISA LLP TAMIL INFORMATION CENTRE TAMIL RELIEF CENTRE TAMIL WOMEN'S DEVELOPMENT FORUM TENDER EDUCATION & ARTS THE ANGELOU CENTRE THE EAGLES WING THE HARBOUR PROJECT THE TESTIMONY PROJECT THE WOMEN'S AID GROUP, BURY TRINITY CHURCH UNITED REFORMED AND METHODIST CHURCH HARROW TUC UK BLACK PRIDE UK COALITION AGAINST POVERTY UK FEMINISTA UK LESBIAN AND GAY IMMIGRATION GROUP UNDUGU – AFRICAN SWAHILI COMMUNITY PROJECT UNITED REFORMED CHURCH UNITY CENTRE, GLASGOW URBAN PARTNERSHIP GROUP UMOJA INC VOLUNTARY ACTION CALDERDALE WALES WOMEN'S NATIONAL COALITION WARRINGTON DOMESTIC ABUSE ADVOCACY WEARSIDE WOMEN IN NEED WECARE+ (WOMEN IN EUROPE AND CENTRAL ASIA REGIONS) WELSH REFUGEE COUNCIL WELSH WOMEN'S AID WELWITSCHIA LEGAL ADVICE CENTRE WESLEY GRYK SOLICITORS WEST LONDON REFUGEE WOMEN'S FORUM WESTMINSTER JUSTICE AND PEACE COMMISSION WESTMINSTER WOMEN'S FORUM WHITE RIBBON CAMPAIGN WHY REFUGEE WOMEN WIDOWS FOR PEACE THROUGH DEMOCRACY WOMANKIND WORLDWIDE WOMEN @ THE WELL WOMEN AND GIRLS NETWORK WOMEN ASYLUM SEEKERS TOGETHER – LONDON WOMEN ASYLUM SEEKERS TOGETHER – MANCHESTER WOMENCENTRE WOMEN FOR REFUGEE WOMEN WOMEN IN PRISON WOMEN SEEKING SANCTUARY ADVOCACY GROUP WALES (WSSAG WALES) WOMEN'S ASSOCIATION FOR AFRICAN NETWORKING AND DEVELOPMENT WOMEN'S AID FEDERATION OF ENGLAND WOMEN'S AID FEDERATION NORTHERN IRELAND WOMEN FOR WOMEN INTERNATIONAL WOMEN'S HEALTH AND EQUALITY CONSORTIUM WOMEN'S HEALTH AND FAMILY SERVICES WOMEN'S HEALTH MATTERS WOMEN'S INTERNATIONAL LEAGUE FOR PEACE AND FREEDOM WOMEN'S NATIONAL COMMISSION WOMEN'S RESOURCE CENTRE WOMEN'S SUPPORT PROJECT YARL'S WOOD BEFRIENDERS ZERO TOLERANCE ZIMBABWE ASSOCIATION 1 PUMP COURT 28 TOO MANY

**"UKBA put me and my unborn baby's life at risk as well. I was not a criminal: I never breached the law in the UK. I just claimed asylum and asked for refuge. But UKBA put me there and kept me in a detention centre for 7 months as a pregnant woman, for no reason…Detention affects the unborn baby mentally and physically… My question to UKBA is that if anything happens to my baby physically and mentally, then who will be responsible for that?"**

**The 337 organisations are signatories of Asylum Aid's Charter of Rights of Women Seeking Asylum. They all support the end of the immigration detention of pregnant women.**

Medical Justice
seeking basic rights for detainees