

**“The detention centre was the second torture that I had... the first was in DRC and was physical, the second one was psychological”**

**Torture Survivor, detained for 80 days**

# **“The Second Torture”:**

**The immigration detention of torture survivors**



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torture survivors**

Natasha Tsangarides



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## Medical Justice

Medical Justice is a network of doctors, lawyers, ex-detainees, and detention centre visitors. It is the only organisation dealing with the denial of adequate healthcare from immigration detainees in the UK. We believe that the harm being caused by immigration removal centres is so widespread that the only solution is to close them down. In the interim, we work to reform the institutions and to stand up for the rights of those incarcerated within them.

Medical Justice currently handles approximately 1,000 cases a year, arranging for independent doctors to assess detainees, investigate inadequate healthcare provision, give medical advice and challenge the denial of medication and care. Medical Justice also carries out research activities based on this case work, as well as policy work and litigation in order to secure lasting reforms and change.

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Our biggest debt of gratitude goes to the (ex) detainees featured in this report. It is with sadness that this report details their experiences both in their home country and in UK immigration detention. It is with a shared hope that presenting their injustice will prevent it happening in the future.

# Foreword

The ostensible purpose of Rule 35, originally rolled out in 2001, was to ensure that asylum-seekers who had been tortured were not held in detention centres. The doctor who routinely examines a newly-detained person was to report immediately to the detention centre manager any claim to have been tortured, and unless there were exceptional circumstances, the individual was to be released. Yet this Report shows that after many debates in both Houses of Parliament and several internal audits by the UK Border Agency, the policy still isn't working. Torture victims are still routinely being detained.

At first the Government claimed that the Chief Inspector of Prisons would pick up non-compliance with Rule 35 and there was no need for a dedicated examination of the process. In 2006 they gave in to pressure from Medical Justice and others to conduct an Audit, but the results were never published and in 2010 the UKBA said the data had been lost. A second Audit was conducted at the end of 2009, finding that one third of Rule 35 reports were not dealt with inside the 48-hour time limit specified, and a third were ignored altogether. The Audit concluded that the process required closer scrutiny and performance monitoring. It recommended that a further audit should be carried out after six months, but this has not taken place.

In the face of such an abysmal record of failure extending over many years, this survey by Medical Justice is a wake-up call. Many of the previously noted defects of the Rule 35 process are seen to be continuing. Forms are being completed incorrectly or with answers missing; UKBA caseowners are still responding outside specified time limits or not at all, and non-medical staff are being allowed to complete the forms. 23% of the vulnerable individuals

who are detained are reacting to the stress by going on hunger strike and no fewer than 35% are self-harming or showing suicidal tendencies.

In the Commons Home Affairs Committee on April 5, 2011 Dr Julian Huppert asked the Acting Head of the UKBA about a follow-up of the UKBA audit, and was told that a new sample of Rule 35 cases would be undertaken later on that year, details of which would be sent to the Committee 'soon'. A year later the necessary Detention Service Order to start the work hasn't yet appeared, and the collection of the data will take three months after that. So as usual they are dragging their feet.

Rule 35 is not working, and hasn't worked ever since it was first introduced. Persistent failure by the Government to ensure that persons claiming to be torture victims have their cases promptly and impartially examined could well be a violation of Article 13 of the Convention Against Torture, to which the UK is a party. In two cases last year, the High Court found that Rule 35 detainees had been subjected to inhuman and degrading treatment, violating Article 3 of the European Convention on Human Rights.

Medical Justice rightly demands that an **independent** audit be conducted of the Rule 35 process, and this requires that the collection and analysis of the data under the new audit should be supervised by an established medical body. In this way, the public will be able to rely on the results, and have greater confidence that at last, torture victims who seek asylum here receive the protection they deserve.

**Lord Avebury**

# Foreword

It gives me no pleasure to write this foreword, but I am delighted to do so, as an ex-detainee, victim of torture and victim of the immigration system failure.

The report shows Rule 35 Policy and Guidance regarding victims of torture is not working. The Home Office is always getting it wrong by violating or breaching their own policies: they don't take it into consideration and do not respect the rules.

I did have a Rule 35 report twice, provided by different immigration detention centre doctors. Despite being a torture victim, I was still locked in detention. I was still detained for many months after my Rule 35 reports and my health conditions were deteriorating.

No one explained to me what Rule 35 was when the report was done. When I received the response from my caseowner, I was so shocked and upset. They said I was fit to be detained but I wasn't and my health was very bad. I felt hopeless. It was a disgrace, really.

The reply from my caseowner was as though they had not even looked at the report. So, the questions I am asking are: Do UKBA and the healthcare staff know exactly what

Rule 35 is according to their own policy guidance and legislation? Or is it something they simply prefer to ignore and reject? If so, that is a disgrace and a stain on the UK's reputation and national pride.

To be released from detention, Rule 35 did not work and I had to wait for an independent doctor who provided me with a Medical-Legal Report. Thanks to the Medical Justice team.

I would like to direct this message to UKBA: they should not mistreat people in detention. Many detainees come from far away just to ask for refuge, and they should respect Rule 35. It is your own rules, policy and guidance but you don't respect it.

I am convinced that the more people read this report, the less likely such failures of Rule 35 will ever happen again. I am hoping this time that UKBA will learn lessons and make sure Rule 35 works for all victims of torture who are still in detention across the UK.

**D. N'kissi – Survivor of torture, Survivor of Detention**



## Acronyms

<b>ACDT</b>	Assessment Care in Detention and Teamwork
<b>AOT</b>	Allegation of Torture
<b>AIT</b>	Asylum and Immigration Tribunal
<b>AVID</b>	Association of Visitors to Immigration Detention
<b>BASHH</b>	British Association for Sexual Health and HIV
<b>BIA</b>	Border and Immigration Agency
<b>BID</b>	Bail for Immigration Detention
<b>BMJ</b>	British Medical Journal
<b>BNF</b>	British National Formulary
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CCTV</b>	Close circuit television
<b>CMT</b>	Contact Management Team
<b>CSIP</b>	Care Services Improvement Partnership
<b>DCR</b>	Detention Centre Rules
<b>DFT</b>	Detained Fast Track
<b>DNSA</b>	Detained Non-Suspensive Appeals
<b>DSH</b>	Deliberate self-harm
<b>DSO</b>	Detention Service Orders
<b>DUG</b>	Detention Users Group
<b>EIG</b>	Enforcement Guidance and Instructions
<b>EMDR</b>	Eye Movement Desensitisation and Reprocessing
<b>FNP</b>	Foreign National Prisoner
<b>FOI</b>	Freedom of Information
<b>FTT</b>	Freedom from Torture
<b>G4S</b>	Group 4 Securicor
<b>GI</b>	Gastrointestinal
<b>HAC</b>	Home Affairs Committee
<b>HCMIP</b>	Her Majesty's Chief Inspectorate of Prisons
<b>HIV</b>	Human Immunodeficiency Virus

<b>HMIP</b>	Her Majesty's Inspectorate of Prisons
<b>HoL</b>	House of Lords
<b>IND</b>	Immigration and Nationality Directorate
<b>IPCC</b>	Independent Police Complaints Commission
<b>IRC</b>	Immigration Removal Centre
<b>IRR</b>	Institute of Race Relations
<b>IS</b>	Immigration Service
<b>JCHR</b>	Joint Committee of Human Rights
<b>MF/ MFCVT</b>	Medical Foundation for the Care of Victims of Torture
<b>MLR</b>	Medicolegal report
<b>MSG</b>	Medical Sub-Group
<b>MSK</b>	Musculoskeletal
<b>NSF</b>	National Service Framework
<b>NICE</b>	National Institute of Clinical Excellence
<b>NGO</b>	Non Governmental Organisation
<b>PCT</b>	Primary Care Trust
<b>PPO</b>	Prison and Probations Ombudsman
<b>PTSD</b>	Post traumatic stress disorder
<b>RMN</b>	Registered Mental Health Nurse
<b>RSC</b>	Refugee Studies Centre
<b>SAR</b>	Subject access request
<b>SSHD</b>	Secretary of State for the Home Department
<b>SSRI</b>	Selective serotonin re-uptake inhibitors
<b>STI</b>	Sexually Transmitted Infection
<b>UKBA</b>	UK Border Agency
<b>UN</b>	United Nations
<b>UNHCR</b>	United Nations High Commissioner for Refugees

# Chapter One – Introduction & Methodology

Around 26,000 people were held within the immigration detention estate in the UK 2010.<sup>1</sup> The majority of these people sought asylum at some stage in the process. Within this population exist survivors of torture.

It is estimated that between 5 and 30% of asylum seekers have suffered torture.<sup>2</sup> Whilst some of these will bear scars of the abuse they underwent, others who may have been raped or electrocuted, for example, will rarely bear physical signs. All, however, share the common injustice of being detained for administrative immigration purposes. The UK Border Agency (UKBA) policy is that where there is independent evidence of torture, an individual will only be detained in very exceptional circumstances.<sup>3</sup>

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment entered into force in 1987. Article 1 (1) provides a definition of torture:

“... any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”<sup>4</sup>

Torture is prohibited under international law but remains widespread across the globe. A systematic and deliberate act of inflicting pain on others, the consequences of torture often involve long-term mental and physical pain.

In the experience of Medical Justice, victims of torture are routinely detained. This is particularly problematic because this population often suffers both the mental and physical effects of their torture for many years afterwards. This, coupled with the trauma of being detained for an indefinite time period, the limbo of their legal status, the specific medical needs of this vulnerable population, language difficulties and isolation from a community can all be highly damaging and/or injurious to one's health.

Immigration detainees have particular health needs, many of whom are afflicted with mental health problems. There is a growing body of evidence that notes that these problems can be associated with their experiences pre-flight (prior to coming to the UK); exacerbated by immigration detention; or indeed caused by immigration detention itself.<sup>5</sup>

The Detention Centre Rules 2001, set up by statute, outline the special regulations for the management of Immigration Removal Centres (IRCs). Rule 35 of the Detention Centres Rules 2001 is designed to safeguard vulnerable individuals.

## **Special illnesses and conditions (including torture claims)**

- 35.** (1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
- (2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

### **(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.**

- (4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.

For vulnerable individuals and victims of torture, Rule 35 is the primary safeguard to facilitate their release from detention. Once a report is generated under Rule 35, the UKBA caseowner must review the individual's detention in light of the findings. Whilst being a victim of torture does not necessarily mean automatic release, where there is independent evidence, individuals should be released absent exceptional circumstances. Moreover, the information contained in Rule 35 reports should be 'capable of constituting independent evidence'.<sup>6</sup>

However, as this report will show, victims of torture are routinely detained and Rule 35 fails to secure their release. Even UKBA itself in its recent audit showed its failure to implement the rule and follow appropriate procedures. Her Majesty's Inspectorate of Prisons (HMIP) and other official bodies have consistently reported on UKBA's failure to follow its statutory duty with regards to Rule 35.

This report will chart the history of UKBA's failure to follow its own policy regarding the detention of victims of torture. It will illustrate the disregard that UKBA shows not only to external criticism but also to the vulnerable individuals themselves, many of whom report of the “second torture” they have had to face in immigration detention since coming to this country to seek sanctuary.

## Methodology

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### Research aims

This report investigates the Rule 35 process. The key aims of the research are to:

- assess whether Rule 35 (3) is being implemented
- chart how Rule 35 (3) forms are dealt with
- assess at what stage the process fails
- analyse the application of the statutory duty and identify who renders the process ineffective
- contextualise Rule 35(3) in the wider healthcare-immigration nexus
- make robust recommendations

### Developing the Sampling Frame

#### Definition:

This report is an investigation into the implementation of Rule 35 of the 2001 Detention Centre Rules. This report will focus on Rule 35 (3): individuals for whom there are concerns that they may have been victims of torture. The analysis that ensues is based on the handling of all Rule 35 (3) cases that fall within the sampling frame.

#### Sampling frame:

The sample includes cases referred to Medical Justice of individuals who were held in detention during the period of May 2010, when the coalition government took office, for one year until May 2011. All cases included in the sample involved torture and had a medico-legal report (MLR) or medical letter produced for them by Medical Justice independent doctors. Only cases where informed consent from the client was gained are included in this sample. The sampling size for this report is 50 cases.

All 50 individuals in this report alleged to be victims of torture and have medical evidence, which accords well with their accounts. In some cases, their allegations of torture have been found to be credible by either UKBA or Immigration Judges, whilst in others they have not been found to be credible or their claims are still being determined.

For the purposes of ease, individuals featured in this report, are referred to as “victims of torture” as opposed to ‘people who have medical evidence that accords well with their account of torture’.

The individuals who were included in the sample were all at different stages of the asylum process including awaiting an initial decision/appeal decision/fresh claim, those whose appeal rights have been exhausted and individuals who have now received status. Between May 2010 and May 2011, Medical Justice wrote medico-legal reports for 98 victims of torture held in immigration detention. However, included in this sample are only 50 of these 98 cases. Great efforts were taken to

trace and secure the consent of all 98 individuals but for various reasons, reaching the remaining 48 people was unattainable.

17 of these individuals have been removed. All of them were untraceable apart from one individual who was traced, gave oral consent, but was unable to provide full, written consent and has therefore been omitted from the final sample.

Six individuals who had since received status also fell within the sampling frame. However, one chose not to participate, three could not be traced and two expressed a desire to take part but did not return their consent forms.

Of the remaining 26, the researchers were unable to trace 15 of them. Furthermore, two individuals who had their cases pending and were still in the UK expressed a desire to participate but did not return their consent forms; three individuals did not want to participate in the research; and a further three individuals were too unwell and vulnerable and the researchers felt that they would not be able to give fully informed consent. The remaining two individuals returned to their countries of origin voluntarily.

### Ethical Considerations

Ethical considerations were central to this project, particularly given the background and experiences of those who participated.

Informed consent was critical and it was clearly explained to everyone in the sample what the project entailed, why their experience mattered, what information was required, and how the information would be used. This explanation was provided orally and on paper. Where participants were unsure or the researchers felt they were too vulnerable even to explain the project to, they were excluded.

All participants remain anonymous in this report and during all phases of data entry, data codes were used to ensure their records were kept unidentifiable and confidential. Names and identifiable features have been removed in all cases.

Finally, project information sheets, consent forms and questionnaires were made available in English, Arabic and Tamil.

### Data Sources

This report relies on diverse sources of data. Different data sources were accessed in order to gain a holistic understanding of whether the Rule 35 process is working; whether there is a particular stage at which the process falls down; to assess whether certain individuals/bodies responsible for Rule 35 are more culpable than others; to chart trends and inconsistencies in reporting; and to situate Rule 35 within the wider context of the asylum process.

The data sources relied upon in this study are:

1. Literature review: a review of the legal and policy framework relating to the detention of victims of torture was conducted. The aim was to identify the statutory duties on individuals and organisations involved in the Rule 35 process in order to later establish whether these obligations were being met. All the information relied upon is in the public domain.
2. Case law: a case law search was undertaken to identify judgments that considered Rules 34 and 35. Recent legislation that drew attention to the prolonged failure of the Home Office and their contractors to comply with the requirements of Rules 34 and 35 were identified and presented.
3. Questionnaires: every individual in the sample was sent a questionnaire together with a consent form. The questionnaire sought to ascertain (ex) detainees' views on how they felt their torture claim had been dealt with and the (perceived) impact of detention on their health.
4. Case file analysis: immigration case files were accessed for each of the individuals. This was in order to ascertain when individuals alleged to be victims of torture; how their claim of torture was dealt with; how long they were in detention for; and to map outcomes.
5. Healthcare notes: these were requested for everyone in the sample from their last place of detention. This enabled us to see what information was documented on each patient; what levels of care they received; how their torture claim was dealt with; and how the effects of their torture were handled from a clinical perspective.
6. Medico-legal reports: everyone in the sample had a medico-legal report produced for them. This report was used to chart mental and physical health conditions, physical scars, and any comments the doctor may have made on the impact of detention.

The use of different sources and methods was employed to enhance the robustness of research findings. Through triangulating the data, the researchers were able to cross-check and corroborate findings and facilitate a deeper understanding.

## Accessing the Primary Data

### Consent:

The first stage of accessing data involved tracking down (ex) detainees and securing their consent to participate in the study. Each individual within the sample was telephoned and given an explanation about the project and the information needed for research purposes. Following this, a letter, a project information sheet, a general consent form as well as consent forms to access information from IRC healthcare teams and their legal representative were sent to the individuals together with Subject Access Request (SAR) forms.

Participants were offered a two-staged level of consent.

Both consent options assured anonymity although one allowed for a greater level of exposure. Whilst one category would only use limited anonymous information, the other allowed information and full details to be used as a "case study". In this scenario, text from their various documents could be quoted to illustrate points.

### Questionnaires:

The questionnaires comprised questions, of which four were closed, five used a likert scale and one was open. Likert questions were used to measure and evaluate the quality of care and the experiences in detention. The open question allowed for greater detail and enabled researchers to establish any new themes and expand upon the results already found. The closed questions facilitated the development of quantitative results.

All questionnaires were coded and then analysed. Certain common themes were generated enabling the identification of trends and key issues both in the questionnaire reporting and within the wider analysis when triangulating the data. Quotes cited in the questionnaires were collated and are presented as part of the questionnaire results as well as stand-alone statements throughout this report.

If there were any anomalies or contradictory responses recorded, data is presented as the questionnaire was completed but a note will appear to highlight such anomalies.

### Immigration Case files:

For every individual in the sample, a SAR was made using the Data Protection Act 1998, enabling us to get copies of the data held by UKBA<sup>7</sup> – this includes case notes, case correspondence, application forms, solicitors' representations, supporting documents and forms served by UKBA. This information provided researchers with the full immigration history: researchers were thus able to trace the history of whether and when a 'torture claim' was made, how it was dealt with and also chart their detention history.

10 subject access requests were rejected because either another request on that individual was pending or one was done fairly recently by their solicitor. In these cases, the information was gathered from the legal representative.

For the remaining 36 files, SARs were received from UKBA. In 34 of these cases, records were kept of the date the SAR was sent, the date UKBA acknowledged receipt and the date the SAR was sent by UKBA (as per the postage stamp). These records show the SARs took from a minimum of 35 days to arrive to a maximum of 188 days. The average time for a SAR case file to arrive took 63 days. In keeping with the Data Protection Act, UKBA has a statutory duty to provide personal data where requested. UKBA state that 'you should receive a response form us within 40 days'<sup>8</sup> However, only one SAR was received in under 40 days and only six between 40 and 50 days.

Furthermore, in many cases, the SAR files were incomplete lacking some of the key documents necessary for cross analysis, which was problematic and raised concerns. In these cases, the researchers referred to the legal representatives for copies of these documents. Where possible, all gaps were filled but in some instances, it proved impossible to access everything and in such cases, the data results will be based on the data available and will be reported as such.

### **Healthcare notes:**

The healthcare notes of (ex) detainees were requested from IRCs. Care was taken to ensure that the notes were requested from the last IRC that the (ex) detainee was held as many in the sample had been in multiple detention centres.

The notes enabled us to see whether Rules 34 and 35 had been followed by IRC healthcare staff and also assess whether the individuals had any other medical issues, how their health issues had been documented and the level of their care.

From the sample of 50 detainees, 44 sets of medical notes were obtained from healthcare. The six sets of notes that were not obtained were reported as 'lost' by the healthcare administration. If the notes were lost or incomplete, efforts were made to source sections of the medical notes from other resources such as Medical Justice's records and the detainees' solicitor. Seven detainees had multiple medical screening notes from different IRCs; these were all included in the analysis of the screening notes.

### **Outcomes:**

Researchers communicated with the (ex) detainees' last legal representative or the (ex) detainees directly to track the stage of the case, whether they had been released from detention, and the final outcome if there was one. This was done after the main data collection phase and approximately two months prior to publication.

## **Methods of analysis**

When analysing the data from the case files and healthcare notes, a framework approach was adopted with the aim of meeting some of the objectives that the research sought to achieve. Typically, this involves five key stages: familiarisation; developing a thematic framework; indexing; charting; mapping and interpretation.<sup>9</sup>

Through reviewing all the data in hand, key ideas and recurrent themes were mapped. This in turn enabled the development of a thematic framework through which all the key issues, themes and statutory duties could be examined. This framework was drawn from the research objectives, the legal and policy framework, and also the data itself.

Indexing the data then took place whereby the coded data was applied to the framework. This was followed by

thematic organisation whereby the data is inserted into charts that consist of headings and subheadings. This process then enabled the analysis of the key characteristics in the chart, thus allowing the researcher to interpret the data set; identify phenomena; find associations; provide explanations; and develop an understanding of how the process functions.<sup>10</sup>

## **Limitations**

A number of limitations have been identified during the course of this project. As noted earlier, the actual sample size could in theory have been 98 people over one year. Great lengths were taken to locate individuals, particularly those who had been removed to their countries of origin. However, this was extremely difficult and the researchers needed to be discrete in their efforts in order to minimise the possibility of harm.

A great challenge was accessing data for this project. As noted previously, there were delays in receiving the SAR case files, which slowed down the data collection and analysis. Furthermore, the incomplete files required the researchers to look elsewhere to access the missing documents.

Problems with the healthcare notes were also encountered. Whilst the majority of the notes were received rapidly, in some instances they were delayed. However, the biggest problem with the notes was that they were often incomplete and in some cases, missing entirely.

With both the case file data and the data from the healthcare notes, the results will be reported on the data available to the researchers. Where there are gaps, readers will be alerted.

There are pros and cons of self-reporting on health issues, which are of relevance to the questionnaire results. This is particularly when the population comprises diverse social and cultural backgrounds with English not necessarily being their first language. Limitations of this type of data include a misunderstanding about concepts. For example, mental health problems are often not considered as an illness in some cultures. Secondly, responses may be constrained by a number of factors: for example, a lack of understanding, misinterpretation or confusion, and/or the perceived social desirability of certain answers.<sup>11</sup> However, the questionnaires were designed using simple language and were translated into two other languages in the hope of overcoming some of these hurdles.

# Chapter Two – Immigration Detention: history, policy & practice

This section presents a historical background to immigration detention charting its inception and increasing use over the years. The legal and policy framework that governs its usage is presented together with a legal exploration of Rule 35 of the Detention Centre Rules 2001.

## Background to Immigration Detention

Since the 1970s, the UK government has detained people for immigration purposes. Intended to be a purely administrative process that is used as a 'last resort', immigration detention is becoming increasingly more common and must be seen within the context of the criminalisation of asylum seekers and the government's hard stance on immigration.

The purpose of immigration detention is administrative in order to effect removal; to establish a person's identity or basis of claim; or where there is reason to believe the person will fail to comply with the conditions associated with temporary release or admission.<sup>12</sup> However, UKBA hold no data on absconding rates and independent research has shown that there is little risk that people abscond,<sup>13</sup> with Bail for Immigration for Detainees (BID) finding that 90% do not.<sup>14</sup>

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, it also stated that there was a presumption in favour of temporary admission and release and where possible, alternatives to detention should be sought.

Section 55.1.3 of the Enforcement Instructions and Guidance (EIG) states:

'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.'

However, immigration detention is on the rise and is certainly not being used as a last resort. 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%.<sup>15</sup> 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.'

The UK opted out of the EU Returns Directive, which includes an absolute maximum of 18 months for immigration detention, and ignored the UN Working group on Arbitrary Detention's recommendation in 1998 to specify an absolute maximum duration and that this should become statutory.<sup>16</sup> More and more people are being detained with indefinite detention emerging as a pressing issue. Based on UKBA statistics, the NGO 'Detention Action' found that 255 people had been detained for over a year at 31 December 2010. Of these, 65 had been detained for over two years.<sup>17</sup>

The practice of immigration detention has not existed without scandal and concern. Criticisms have included the lack of any statutory time limit in detention; the outsourcing to private contractors with limited monitoring and accountability; the practice of detaining children; 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; the continued detention of foreign national prisoners (FNPs) following the completion of their criminal sentences; and the inadequate healthcare provision in IRCs

## Facts and figures

The numbers detained for immigration purposes has grown rapidly. The UK immigration estate is now one of the biggest in Europe with approximately 26,000 people detained in 2010<sup>18</sup> in IRCs. These statistics do not include persons detained in police cells, Prison Service establishments, and those detained under both criminal and immigration powers.

The largest category of immigration detainees is persons who have sought asylum at some stage of their immigration process. In 2010, asylum detainees accounted for 48% of the immigration detainee population.<sup>19</sup> Many immigration detainees are often traumatised individuals who may have survived war, torture or inhumane treatment in their home countries. Many endure perilous journeys to the UK, only to get unexpectedly detained without charge or trial, where they may relive past traumas of imprisonment.

IRCs are desperate places that house a vulnerable population. There are currently 10 IRCs in the UK. However, Lindholme IRC closed at the end of 2011 during data collection and so is included in this report. There are three main types of IRC. Four of them (including Lindholme) are run by HM Prison Service and are either located in wings

of existing prisons or on the site of former prisons. Two are high security IRCs that have been built to category B prison standards with limited freedom of movement. The remaining IRCs are similar to 'open prisons' with movement permitted across the centre during the certain hours of the day.

The total bed spaces available in these centres are 3341. However, many people are held under immigration detention outside of IRCs in a variety of locations including prisons, residential short-term holding facilities (of which there are three and are used to detain people for up to 7 days), non-residential holding facilities and hospitals. In addition, there is Cedars, Pease Pottage detention facility for families with children. G4S, a private security

company, is responsible for delivering security and facilities management, and Barnardo's is providing welfare and social care services. Also, as of 5 July 2010, there were a further 581 FNP's held in prisons after the completion of their sentences.<sup>20</sup> Figure 1 below breaks down the management and capacity of the detention estate.

According to the Migration Observatory at the University of Oxford, 'about half of immigration detainees are held for more than two months. A relatively stable share of about half of immigration detainees are held for less than two months (Figure 2). It is also not uncommon for detention to span two to six months. A small but consistent minority of detainees – just under 10% – are held for more than one year.'<sup>24</sup>

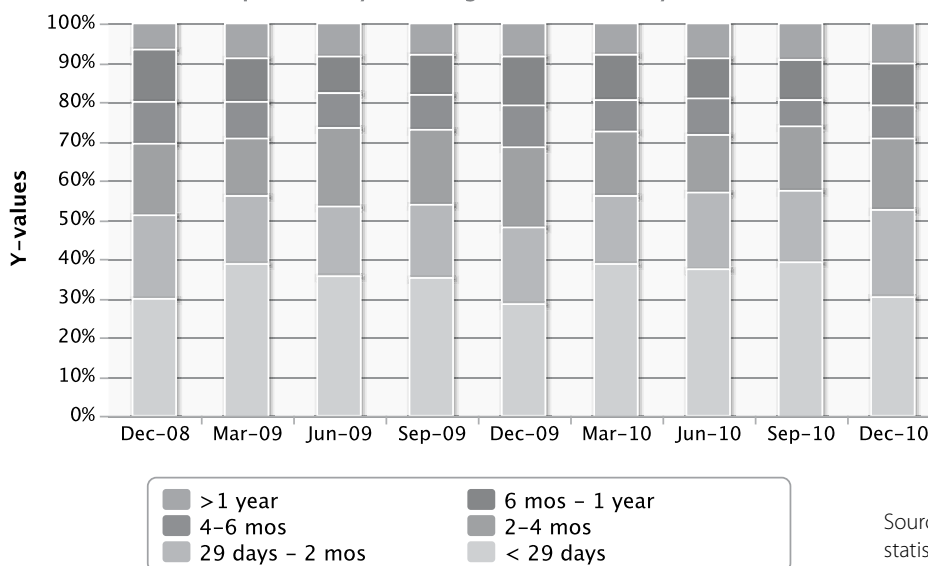
**Figure 1: Immigration Removal Centres**

IRC	Location	Contractor	Detainees	Capacity
<b>Brook House</b>	Gatwick	G4S	Male	426
<b>Campsfield House</b>	Kidlington, Oxfordshire	Mitie PLC	Male	216
<b>Colnbrook</b>	London Heathrow	Serco	Male (300) female (8) <sup>21</sup>	308
<b>Dungavel</b>	Strathaven, Lanarkshire	G4S (to Sept 2011, then GEO Group)	Male and Female	219
<b>Dover</b>	Dover	Prison Service	Male	314
<b>Haslar</b>	Gosport, nr. Portsmouth	Prison Service	Male	160
<b>Harmondsworth</b>	London Heathrow	The GEO Group	Male	623
<b>Lindholme</b>	Near Doncaster	Prison Service	Male	124
<b>Morton Hall</b>	Lincolnshire	Prison Service	Male	392
<b>Tinsley House</b>	Gatwick	G4S	Male, families <sup>22</sup>	154
<b>Yarl's Wood</b>	Bedfordshire	Serco	Women and families (over 18) <sup>23</sup>	405
<b>TOTAL IRC</b>				<b>3341</b>

**Figure 2:**

**Duration of Immigration Detention, 2008-10**

Chart provided by [www.migrationobservatory.ox.ac.uk](http://www.migrationobservatory.ox.ac.uk)



Source: UK Home Office statistics

## Costs of detention

In 2010/ 2011, £205,830,000 was spent on detention and removal. Of this figure, £44,002,000 (21%) was spent on the Immigration Group; £2,994,000 (1%) on the Border Force; and the vast majority of £157,696,000 (76%) on the Criminality and Detention Group.<sup>25</sup>

According to a Freedom of Information (FOI) request submitted by Medical Justice on 8 December 2011, of the £206 million spent by UKBA in 2010/ 2011, approximately £47 million (23%) was spent on removals and approximately £159 million (77%) on 'detention costs' and 'other detention costs'. The table below demonstrates the breakdown.<sup>26</sup>

On 4 February 2010, in response to a question from Baroness Warsi posed in Parliament, it was reported that the average overall cost of one bed per day in the immigration detention estate is £120.<sup>27</sup> The Migration Observatory used this figure to estimate the average costs of certain IRCs. Using the knowledge that Campsfield IRC usually operates at 90% capacity, they were able to estimate that with the 194 (of a possible 216) migrants detained there, Campsfield IRC costs approximately £8,497,200 per year to run.<sup>28</sup>

Since this time, the cost of detention has fallen. In October 2011, Damian Green announced that the average cost of detaining someone for one night is £102.<sup>29</sup> By comparison, the cost to support an asylum seeker who is in the community has been estimated at £150 per week.<sup>30</sup> Thus, the cost of detaining one individual is £80.57 per day or £29,408.05 per year more expensive than supporting them in the community.

With approximately 26,000 individuals detained per year, one can thereon estimate that the government is spending millions more pounds on detaining people rather than supporting them in the community.

Bail for Immigration Detainees (BID) found in 2009 that "42 percent of asylum seekers detained in the UK go on to be released, their detention having served no purpose other than wasting human lives and taxpayers' money".<sup>31</sup>

Removals and deportations are costly yet represent only 23% of the spend versus 77% on detention. Over £47 million pounds was spent in the year 2010/2011 on removals. This includes costs associated with overseas escorts and voluntary assisted returns but will also include the costs associated with failed removals.<sup>32</sup> The Migration Observatory estimates that it costs approximately £11,000 per enforced removal of a rejected asylum claimant.<sup>33</sup>

In the financial year 2008/2009, the Home Office chartered 67 private planes to effect the removal of refused asylum seekers being removed as a result of deportation action, administrative removals and voluntary departures.<sup>34</sup> In response to a Medical Justice FOI request, received on 9 November 2011, UKBA detailed the costing of six charter flights where less than five people were removed. It was confirmed that for the six charter flights, a total of 14 people were returned at a total cost of £347,770.<sup>35</sup>

In 2010, UKBA paid out over £12 million on legal costs, compensation and ex gratia payments in cases involving the unlawful detention of asylum seekers and other immigrants in IRCs. A UKBA spokeswoman stated: "We use our powers to detain individuals when we believe it is reasonable and lawful to do so and regularly review the system."<sup>36</sup> However, detention and removal are clearly highly costly and the unlawful detention payments demonstrate the inefficiency and injustice of the system.

## The power to detain

The statutory provisions for the powers to detain originate from the Immigration Act 1971. Paragraph 16(2) of Schedule 2 of the Act states:

"If there are reasonable grounds for suspecting that a person is someone in respect of whom directions may

## Breakdown: costs of detention

	Immigration Group	Criminality & Detention Group	International Group	Corporate Services	Border Force	Total
<b>2009/10</b>	£'000	£'000	£'000	£'000	£'000	£'000
Removal Cost	33,134	18,918	0	0	0	52,052
Detention Cost	64	88,477	0	0	1	88,542
Other Detention Costs	29,263	37,597	59	259	2,916	70,094
<b>Total</b>	<b>62,461</b>	<b>144,992</b>	<b>59</b>	<b>259</b>	<b>2,917</b>	<b>210,688</b>
<b>2010/11</b>	£'000	£'000	£'000	£'000	£'000	£'000
Removal Cost	30,345	16,763	0	0	1	47,109
Detention Cost	26	87,269	0	594	1,050	88,939
Other Detention Costs	13,632	53,664	305	239	1,943	69,783
<b>Total</b>	<b>44,002</b>	<b>157,696</b>	<b>305</b>	<b>833</b>	<b>2,994</b>	<b>205,830</b>



be given under any of paragraphs 8 to 10 or 12 to 14, that person may be detained under the authority of an immigration officer pending a) a decision whether or not to give such directions; b) his removal in pursuance of such directions.’

The power to detain pending deportation is laid out in paragraph 2 of Schedule 3 of the 1971 Act, which states that there is a power to detain:

- (a) Where a recommendation for deportation made by a criminal court is in force (para 2(1)).
- (b) Pending the making of a deportation order where notice has been given of an intention to make a deportation order (para 2(2));
- (c) Where a deportation order is in force against any person, pending his removal or departure from the United Kingdom (para 2(3)).

Sections 62 and 71 of the Nationality, Immigration and Asylum Act 2002 amplified the powers of detention, enabling the Secretary of State for the Home Department (SSHD) to detain:

- (a) persons seeking leave to enter who have claimed asylum or made a human rights claim or requested departure from the Immigration Rules, pending examination, a decision whether or not to grant leave, a decision whether or not to remove, and removal; and
- (b) persons who have made a claim for asylum when they have limited leave and who failed to comply with restrictions imposed on them.

The UK Borders Act 2007 takes a step further with regards to deportation, making the presumption that “foreign criminals” are not conducive to the public good and should be made subject to a deportation order.<sup>37</sup> Section 36 outlines SSHD’s power to detain as per the 1971 Act for those persons who are subject to a deportation order. The key parts of section 36 are as follows:

- (1) A person who has served a period of imprisonment may be detained under the authority of the Secretary of State –
  - (a) while the Secretary of State considers whether s.32(5) applies, and
  - (b) where the Secretary of State thinks that s.32(5) applies, pending the making of the deportation order.
- (2) Where a deportation order is made in accordance with s32(5) the Secretary of State shall exercise the power of detention under paragraph 2(3) of Schedule 3 to the Immigration Act 1971 (detention pending removal) unless in the circumstances the Secretary of State thinks it inappropriate.

However, the power to detain is limited. As laid down in the case of *R v Governor of Durham Prison ex parte Hardial Singh* [1984] 1 WLR 704, detention under the Immigration Acts is limited to the period reasonably necessary for the machinery of deportation or removal to be carried out.

Furthermore, 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.

Further, Article 5(5) states: “Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.” Detention is subject to restrictions imposed by the Secretary of State’s policies which are published as operational guidance. In the case of *Lumba (WL) v Secretary of State for the Home Department* [2011] UKSC 12, the Supreme Court confirmed that detention is unlawful where it is in conflict with the Secretary of State’s policy.

## UKBA policy on immigration detention

Chapter 55 of UKBA’s Enforcement Instructions Guidance (EIG) outlines the SSHD’s policy of detaining people for immigration purposes. The key principles, for the purposes of this report, are as follows:

- A presumption in favour of temporary admission or release and that, wherever possible, we would use alternatives to detention. (55.1.1)
- 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)
- 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)
- **To be lawful, detention** must not only be based on one of the statutory powers and accord with the limitations implied by domestic and Strasbourg case law but **must also accord with this stated policy**. (55.1.1)
- Detention can only lawfully be exercised under these provisions where there is a realistic prospect of removal within a reasonable period.<sup>38</sup> (55.2)
- Detention reviews are necessary in all cases to ensure that detention remains lawful and in line with stated detention policy at all times. (55.8).

The decision to detain is outlined in Section 55.3, where there are 3 guiding principles:

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

The decision to detain is not subject to automatic judicial oversight. When making the decision, UKBA caseowners are instructed to select from six possible reasons for detention. These reasons are detailed in the EIG Chapter 55, Section 6.3.<sup>39</sup>

The power to detain is not an unlimited power. Indeed, the SSHD's power is not solely restricted by the need to follow its own guidance, but also to remain within the ambit of common law, notably that detention must be reasonable in all circumstances.<sup>40</sup> Furthermore, there are a number of groups of persons who are considered to be unsuitable for detention.

## Persons unsuitable for detention

Chapter 55 of the EIG outlines those individuals who should normally be considered *unsuitable* for detention. This includes people who have independent evidence of torture except "under very exceptional circumstances".<sup>41</sup>

The EIG, amended in August 2010, also noted individuals with serious mental or physical health problems that cannot be satisfactorily managed in detention should be considered unsuitable. Prior to this, mentally ill people would only be detained in "very exceptional circumstances" but the new policy allowed for the exclusion from detention where their health "cannot be satisfactorily managed within detention". In changing the policy, there was no consultation with stakeholders and NGOs raised serious concerns over this change.

However, in April 2012, in the case of *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin), the Judge ruled that the Home Secretary acted unlawfully in August 2010 in making changes to the Home Office policy for detaining those with mental illness in immigration detention. 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. UKBA, at the time of publishing this report, has not amended their policy guidance online and is cited below.

Section 55.10 states:

'The following are normally considered suitable for detention in only very exceptional circumstances, whether in dedicated immigration detention accommodation or prisons:

- unaccompanied children and young persons under the age of 18 (but see 55.9.3 above);
- the elderly, especially where significant or constant supervision is required which cannot be satisfactorily managed within detention;
- pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this (but see 55.4 above for the detention of women in the early stages of pregnancy at Yarl's Wood);

- those suffering from serious medical conditions which cannot be satisfactorily managed within detention<sup>42</sup>
- those suffering serious mental illness which cannot be satisfactorily managed within detention (in CCD cases, please contact the specialist Mentally Disordered Offender Team). In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act;<sup>43</sup>
- **those where there is independent evidence that they have been tortured;**
- people with serious disabilities which cannot be satisfactorily managed within detention;
- persons identified by the Competent Authorities as victims of trafficking (as set out in Chapter 9).<sup>44</sup>

This is supported by the 1998 White Paper where it was noted that 'The Government also recognises the need to exercise particular care in the consideration of physical and mental health when deciding to detain. Evidence of a history of torture should weigh strongly in favour of temporary admission or temporary release whilst an individual's asylum claim is being considered.'<sup>45</sup> In addition, the Detention Centre Rules 2001 provide an additional stage at which safeguarding individuals who should be deemed unsuitable for detention are recognised.

## Detention Centre Rules

In 2001, the government introduced the Detention Centre Rules. This statutory instrument makes provisions for the regulation and management of IRCs. Prior to this piece of secondary legislation, there were no special regulations for individuals detained for the purposes of immigration purposes.

Rules 33 – 37 inclusive of the Detention Centre Rules 2001 outline the statutory obligations towards immigration detainees. Rule 33 (1) states: 'Every detention centre shall have a medical practitioner, who shall be vocationally trained as a general practitioner and a fully registered person within the meaning of the Medical Act 1983.'

Rule 34 outlines the statutory obligation for a medical practitioner to conduct a physical and mental examination within 24 hours of admission to the IRC:

'34.(1) Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) or (10)) within 24 hours of his admission to the detention centre.

(2) Nothing in paragraph (1) shall allow an examination to be given in any case where the detained person does not consent to it.

(3) If a detained person does not consent to an examination under paragraph (1), he shall be entitled to the examination at any subsequent time upon request.'

Under Rule 35<sup>46</sup> of the Detention Centre Rules 2001, healthcare teams at Immigration Removal Centres (IRCs) who have concerns that a detained person has a special illness or condition or may have been a victim of torture, are required to report such cases to the centre manager.

Rule 35 states:

**‘Special illnesses and conditions (including torture claims)**

**35.** (1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.

(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

**(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.**

(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.

(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.<sup>47</sup>

The duty then rests with the SSHD to review the detention of the individual in question. The EIG in Chapter 55.8A outlines the procedure:

“Upon receipt of a Rule 35 report, caseworkers must review continued detention in light of the information in the report ... and respond to the centre, within two working days of receipt, using the appropriate Rule 35 pro forma.”

Thus, whilst Rule 34 places a statutory obligation for a full mental and physical examination to take place, Rule 35 allows the medical practitioner to alert caseowners where they have a concern that a detainee is a victim of torture. In turn, the detainee’s detention is reviewed.

In 2002, Lord Filkin commented on Rule 35 in the House of Lords on behalf of the Government. He spoke in response to a proposed Amendment by Lord Dholakia and Lord Avebury, which called for the exemption of victims of torture whose trauma is likely to be compounded by being detained from immigration detention. He stated:

*“We made it clear in our 1998 White Paper, Fairer, Faster and Firmer, that evidence of a history of torture should weigh strongly in favour of temporary admission or temporary release when deciding whether to detain while*

*an individual’s asylum claim is being considered. That remains the case.*

*The instructions to staff authorising detention are clear on that. Independent evidence that a person has a history of torture is one of the factors that must be taken into account when deciding whether to detain and would normally render the person concerned unsuitable for detention other than in exceptional circumstances. Such evidence may emerge only after the detention has been authorised. That may be one of the circumstances referred to by the noble Lord, Lord Hylton. If that happens, the evidence will be considered to see whether it is appropriate for the detention to continue.*

*We reinforced that in the Detention Centre Rules 2001. Rule 35(3) specifically provides for the medical practitioner at the removal centre to report on the case of any detained person who he is concerned may have been the victim of torture. There are systems in place to ensure that such information is passed to those responsible for deciding whether to maintain detention and to those responsible for considering the individual’s asylum application.*

*However, unfortunately, there cannot be a blanket and total exclusion for anyone who claims that they have been tortured. There may be cases in which it would be appropriate to detain somebody who has a history of torture. For example, the person concerned might be a persistent absconder who is being returned to a third country. It might be necessary to detain such a person to effect removal. There will be other cases in which the particular circumstance of the person justifies such an action. There will be yet other cases in which we do not accept that the person concerned has been the victim of torture. Despite that, I repeat my earlier comments about the importance of seeking to interpret these cases with the utmost care and not lightly using the exceptions to which I referred.”<sup>48</sup>*

This statement by Lord Filkin makes it clear that a claim of torture alone does not mean an individual will be released. What is needed is independent evidence. If there is sufficient independent evidence then ordinarily, and in the absence of exceptional circumstances, an applicant will not be detained. Lord Filkin stresses that the creation of the Detention Centre Rules 2001 reinforced this provision. Thus, Rule 35 is the safeguard that allows for the identification and potential release of victims of torture. However, as this report will show, this rule is frequently flouted.

## Rule 35 Process

The Rule 35 process is detailed in various guidance documents:

- Asylum Process Guidance, ‘Detention Rule 35 Process’<sup>49</sup> – targeted at UKBA’s Immigration Group
- Detention Service Order (DSO) 03/2008, ‘Special Illnesses and conditions (including torture claims)’<sup>50</sup> – for contractors and Detention Services staff and officers in IRC
- Operating Standards, ‘Detention Services Operating

Manual for immigration service removal centres<sup>51</sup> – a manual including auditable requirements to improve the performance of private contractors and bring them into compliance with UK policy

- Enforcement Instructions and Guidance, Section 55.8 – guidance and information for officers dealing with enforcement immigration matters.

The Detention Service Order 03/2008 lays out the basic procedures for recording and dealing with Rule 35 reports by contractors and Detention Services staff and officers.<sup>52</sup> It contains proformas including a template Rule 35 report, otherwise known as an ‘Allegation of Torture’ (AOT) form, fax letter head to send to UKBA caseowner, and a Rule 35 response letter template. These are available in the Appendix.

The Asylum Process Guidance clearly explains the function and purpose of Rule 35:

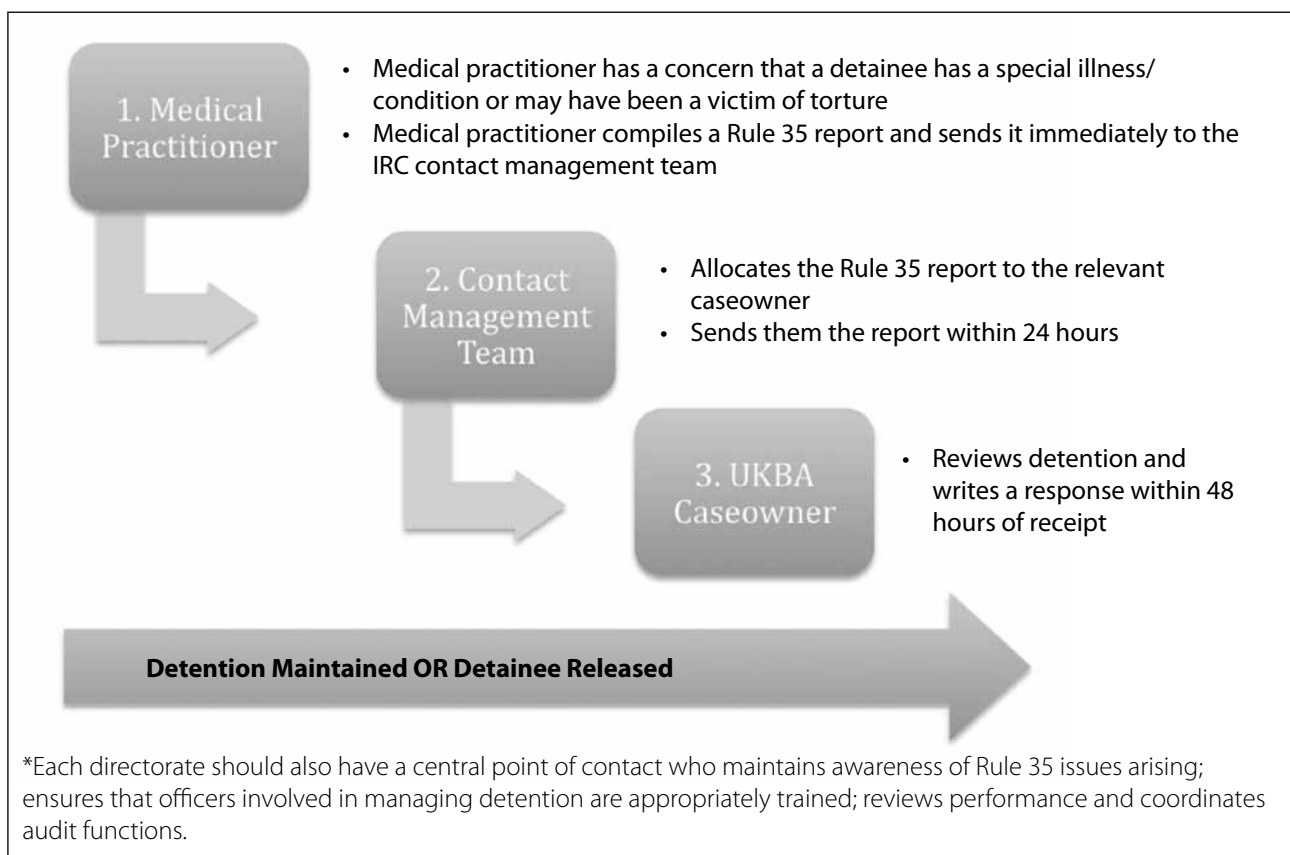
‘Under Rule 35 of the Detention Centre Rules 2001, healthcare teams at Immigration Removal Centres (IRCs) who have concerns that a detained person has a special illness or condition or may have been a victim of torture,

are required to report such cases to the centre manager. These reports are then passed via the UK Border Agency teams at the IRCs, to the office responsible for managing and/or reviewing the individual’s detention and to the casework unit/case owner dealing with the individual’s substantive case (...)

The principal purpose of Rule 35 is to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing their detention. The information contained in such reports will in every case need to be considered in deciding whether continued detention is appropriate, and may also need to be considered in relation to its possible impact on the prospects for removal. It is also important that due consideration is given to these reports in connection with considering the substantive asylum and Human Rights Act application.’ (Para 1.3)

In some cases, an individual may have multiple Rule 35 reports, where their health has continued to deteriorate during detention. The Rule 35 process involves different individuals from both UKBA and IRC healthcare teams. The process is detailed below:

## Rule 35 Process



## Rule 35 responses

Immigration detainees receive monthly detention reviews whilst held in IRCs. However, research and legal cases have shown that these may not be regularly and/or

not meaningfully done.<sup>53</sup> In addition to these detention reviews, Rule 35 reports require a further *ad hoc* detention review at the time of receipt. The key features of what the review should constitute and how responses should be compiled are detailed in section 3 of the Asylum Process

Guidance. The key points are provided here with the paragraph numbers provided:

- As with all detention reviews, the suitability of ongoing detention must be assessed against the issues raised in the context of the wider facts of the case, and against the basis of detention under detention policy. (3.1)
- The weight to be placed on a Rule 35 report will depend upon what the report qualitatively states, and what is already known about the applicant and his/her case. (3.2)
- Any particularised concerns outlined in a Rule 35 report by a medical practitioner will constitute independent evidence, which is relevant to all considerations, but especially to the published detention policy that independent evidence of torture weighs heavily against detention. (3.2)
- Rule 35 reports are not medico-legal reports, but the evidence they contain must not be simply dismissed (...) all information must be carefully and critically considered. (3.2)
- Written responses to the Rule 35 report must address the substantive issues raised. It is not enough to simply state that the issue/s raised were considered in full in previous correspondence (3.1.1)
- Case owners must treat Rule 35 reports in exactly the same way as any other piece of material evidence coming to light in respect of an asylum and human rights claim. (4.1)

## Lack of scrutiny of the Rule 35 process

Rule 35 is an important safeguard for victims of torture or individuals who may be injuriously affected by immigration detention.

However, as this report will show, vulnerable people are routinely detained, highlighting firstly UKBA's failure to implement its own policy as per Chapter 55 of UKBA's Enforcement Instructions Guidance, and secondly the vital importance of implementing, monitoring and ensuring accountability within the Rule 35 process.

With regards to guidance, a key problem lies in the fact that UKBA fails to define its key terms in its instructions. There is no definition of "torture" offered within the *Rule 35 Process* instruction and no definition of "exceptional circumstances". Furthermore, whilst the new policy instruction is detailed with regards to administrative processes, lines of duty and timescales, there is a failure to address the consistent problem of how UKBA caseowners must respond effectively to Rule 35 reports nor how to interpret the information contained therein.

A third problem lies in the fact that the majority of IRCs and their healthcare teams are run externally by private contractors. In 2005, the 'Detention Services Operating Manual for immigration service removal centres'<sup>54</sup> was created. The manual consists of standards and auditable

requirements for detention centre staff to ensure they comply with UK policy. However, this document is not legally binding and was not even used by UKBA when they conducted their own internal audit of the functioning of Rule 35.

In accordance with the *Prisons Act 1952* and the *Immigration and Asylum Act 1999*, each IRC must be monitored by an Independent Monitoring Board (IMB). The centres are also monitored by HM Inspector of Prisons (HMIP). The statutory role of the Independent Monitoring Board is to satisfy itself as to the just and human treatment of those held in IRCs; inform the SSHD if they hold concerns; and to "report annually to the Secretary of State on how far the immigration removal centre has met the standards and requirements placed on it and what impact these have on those held in the centre."<sup>55</sup>

However, the IMBs are run by volunteers who are appointed by the Secretary of State and their resources are limited. Thus, Rule 35 has had little attention. For example, in 2010 of the 8 annual reports compiled on IRCs, only one considered Rule 35. This report was for Harmondsworth IRC, and whilst the IMB is unable to monitor casework decisions regarding Rule 35 reports, they do monitor the implementation of procedures. On this, their feedback was highly critical:

'Monitoring by the IMB found that of 29 reports made by healthcare staff at Harmondsworth in the five months from August to December 2010 there were only 7 responses recorded as received by healthcare by the end of each month.

UKBA's Audit Report says that procedures are being tightened. We were surprised to find that even in April 2011 local UKBA staff were unsure of the correct procedure for informing the doctor and the detainee of the outcome of the referral.'<sup>56</sup>

The IMB's recommendation to the Minister was:

'Issues for the minister:  
(...) 10. Action should be taken to ensure that Rule 35 of the Detention Centre Rules is correctly applied.'

In its 2011 Annual Report on Harmondsworth IRC, the IMB found that in 2011 there were 109 Rule 35 reports made to UKBA about Harmondsworth detainees; in only 5 cases was the safety net applied and the detainee released. The IMB recommended an independent review of the application of Rule 35.

Despite standards, the performance of IRCs and the implementation of Rule 35 have continued to be the subject of intense criticism, including from official bodies. Criticism of Rule 35 is widespread with many of the same recommendations repeatedly made and repeatedly ignored. This contributes to the development of a clear history of the continuous, systemic failure to implement Rule 35 and will be outlined later in this report.

# Chapter Three – Healthcare in Immigration Detention

## Commissioning and Provision

UKBA is ultimately responsible for healthcare commissioning and provision within IRCs. Commissioning is the process of planning, funding and monitoring the health services provided.

In public sector prisons, healthcare funding was transferred from the Home Office to the Department of Health in April 2006, with subsequent provision of healthcare by the NHS. However, IRCs were not subject to this transfer and remained under UKBA.

On a day to day level UKBA has devolved its duty via contracts to other organisations; seven of the 11 IRCs are run by private companies that further sub-contract to private healthcare providers (although centres run by Serco are run by Serco Health). The other four centres (including Lindholme) are managed by Her Majesty's Prison (HMP) service under a service level agreement. Figure 3 below lists the contractors and the healthcare providers that they sub contract services to at each IRC.

In addition, healthcare services are split such that primary care services are commissioned by the private organisation running the IRC and secondary and tertiary care is commissioned by the local PCT. However, as stated earlier, UKBA is ultimately responsible.

UKBA has national operating standards, which all IRCs are required to follow. However there is considerable variation among healthcare providers and the institutions are each

quite different from one another in terms of physical lay-out, population, and how they are run. As there is no single national service provider, the private contractors are competitors with one another.<sup>57</sup>

The fact that healthcare in private IRCs is not the Department of Health's (DOH) responsibility has led to concerns that it is not subject to the same robust clinical accountability and governance mechanisms that prevail in the NHS.<sup>58</sup>

Clinical governance is how health services are held accountable for the safety, quality and effectiveness of the clinical care delivered to patients. Clinical governance is a statutory requirement of NHS Boards, and includes key elements such as education, training, adherence to national and local best practice guidance, clinical audit, robust accountability and responsibility arrangements, openness and transparency. Clinical governance systems within IRCs have repeatedly been criticised.<sup>59</sup> For example, in a HMIP report of Colnbrook IRC in 2010, clinical governance was described as "fragile".<sup>60</sup>

In 2011 Emma Plugge, director of Global Health, University of Oxford, told the British Medical Journal (BMJ), 'Certainly scrutiny of the quality of care provided by these private contractors may not be equivalent to that in the NHS'.<sup>61</sup>

In July 2010 in an interview with The Independent newspaper, Anne Owers, the then Chief Inspector of Prisons, argued that that there was a conflict between forced removal of non-citizens and the appropriate treatment of detainees; *'The job [of UKBA senior*

**Figure 3: IRC Contractors and Healthcare Providers**

IRC	Contractor	Healthcare Provider
Brook House	G4S	Saxonbrook Medical Centre (local GP practice contracted by G4S)
Campsfield House	Mitie PLC	The Practice PLC
Colnbrook	Serco	Serco Health
Dungavel	GEO Group	Primecare forensic medical.
Dover	Prison Service	Primary Care NHS Trust (the PCT).
Haslar	Prison Service	Primary Care NHS Trust (the PCT).
Harmondsworth	The GEO Group	Primecare
Lindholme	Prison Service	Primary Care NHS Trust (the PCT).
Morton Hall	Prison Service	G4S
Tinsley House	G4S	Saxonbrook Medical Centre (local GP practice contracted by G4S)
Yarl's Wood	Serco	Serco Health

*management] is removal, and detention is incidental to removal. So I don't think there is always an appreciation [of] what is happening on the ground about detention. So I float the idea of whether the process of looking after people who are in detention wouldn't be better separated from the perfectly proper role of UKBA as an organisation that has to enforce immigration controls.<sup>62</sup>*

This concern has also been voiced by Alistair Burt MP who stated in March 2010: 'If there is an issue over 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?<sup>63</sup>

## **HMIP Inquiry into the quality of healthcare at Yarl's Wood Immigration Removal Centre**

In 2006 an inquiry into the quality of healthcare at Yarl's Wood found that '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'.<sup>64</sup>

The inadequacy of healthcare systems in the IRC<sup>65</sup> was compounded by the unresponsiveness of UKBA to clinical concerns about an alleged history of torture or adverse medical consequences of continued detention. When clinical concerns were raised, the information was not systematically addressed or actioned. Nor was independent medical opinion sought or adhered to.

The main recommendations of the report were that:

- UKBA and the Department of Health (Prison Health) should expedite arrangements for healthcare provision in immigration removal centres to be commissioned by the National Health Service (NHS).
- All healthcare provision in IRCs should be registered with the Healthcare Commission (now the Care Quality Commission) and their specified standards of care should be implemented as a matter of urgency.

## **Care Services Improvement Partnership (CSIP) Report on Healthcare in Private Immigration removal centres**

In 2008, a Report on Healthcare in Private IRCs by the CSIP was commissioned by the Home Office to explore the above recommendations of the Yarl's Wood Inquiry.<sup>66</sup>

The report found a number of factors negatively impact on delivery of health services for detainees including:

- Fragmentation of information and failure of information to follow the patient throughout the asylum claim process, making it difficult to know which refused asylum seekers are unsuitable for detention.

- The short time scale that healthcare providers have to ascertain health needs as detainees move in, out and around the detention estate.
- The lack of consistency of healthcare provision and clinical governance processes across the estate with variable use and development of:
  - o Evidence based procedures and policies
  - o Staff development and audit
  - o Review of healthcare provision against clearly defined outcomes.

However, the report concluded that moving funds and commissioning from the immigration estate into PCTs would not necessarily overcome the above factors and might disadvantage detainees in areas where local health services are struggling to balance their finances.

The main recommendation of the report was a joint commissioning framework at policy level between the DOH and the Home Office and at operational levels between providers of the secure estate and PCTs. The immigration services would retain responsibility for the health of their detainees but this would be supported by the expertise within the NHS.

## **UKBA response to the recommendations**

At the present time, contractors continue to have responsibility for the provision of primary care services in their establishments under terms specified in their contracts with the UKBA. However UKBA stated that a full strategic review would be conducted of the health care elements of the contracts to run privately managed prisons to ensure that they bind contractors robustly into the principle of equivalence with the NHS.<sup>67</sup>

On 31 January 2012, Paul Burstow MP (and Minister of State for Care Services) commented on who will have responsibility for commissioning healthcare in IRCs from April 2013. He stated, 'The Department will assume policy responsibility for IRC healthcare commissioning policy from UKBA from 1 April 2012. UKBA budgetary provision and commissioning responsibility for healthcare in IRCs will be transferred to the Department during 2012-13 and, subject to legislation, these responsibilities will be fully transferred to the National Health Service Commissioning Board by April 2014.'<sup>68</sup> 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.

UKBA have been slow to action the other recommendations of the report. At the time of the last inspectorate many centres still had no up to date health care needs assessment completed and in others the health needs assessment had only been completed as late as 2010.

Only in recent years have the centres been required to register with the Health Commission (now the Care Quality

Commission (CQC)). The memorandum of understanding between UKBA and the CQC has yet to be published. The CQC website states that it is currently in progress.<sup>69</sup>

## Recent Immigration Removal Centre Inspection Reports<sup>70</sup>

While many of the recent inspectorate reports noted some improvements in healthcare since the 2006 Yarl's Wood Inquiry, there were still many key objectives that were consistently not achieved in the majority of centres.

Notably in 10 of the 11 centres inspected, there was no training of any kind for healthcare staff in the recognition of signs of trauma and torture, and how to support these detainees. In all inspections, it was noted that Rule 35 reports were poorly filled and dealt with by healthcare.

Attitudes of healthcare staff towards detainees were poor; at Tinsley house healthcare staff were "inappropriately abrupt... towards detainees";<sup>71</sup> at Yarl's Wood the "brusque attitude of health care staff towards detainees" was of concern.<sup>72</sup>

In Harmondsworth, healthcare was described as 'unacceptably poor – both in terms of the approach of healthcare staff and the quality and quantity of provision, particularly in relation to mental health, primary care and clinical governance.'<sup>73</sup>

The summary below shows some of the healthcare failings from the most recent inspections by HMIP for each IRC. The most relevant to the report were included, however they only represent a small number of the reports' findings.

Brook House March 2010	<ul style="list-style-type: none"> <li>Health care staff had received very limited training in the recognition and assessment of alleged victims of torture. Work with the University of Cumbria to develop a course had recently started.</li> <li>There was no routine secondary screening process, but all detainees were given the opportunity to be seen by a GP the following day.</li> </ul>
Campsfield May 2011	<ul style="list-style-type: none"> <li>Too little progress had been made in remedying areas that were previously identified.</li> <li>Staff had not had any training in the recognition and treatment of torture.</li> <li>Rule 35 letters lacked detail and rarely provided clear medical assessments</li> </ul>
Colnbrook August 2010	<ul style="list-style-type: none"> <li>Safety remained a concern at Colnbrook</li> <li>Vulnerable detainees did not have individual care plans and access to appropriate specialist input.</li> <li>Clinical records were not maintained in line with professional guidelines</li> <li>Health services staff were not trained in the recognition and treatment of torture</li> </ul>
Dover May 2010	<ul style="list-style-type: none"> <li>Health care records indicated that 22 rule 35 reports had been made in 2010; however, UKBA records suggested that only 7 applications had been received</li> <li>Training in the recognition of victims of torture was not available to staff</li> </ul>
Dungaval June 2010	<ul style="list-style-type: none"> <li>Health care staff had not been trained in its recognition or treatment.</li> <li>Only three-quarters of R35 had received responses and only half of these had arrived within the required two working days.</li> <li>Rule 35 responses were abrupt and unhelpful.</li> </ul>
Harmondsworth January 2010	<ul style="list-style-type: none"> <li>Healthcare, was unacceptably poor – both in terms of the approach of healthcare staff and the quality and quantity of provision, particularly in relation to mental health, primary care and clinical governance.</li> <li>There was no mental health needs analysis to provide evidence of the level and type of need. Primary mental health services were limited to GP consultations, there was no dedicated RMN time. There was no counselling service</li> </ul>
Haslar June 2011	<ul style="list-style-type: none"> <li>Health care staff were not trained in the recognition of signs of trauma and torture, and how to support these detainees.</li> <li>Rule 35 reports submitted by the health care department were of variable quality. The health services team offered no opinion. UKBA had not released any detainees. Most of the responses by case owners were brief and dismissive</li> </ul>
Lindholme January 2011	<ul style="list-style-type: none"> <li>Rule 35 reports from the health care department were poor and not written by a doctor, as required by the detention centre rules. There had been a large reduction in the number of these reports, from 17 in 2009 to three in 2010. The reasons for the reduction were not clear.</li> <li>Following their initial health screen, a secondary screening of all detainees by the GP was not carried out. <ul style="list-style-type: none"> <li>None of the health services staff had received any training in recognising the signs of torture or treating detainees.</li> <li>Detainees did not have access to any counselling services.</li> </ul> </li> </ul>
Oakington August 2010	<ul style="list-style-type: none"> <li>The use of interpreting services by G4S staff was very limited. <ul style="list-style-type: none"> <li>Counselling services were not available within the centre.</li> </ul> </li> <li>Nurses did not receive clinical supervision.</li> <li>There had been 201 declarations of torture under Rule 35 by detainees to health care between January and July 2010, but the health care department had had confirmation of receipt and an update from UKBA on only a very small number</li> </ul>
Tinsley House February 2011	<ul style="list-style-type: none"> <li>Rule 35 procedures were not carried out effectively; often written by a nurse rather than a GP as required, Replies were late, and did not always adequately consider the information put forward</li> <li>They noted some inappropriately abrupt behaviour from some healthcare staff towards detainees</li> <li>There was no evidence of multidisciplinary meetings to discuss whether continued detention could be detrimental to a detainee's health</li> </ul>
Yarlswood July 2011	<ul style="list-style-type: none"> <li>Rule 35 reports that should have alerted immigration staff to detainees whose health might be adversely affected by detention were poorly understood by health staff and badly completed. None of the 10 Rule 35 reports we examined had resulted in detainees being released from detention. Many of the replies were dismissive and lacked logic.</li> </ul>



In April 2012, HMIP produced its most recent report on Harmondsworth IRC. The report noted:

'Rule 35 reports and subsequent responses to detainees who may have been the victims of torture or who were unfit to detain were often insufficient or formulaic, and gave limited assurance that the needs of individuals had been fully considered. The report paid reference to its earlier recommendation, which stated: 'Rule 35 healthcare reports should clearly identify whether injuries are likely to have resulted from torture.' However, this was found not to have been achieved. Thus, in this report at 5.13, it is noted that: 'The quality of Rule 35 reports by clinical staff was poor. They merely repeated what the detainee had said and clinical evaluations failed to state the likely cause of the alleged torture injuries (see casework section).

We repeat the recommendation.'

## Immigration detention – Expectations of Healthcare

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'.<sup>74</sup>

Other requirements include;

- All detainees should be screened by health services staff in private on arrival, with a translated health questionnaire if needed, and offered an appointment with a doctor
- Detainees should be assessed for the risk of self-harm or suicide before location on residential units
- Specialist interpreters or a telephone interpreting service should be offered for any medical consultations with detainees who do not understand English
- Under Rule 34 of the detention centre rules IRCs are required to ensure that arrangements are in place for detainees to have a physical and mental examination by the medical practitioner within 24 hours of their arrival at the removal centre
- There is evidence of treatment plans for patients that reflect national clinical guidance, such as, for example, that provided by National Institute of Clinical Excellence (NICE) and National Service Frameworks (NSFs). Such treatment plans are subject to clinical audit
- The IRC should provide health promotion and harm minimisation services. The requirement for these services should be based on the Health Needs Assessment of the specific population
- The health care team must obtain, so far as is reasonably practicable, relevant health information from previous healthcare providers. This should be done with the consent of the detainee

- Where detainees are being transferred to another removal centre or to prison, the Centre must ensure that clinical records are transferred to the receiving centre or prison at the time of transfer
- The Health Care team must report to the centre manager cases where a detainee's health is likely to be significantly harmed by being detained (Rule 35 (1) refers). In doing so the Health Care team must be mindful of the need to maintain medical confidentiality unless the patient has given consent to disclosure of information
- The Health Care team will report, with the patient's consent, to the manager on the case of any detained person where there is concern that the person concerned may have been the victim of torture (Rule 35 (3) refers)

Independent doctors are able to enter IRCs and visit patients. In accordance with Detention Centre Rule 33 (7), they can provide a second medical opinion of the patient's medical needs and the current medical treatment and/ or prepare medical reports for the patient's legal advisors. They may enter information into the medical notes but are unable to prescribe medication.

## Reception and Screening

There is a requirement that all new entrants to the IRCs are screened by a health professional within two hours of arrival, including assessment of risk of self-harm or suicide. Detainees who have been transferred from other IRCs usually come with medical records but are still required to be screened.

The screening process should take around 30 minutes however in practice it may be very brief, often around 10 minutes.<sup>75</sup>

Different types of proformas are used for screening throughout the different centres; most include questions on past medical history, medication and including specific questions on mental illness or experience of torture.

Interpreters are rarely used in the reception screening process. It is not uncommon for health screening to take place in the middle of the night due to overnight transfers.<sup>76</sup>

Under Rule 34 of the Detention Centre Rules 2001, IRCs are required to ensure that arrangements are in place for detainees to have a physical and mental examination by the medical practitioner within 24 hours of their arrival at the removal centre.

This assessment should identify any immediate and significant mental or physical health needs (including drug and alcohol addiction), the presence of a communicable disease and whether the individual may have been the victim of torture. However there is no requirement for detainees to attend.

The screening process should identify those who are vulnerable and not fit to be detained so this can be reported to the detaining authorities under Rule 35.

## Health Needs of the Population within Detention

*“Evidence to the Joint Committee indicated that there was an institutional failure to address health and health concerns among those in detention, including a resistance to accept evidence of torture and abuse.”<sup>77</sup>*

The population within detention has complex health needs, differing from those of the general and prison population. Asylum seekers and refugees in the UK have been associated with poor physical and mental health status. They are a vulnerable group within society and often face barriers when accessing healthcare both in detention and in the community.<sup>78</sup>

Serious infectious diseases including TB, sexually transmitted infections, hepatitis B, HIV, malaria, and other parasitic infections are also more prevalent within this population.<sup>79</sup>

A study by the Home Office found that 16% of the refugees sampled reported suffering from physical health problems, and two-thirds reported feelings of anxiety or depression.<sup>80</sup> 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.<sup>81</sup>

## Mental Health Provision in IRCs

All centres should employ Registered Mental Health Nurses and have arrangements for psychiatric support from consultants employed on a sessional basis.

HMIP reports continually highlight inadequate mental health provision in many centres. Of note is that some centres only had mental health nurses available during the night shifts. Many centres have no counselling services or services solely provided by outside charitable agencies.

The mental health charity Mind reported last year that the UK was ‘regularly failing refugees and asylum seekers’.<sup>82</sup> It found that the process of asylum itself was damaging to mental health and that IRCs had ‘restricted mental healthcare resources with no specific guidelines about what mental health care should be in place’.

In the past year, the High Court has found in three separate cases that the treatment individuals with serious mental illness held in immigration detention was in breach of Article 3 of the European Convention on Human Rights. In all cases, the Court found that the circumstances of detention amounted to inhuman or degrading treatment of the individuals concerned. This is a damning finding.

See the cases of *R (S) v SSHD* [2011] EWHC 2120 (Admin) (5 August 2011); *R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748 (Admin) (26 October 2011); and *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin) in the chapter on *Case Law* for further information.

## Torture and The Istanbul Protocol

It is estimated that up to 5-30% of asylum seekers or refugees have been tortured depending on the definition of torture used and the country of origin.<sup>83</sup>

Some people do not initially admit to their experiences of torture. Studies have shown this to be linked to shame or unwillingness to disclose sensitive information of, for example, sexual violation to an immigration officer of the opposite sex.<sup>84</sup>

Some methods of torture are commonly experienced, such as beating, kicking and slapping. Other methods include suspension, burning, electrocuting sensitive parts of the body such as the genitals, food deprivation and mental torture techniques such as sleep deprivation. Many women and some men are survivors of rape or other sexual violence. Some methods are typical of certain geographical areas.

The absence of any training of any kind in the recognition of signs of trauma and torture for healthcare staff in detention centres is of concern. Some centres have currently proposed plans to implement training such as using on-line courses or ‘E-learning’s but there was no transparent consistent plan on how they will implement the training and ensure the quality between the different centres. Furthermore, the training method of ‘E-learning’s is questionable and it is unlikely that this method alone will be sufficient for the task in hand.

*The Istanbul Protocol; The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*<sup>85</sup> contains internationally recognised standards and procedures on how to recognise and document symptoms and signs of torture. It provides useful guidance for doctors and lawyers who want to investigate whether or not a person has been tortured and report the findings to the judiciary and any other investigative bodies.

The Istanbul Protocol describes in depth how to assess lesions that are potentially related to torture:

*‘For each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient. The following terms are generally used:*

*(a) Not consistent: the lesion could not have been caused by the trauma described;*

*The following discussion is not meant to be an*

*(b) Consistent with: the lesion could have been caused by*

*the trauma described, but it is non-specific and there are many other possible causes;*

- (c) *Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes;*
  - (d) *Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes;*
  - (e) *Diagnostic of: this appearance could not have been caused in any way other than that described.*
187. *Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story.'*

It gives advice about how to interpret clinical findings both physical and psychological:

1. *Physical evidence*
  - A. *Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.*
  - B. *Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)*
  - C. *Correlate the degree of consistency between examination findings of the individual with knowledge of torture and their common after-effects used in a particular region.*
2. *Psychological evidence*
  - A. *Correlate the degree of consistency between the psychological findings and the report of alleged torture.*
  - B. *Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.*
  - C. *Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time-frame in relation to the torture events and where in the course of recovery is the individual?*
  - D. *Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.*
  - E. *Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.'*

An MLR is written in accordance with the Istanbul Protocol. It documents an asylum claimant's account of torture, the clinical evidence of torture and addresses the degree of consistency between this clinical evidence and the

claimant's account. MLRs can carry significant evidentiary weight.<sup>86</sup>

## Post Traumatic Stress Disorder

The Department of Health identified Post Traumatic Stress Disorder (PTSD) as the most common problem amongst asylum seekers as defined in ICD-10 (World Health Organization, 1992), code number F43.1.<sup>87</sup> The diagnostic criteria for PTSD are provided in the Appendix.

The diagnosis of PTSD is restricted to people who have experienced exceptionally threatening and distressing events. The ICD-10 definition states that PTSD may develop after 'a stressful event or situation ... of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone'.

People at risk of PTSD include victims of war, torture, state-sanctioned violence or terrorism, and refugees. The core symptoms of PTSD include:

- re-experiencing aspects of the traumatic event in a very vivid and distressing way
- avoidance of reminders of the trauma such as situations or circumstances resembling the event
- hyperarousal including hypervigilance for threat, exaggerated startle responses, irritability and difficulty concentrating, and sleep problems.

Whilst most detainees who suffer PTSD developed it as a direct result of their experiences in their home countries, some detainees have developed PTSD as a result of excessive force during deportation attempts and/or conditions of detention in the UK.

Many PTSD sufferers experience other associated symptoms, including depression, generalised anxiety, emotional numbing, feeling detached from other people, and shame and guilt which contribute to their distress and affect their functioning.

The NICE guidelines advise that "those managing refugee programmes should consider using a brief screening instrument for PTSD."<sup>88</sup> This should be part of the initial refugee healthcare assessment and of any comprehensive physical and mental health screen.

The current first line treatment for severe PTSD advised by NICE guidelines is a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR)). However, it is difficult to deliver this therapeutic intervention in the detention setting. Drug treatment should not be first line.

## Suicide and Self-Harm

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. 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. The ACDT document should be reviewed at regular intervals to ensure the correct support is provided while the individual is thought to be at risk.

The majority of self-harm prevention information for staff is contained in Detention Services Order 6/2008.<sup>89</sup> The Detention Services Order draws on the Prison Service Order on Suicide Prevention and Self-Harm Management (PSO 2700).<sup>90</sup>

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.<sup>91</sup>

Unlike the prison estate, figures on self-harm are not routinely published by UKBA. An FOI request (FOI 20881) from the Association of Visitors to Immigration Detainees (AVID) to UKBA revealed that the number of recordings of individuals placed on Assessment Care in Detention and Teamwork (ACDT) between January and October 2011 inclusive was 1361.<sup>92</sup>

The chart below details death and suicide rates in IRCs from 2010 to 2011. The figures are taken from the Department of Health's Independent Advisory Panel on Deaths in Custody Report.<sup>93</sup> 6 of the suicides took place in Harmondsworth IRC, a high security prison-like detention centre. Many of the most sick detainees are transferred to Harmondsworth because their healthcare centre has greater capacity and resources. However, this IRC not only has the highest number of suicides, but also is where the High Court ruled that two individuals were subjected to inhuman and degrading treatment in 2011.

In one month in 2011 there were three deaths of asylum seekers in the care of UK immigration detention centres (2 at Colnbrook, 1 at Campsfield). This has reignited concerns that the state of healthcare provision for detainees remains inadequate and unsafe.<sup>94</sup> These deaths are currently being investigated by the Prisons and Probation Ombudsman (PPO).

## The effect of detention on health

There is growing evidence that immigration detention may be detrimental to the mental and physical health of detainees. This is of particular concern amongst vulnerable detainees with a history of torture and who may have pre-existing mental health conditions.<sup>95</sup>

A large Australian study (based on 241 participants) addressed the question of the impact of **immigration** detention on the mental health of refugees and demonstrated that past immigration detention contributed independently to the risk of ongoing PTSD, depression and mental health-related disability.<sup>96</sup>

There have been no equivalent large-scale studies in the UK, however there have been multiple case studies and reviews that have reported that torture victims experience reactivation of their distress in UK Immigration Removal Centres.<sup>97</sup>

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.<sup>98</sup>

Previous reports by Medical Justice have further documented deleterious effects of detention on two other vulnerable groups: children and HIV positive patients. The *Detained and Denied* report by Medical Justice found that care of detainees with HIV was substandard and there were frequent breaches of National Guidelines for the treatment of HIV such as interruptions in access to antiretroviral medications. The report reviewed a series of case studies and found that "taken together, these breaches amount to a system of care which is frequently detrimental to health."<sup>99</sup> Psychological and physical harm to children as a result of prolonged detention were key findings of the Medical Justice report *'State Sponsored Cruelty': Children in immigration detention* published in 2010.<sup>100</sup>

Given the specific medical needs of many asylum seekers and in particular torture survivors, high quality tailored clinical care should be available within the detention setting.

## Death and Suicide Rates in Immigration removal centres from 2000 to 2011.

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>Deaths in IRC</b>	1	0	0	2	4	2	1	0	0	0	2	3
<b>Suicides in IRC</b>	1	0	0	1	3	2	1	0	0	0	0	1

# Chapter Four – The History of the Continuous, Systematic failure to Implement Rule 35

Medical Justice has raised concerns about the Rule 35 process and its failure to adequately protect victims of torture since the organisation was formed in 2005. Concerns have been raised and demands for effective implementation have been made using a variety of different avenues. These include attending stakeholder meetings, participating in consultations on policy documents, giving evidence at committee hearings, lobbying parliamentarians, informal email and telephone communications, discrete meetings with UKBA on the subject as well as commencing litigation.

Despite these endless and arduous communications, little has changed. UKBA has consistently fobbed off the criticisms arguing that concerns were isolated instances rather than a systemic issue that needs addressing. An example of the uninterested responses to evidence provided by Medical Justice of Rule 35 breaches in cases of victims of torture, include the following: 'UKBA is not able or prepared to comment on matters of professional competence' (David Wood, Director of Criminality and Detention Group, 10 February 2009).

There have been some successes in the interim where Medical Justice and other NGOs have managed to hold UKBA to account but real progress is yet to be seen. A few changes have been made but they are superficial. For example, in 2008, a new DSO on Special Illnesses and Conditions (including torture claims) was issued but hardly any information is provided and it is inadequate: there is little guidance on what substantive information is required with the focus on administrative procedures. In 2011, UKBA finally published an audit of Rule 35 for which we had been lobbying for years. However, as will be described later, this was a farcical exercise and came after an earlier audit it conducted where it had "lost" the results. Finally, the asylum process guidance instruction has been revised a number of times over the years but still fails to cover the crucial question of how UKBA caseowners should interpret information in Rule 35 reports and what is required to adequately and meaningfully review detention.

It was only the recent threat of litigation and the issuing of a pre-action protocol letter that ultimately spurred UKBA into action, proposing a meeting focusing on Rule 35 (held on 10 June 2011) and a series of commitments. These commitments included the publishing of a new DSO and Asylum Process Guidance on Rule 35 as well as a training package on Rule 35 (3). The promised dates of these have been pushed back on multiple occasions and the latest deadline for delivery, as promised on 16 January

2012, is March 31 2012. However, when this report went to print on 11 May 2012, none of these documents had yet been published. It should be noted that no official interim measures have been put in place whilst delays to improving the process have taken place despite Medical Justice's requests to do so.

UKBA have been working on a new policy guidance for Rule 35 for some time now. The proposed new guidance, which is now significantly delayed has recently been circulated for consultation. There are serious concerns that the revisions still do not address some of the key failing areas and fail to emphasise the key message that it is a safeguarding tool. Of great concern are the standardised template letters instructing caseowners on how to respond to the reports. Medical Justice will make submissions and continue to maintain pressure on UKBA to take seriously its duty to implement Rule 35.

Historically, Medical Justice is not alone in raising concerns about the Rule 35 process. The Joint Committee on Human Rights (JCHR) in 2006 drew attention to the disjuncture that exists between policy and practice, and in their conclusions and recommendations, made the following points:

*236. We are deeply concerned by the evidence we have heard about the current gap between policy and practice in relation to the detention of vulnerable adults. The Home Office acknowledges that victims of torture, pregnant women and those with serious physical and mental health conditions should not be detained and yet it continues to happen in practice. This is clearly a violation of the UK's human rights obligations towards those individuals. We welcome the acknowledgement by the Home Office that this is an issue which needs to be addressed and the news that some steps are being put into place to improve current practice.*

*(...)*

*305. We are not satisfied that the quality of healthcare currently provided to asylum seekers in detention is fully compliant with international human rights obligations, in particular the rights to freedom from inhuman and degrading treatment and to the enjoyment of the highest attainable standard of physical and mental health. We are particularly concerned about gaps in care for people with HIV and with mental health problems. It is not clear that procedures for identifying and supporting torture victims work in practice. We recommend*

*that the Department of Health establish a policy for supervising the health services that are available in detention centres, and that the standard of services should be monitored. ...<sup>101</sup>*

Indeed, from the inception of the Detention Centre Rules in 2001, issues with implementing Rule 35(3) have been raised at both the operational and legislative level. HMIP reports, the JCHR and the audit recently undertaken by UKBA provide evidence of the continued failures found in implementing Rule 35 procedure. A review of the issues raised during the House of Lords discussions on Rule 35 demonstrates how these systematic failures have a history of being raised but have yet to be solved in UKBA's operational implementation.

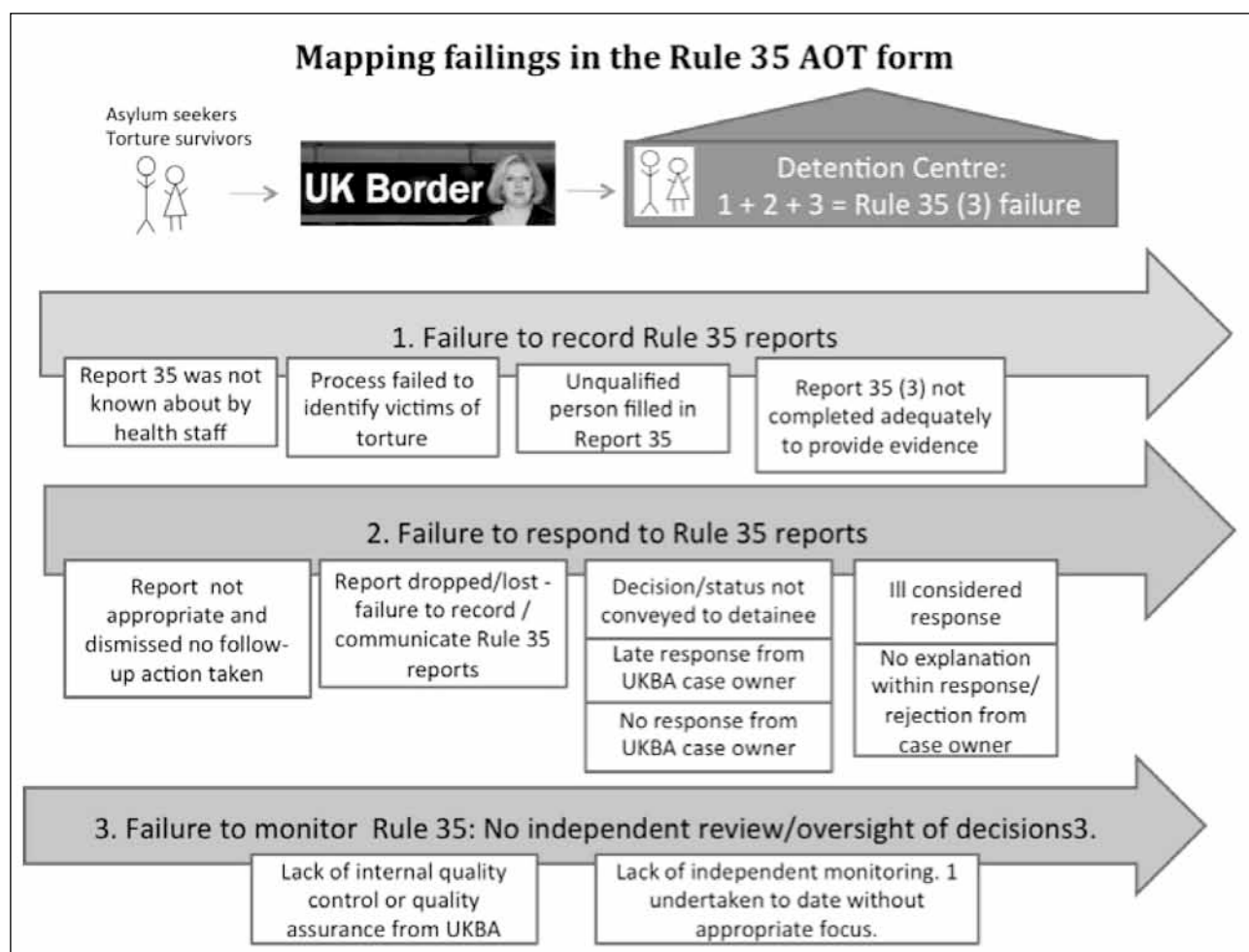
This review aims to chart the historical failings of Rule 35 (3) as identified at a policy and implementation level. This review aims to identify systematic failings and look at the history of how they have been handled. The primary sources of information include:

- Hansard search for Rule 35
- Her Majesty's Inspectorate of Prisons (HMIP) detention centre reports<sup>102</sup>
- Human Rights Joint Committee hearings
- Legal Cases
- UKBA Audit 2010

By reviewing this evidence, problems can be mapped to show systematic failings. Problems have been mapped on a Rule 35(3) process diagram to demonstrate where the implementation of Rule 35 (3) is failing. Serious failings are diagnosed where the same problem is found in several IRCs.<sup>103</sup> The most recent HMIP reports are referred to, but the review also pays reference to the earlier reports where the same criticisms were raised. The problems are exemplified with supporting evidence.

Since conducting this review, a new report on Harmondsworth IRC was published in April 2012. It reiterated many of the problems which will be outlined in this chapter. One example is that it was noted that the earlier recommendation for Rule 35 reports to "clearly identify whether injuries are likely to have resulted from torture" had not been achieved and that "the quality of Rule 35 reports by clinical staff was poor".

The Hansard search was undertaken to identify where Rule 35 issues were discussed at policy level. Key questions and issues regarding the implementation of Rule 35(3) raised during legislative debates in the House of Lords have been set out on a timeline (a full listing of the issues can be found in the Appendix). Independent review at policy level has been used to highlight biting points where policy implementation is contested, furthermore shows where issues have been repeatedly raised, and how responses have failed to fix the problem.



By cross-referencing outstanding problems with the history of issues raised, it is hoped to show where systematic problems have been known about and not corrected. By looking at responses and failed solutions, the appropriate solutions are sought.

## A review of the persistent, system-wide failures

HMIP reports provide a good record of problems arising in the implementation of Rule 35 (3).<sup>104</sup> The key findings are presented below with the following issues being covered:

### I. Identifying torture survivors and providing evidence in the form of Rule 35 Reports

1. Competency of staff to identify/support torture survivors
2. The procedure to identify victims of torture
  - a. UKBA detention of torture victims
  - b. Rule 34 screening process
3. Unqualified person filled in Report 35
4. Report completed inadequately

### II. Handling and Responding to Rule 35 AOT Reports

5. Late or no responses to Rule 35 Reports
6. In-substantive replies
7. Decision-making problems

### III. Record keeping & Monitoring

8. Incomplete logs/records of Rule 35
9. UKBA performance in monitoring Rule 35
10. Lack of independent oversight

## I. Identifying torture survivors and providing evidence in the form of Rule 35 Reports

### 1. Competency of staff to identify/support torture survivors

The problem of staff being unable to undertake the requisite procedures around Rule 35(3) and all too often, not knowing about the existence of Rule 35(3) has been a long standing problem and a key obstacle to its implementation. The issue was first raised in the House of Lords in September 2006 during a Joint Committee on Human Rights inquiry, whereby the Chief Inspector of HM Prison Inspectorate stated, 'it is not clear that health professionals are alert to or competent to detect signs of previous trauma or torture.' However, it has yet to be dealt with appropriately in nearly all of the detention centres.

The response to this issue was to recommend training for all health care staff in detention centres in repeated HMIP reports. Unfortunately the most recent reports show that the

competency of health care staff is still an outstanding problem and that training has not been provided across all centres

HMIP reports have consistently found a lack of training available and in some centres lack of awareness to Rule 35(3). In two thirds of the most recent HMIP reports it was found that there is not training available for identifying and supporting victims of torture. 10 of the 11 reports recommend training for this. However it seems there has been little effort made at any of the IRCs to amend this. The comment in the HMIP report for Dungavel is typical of this problem, "We were told that no appropriate training had been identified and that Primicare was considering creating its own training material. This was not available to staff at the time of the inspection." (Dungavel 21 – 25 June 2010) It is also of concern that training materials would be generated in-house by a contractor that has consistently failed to implement the rule.

## 2. The procedure to identify victims of torture

### a. UKBA detention of torture victims

Raised at the House of Lords on October 11 2007, amendment 13 was put forward, which proposed that asylum seekers who claim to be victims of torture should not be detained. The amendment was rejected, with the response that claims of torture need to be proven and therefore only evidence of torture will precipitate release from detention. This is precisely why Rule 35 is of vital importance because it should enable the identification of torture victims, but this safeguard is ineffectual with victims of torture not being released from detention. The response of Lord Bassam details some of the "exceptional circumstances" that may override release through the Rule 35 mechanism:

*"Detention may be appropriate for reasons of public protection in the case of convicted criminals. The person concerned might be a persistent absconder. Detention might be appropriate in the case of a person who is to be returned to a third country for consideration of their asylum claim. Most commonly, it is likely to be appropriate in the case of persons who have no lawful basis to remain in the United Kingdom and whose removal is to be enforced."* (HOL, 11 October 2007, Lord Bassam)

The response of Lord Sheikh, November 11 2009 to Lord Hylton's identification of the failure of UKBA to protect victims of torture has been unheeded, "More stringent checks should be carried out by immigration officers prior to making a decision to place a person in detention. Greater transparency in the process is a priority, especially as there is no maximum period of detention. This situation does not sit well with many asylum applicants and could be perceived as breaching Article 8.2 of the European Convention on Human Rights."

### b. Rule 34 and the healthcare screening process

Mechanisms in place to identify and safeguard victims of torture held in IRCs are insufficient for the task. It has been found that the procedure is not effective at identifying

whether asylum seekers have been victims of torture. Independent evidence provided by Dr Charmian Goldwyn at the House of Lords in October 2008 detailed the failings in identifying victims of rape, "Those asylum seekers who are detained pending removal are interviewed within two hours of their arrival at an IRC. The nurses I met who mainly do this task confided that it is extremely difficult to assess someone in the short time they have. There is pressure of numbers and frequently language problems. Many asylum seekers prefer not to talk about being tortured, and the women hardly ever talk about their rape." (October 2008 Border, citizenship and Immigration Bill, HAC, supplementary memo).

Torture survivors slip through the net completely often due to inconsistent screening processes, they are not identified by the initial screening process nor are they 'spotted' by a doctor. This is related to the health staff knowing about and being trained in Rule 35(3), as identified in the 2010 ruling for R (E) v SSHD Home Office Claim No: 9CL01651:

*"It is clear from those records that the doctor was concerned, and rightly concerned, that the Claimant might have been tortured and there is no explanation as to why he did not make a Rule 35 report. Accordingly, it was potentially a serious dereliction of duty by the doctor although I suspect the doctor may not have been personally responsible. The failure appears to be a systemic one at Yarl's Wood in understanding what Rule 35 required and ensuring that it was complied with. Insofar as it is said to be a physical and mental examination, it was fairly superficial in any event."*

There is little consistency across detention centres in identifying victims of torture during the initial screening. Many IRCs leave it to the discretion of health workers, but without appropriate training there was no way for them to identify possible victims of torture. "Detainees were asked at reception if they had been subject to torture. However, health care staff had not been trained in its recognition or treatment." (Dungavel 2-5 August 2010).

Some IRCs left the question out altogether, which is of grave concern. "The reception screening pro-forma in use did not include a question about detainees' experiences of torture or trauma. We were told that this question had been omitted during a recent amendment to the screening tool. The tool was amended to include this question as soon as the problem was brought to the attention of health services staff." (Colnbrook 17-21 November 2008).

There have been improvements made to the procedures of several detention centres but a consistent screening process across IRCs is still not in place. Of the most recent HMIP reports, it was found that a question to identify survivors of torture was posed during the initial health screening at eight of the 11 detention centres.

### **Problems with identifying and documenting evidence of torture as noted across the HMIP reports are as follows:**

- There is not enough time to ask the question/collect information
- It is difficult to gather such sensitive information (arrival, little time, language)
- Right people not in the right place (asylum seekers do not get to see the doctor)
- Inconsistencies in how detention centres handle data collection. (Some do it well, some do it badly)
- Interpreters: most asylum speakers are not native English speakers and are not provided the facility to understand what is being asked of them

### **3. Unqualified person filled in Report 35**

This problem relates to organizational design, specifically having well-understood roles and responsibilities. As identified earlier under the issue of competency of staff, roles and responsibilities are not always clearly defined; healthcare staff do not always know what they should be doing to implement Rule 35(3) and therefore there are many documented instances of the wrong staff member filling in the Report for Rule 35.

As this is one of the few points at which information is collected, this gives an indication of the extent to which UKBA staff and healthcare staff do not know how, or are unable, to implement this rule, failing to safeguard victims of torture. Unfortunately this issue is not consistently reported on across all HMIP reports, and so there are only a couple of comments made, indicating this problem. For example, in the Tinsley House 2011 HMIP report, it was noted that Rule 35 reports were not always written by a doctor, and 'Rule 35 reports, issued by health services staff if there was evidence that a detainee had been tortured or was physically or mentally unfit to be detained, were often written by a nurse rather than a GP as required.' (Tinsley House, 7-11 February 2011)

### **4. Report completed inadequately**

Linked to the problem of the wrong person filling in the Rule 35 report, is the problem of filling in the report incorrectly. This requires the doctor at the IRC to provide clinical information relevant to the allegation of torture. Out of 11 HMIP reports, four commented on the poor quality of Rule 35 reports. Out of the four comments, all IRCs were found to have provided incomplete Rule 35 reports. For example, "We saw several Rule 35 assessments by GPs... entries were usually descriptive and inconclusive." (Harmondsworth, 2-5 August 2010). The knock-on effect of this means that a review will not be based on adequate evidence, and it is highly likely that the victim of torture will remain in detention.

Out of the most recent HMIP detention centre reports, the recommendations talk to this failing requesting that health care staff document evidence of torture; the fact that these



recommendations are being made highlights the reality that it is not being done. For example, "If an allegation of torture is made, healthcare staff should document and describe any scarring." (Brooke House 15 - 19 Mar 2010).

## II. Handling and Responding to Rule 35 Reports

The following three failings relate to failure of UKBA caseowners to respond appropriately to Rule 35 reports once they have been created and submitted. Failings have been grouped into the failure to respond, insubstantial responses and decision-making problems. The failure to respond covers the physical response of the caseowner, grouped into late responses and no responses. Insubstantial replies are about the inadequate provision of information in the response to the detention centre and asylum seeker on the decision-making of the caseowner. Decision-making problems are about the decision of a caseowner being ill-considered when reviewing the continued detention of a detainee. The three groupings have been made for the purposes of reviewing the evidence, however there is cross-over between the areas.

### 5. Failure to respond

The issue of the failure of caseowners to respond to Rule 35 (3) reports has been raised repeatedly in the House of Lords without adequate response. First raised in September 2006, evidence from the JCHR inquiry highlighted that Rule 35 reports had not got any responses from UKBA. The result of the Yarl's Wood Inquiry in 2006 also found the Home Office failing to respond or to act at all when told that a detainee had a history of torture.

Two amendments to the UK Borders Bill were proposed in October 2007: Amendment 13, automatic exemption of torture victims from detention and Amendment 26, the requirement to detail specific action taken for each Report 35.<sup>105</sup> Both amendments were rejected and the response was instead to review operational guidance, despite Lord Avebury strongly advising against such a move in light of persistent, systematic failure, "I expect that the Minister will say in reply to my amendment that this matter belongs in the Operational Enforcement Manual rather than on the statute book, but is that a real answer when the chief inspector's recommendations have been so persistently ignored? As your Lordships are aware, the chief inspector has drawn attention to the failure in all immigration and removal centres to respond radically to the Rule 35 letters."<sup>106</sup>

Instead Lord Bassam relegated it to operational review, "The agency will look at the current guidance to see what more could be said, subject to any issue of confidentiality. For example, the response could indicate to the doctor whether the information about the claim of torture is already known to the BIA [UKBA] and has been considered or whether it is being considered as part of the individual's asylum application. The guidance should also make clear

the need for a prompt response to the doctor's report. ... I hope that the commitment to review the relevant guidance to staff will meet, at least in part, the concerns that lie behind Amendment No. 26." (HoL 11 October 2007 Lord Bassam).

However, Lord Bassam failed to make it explicit that Rule 35 serves as a release mechanism, safeguarding individuals whose health may be injuriously affected by detention rather than something that assists part of the substantive asylum claim.

### Late or No Responses to Rule 35 Reports

Failure to meet the requirement for caseowners to reply within 48 hours has been found to be a consistent and systematic failure.<sup>107</sup> All HMIP reports repeatedly note either the lack of responses or late responses. Over half of the IRCs (seven) are noted for receiving responses late and an equal number are noted for not getting responses. There is some overlap where Haslar, Dover and Dungavel are noted for having both failures.<sup>108</sup>

Inspections by HMIP in 2010 and 2011 often found late responses from the caseowners, Brook House receiving a particularly bad report in 2010, 'Few applications were responded to within the required two days. In one case, the reply took two weeks.' The most recent investigation on Yarl's Wood in July 2011 found that the contact management team who track the progress of replies to Rule 35 reports had to chase outstanding replies on two cases on five occasions.

This failing indicates the fact that caseowners are unwilling or unable to comply with simple directives. This points to the pervasive failure of UKBA caseowners to take Rule 35(3) seriously. However, focusing on late responses is to distract from much more critical failings. The failure to respond within the required 48 hours is probably the least critical failings of caseowners with regards to Rule 35(3).

The failure to respond at all to a Rule 35 report is a critical failing and points to the lack of accountability of caseowners. Seven out of eleven detention centre reports noted no response from case owners and only one report noted improvement. This not only demonstrates failure to act on the part of UKBA caseowners, but also the failure to follow-up on and enforce the implementation of Rule 35 by both UKBA and IRC healthcare teams. This is a serious dereliction of duty.

Most recently, four out of five 2010 detention centre reports found a considerable number of no responses. Dungavel had a relatively good track record where 'only three-quarters had received responses.' With Harmondsworth, 'Caseworkers [caseowners] often failed to respond to Detention Centre Rule 35 letters concerning potential torture and fitness to detain.' Despite the issue of the failure to respond to and act on Rule 35 reports being raised repetitively, caseowners do not seem to be brought to account.

## 6. In-substantive replies

This failure is about the ability of the UKBA casowner to adequately convey the reasoning behind the responses to Rule 35 reports. Ten out of eleven HMIP reports noted in-substantive replies.

Examples include:

- ▶ *"Rule 35 letters elicited little useful response. Recent Rule 35 letters examined showed no substantive responses from caseworkers." (Lindholme 16-21 February 2009)*
- ▶ *"UKBA replies were often cursory, sometimes consisting of a single sentence." (Brook House 15-19 March 2010)*
- ▶ *"Responses were often brief and ill considered." (Dover 24-28 May 2010)*

These quotes are chronological and there seems to be little improvement in getting more substantial replies from caseowners. HMIP recommendations have not been successful in dealing with this failure.

This failing is a matter of quality control, whereby monitoring and following-up poor responses by detention centre staff could lead to improvements, (assuming that UKBA caseowners will respond to this). However it is found that very few detention centres showed any signs of following up on insubstantial responses, the exception being Campsfield House where it was noted, 'with two other cases, the UKBA team had followed up what they had identified as inadequate responses by asking for more details.'

## 7. Decision-making problems

This failing cuts to the heart of the failure to implement Rule 35(3). If UKBA caseowners are unable to produce a considered response to concerns of torture, it does not matter how much you improve the administrative side of the process, release will not be facilitated. Eight out of 11 HMIP reports note ill considered decisions/replies by UKBA case owners and three reports do not comment.

On November 12 2008, an independent doctor provided evidence to the House of Lords; Dr Charmian Goldwyn found that Rule 35 reports were not being undertaken properly in the 46 cases that she had seen in detention.<sup>109</sup> This is a damning finding.

There seems to be a pre-disposition towards declining release from detention on the basis of Rule 35. One HMIP report for example noted, "None reported temporary release as an alternative to detention" (Colnbrook 17-21 November 2008). Medical evidence is simply disregarded; this has been noted in several recent detention centre reports.

*"Even in detailed responses, the caseworker often relied solely on the fact that the torture claim had been considered in the asylum appeal without an evaluation of the fitness to detain in light of present clinical evidence... There were also examples of women reporting a claim of*

*torture, but not wishing to disclose further details. These matters, together with the lack of statistical or research evidence on the impact of rule 35 procedures, highlighted the need for a comprehensive audit of the workings of the provision to ensure that it was achieving its intended purpose." (Yarl's Wood 9-13 November 2009)*

*"Although a centre doctor had stated in one case that the detainee had scabs on his back that 'looked like stubbed-out cigarettes', the caseworker had considered there was 'no diagnostic finding' about the injuries and that the case remained suitable for the DFT process." (Harmondsworth 2-5 Aug 2010)*

HMIP review recommendations repeatedly call for responses to Rule 35 reports to be on time and in detail. For example, *"UKBA should urgently improve... and the response to rule 35 letters. Rule 35 applications should be responded to on time and in detail."* (Dover, 24 – 28 May 2010)

## III. Record Keeping and Monitoring

The problem of recording, disseminating and acting on information on the implementation of Rule 35(3) was one of the first issues raised on the subject of Rule 35 in the House of Lords on March 21 2006. The problem of the opaque process was not originally responded to with any counter measures. In response to the question of what the numbers are and the time taken to make decisions on their case, Mr McNulty declared, "Records of the number of cases referred under Rule 35(3) and details of what happened in those cases is not held centrally and could only be obtained through examination of individual files at disproportionate cost."<sup>110</sup>

## 8. Incomplete logs/records of Rule 35

Incomplete and non-existent logs have always been a problem with regards to implementing Rule 35 reports and HMIP have made repeated recommendations based on their findings, including to keep a central log of Rule 35 reports. Some IRCs have responded by improving their record keeping systems.<sup>111</sup> However it is found on follow-up visits that many centres have not acted on these recommendations and the same problems have been found to be outstanding in five of the eleven detention centres.<sup>112</sup>

There are many examples recorded by the HMIP inspection team, which shows the haphazard way in which IRCs are recording and monitoring Rule 35 reports. For example, "Records were poorly collated and managed and there was no tracking system. We were unable to locate several sets of records." (HMIP Harmondsworth, 2-5 August 2010)

Discrepancies between IRC logs and UKBA logs continue to highlight the inconsistent record keeping, "The health care log recorded fewer responses than the UKBA log." (HMIP Dungavel, 21 – 25 June 2010). This also points to a failure in disseminating Rule 35 reports and a breakdown

in information getting to the necessary people for review. In turn, Rule 35 reports and responses are poorly monitored.

The findings relating to lack of information have also been laid to bear in Parliament. On 28 June 2011, Julian Huppert MP's question asked how many people in immigration detention (a) have been diagnosed with serious mental health conditions, (b) are torture survivors, (c) are pregnant, (d) are children and (e) are elderly [61442]. Damian Green, the Minister of Immigration stated in response: 'The UK Border Agency does not hold information centrally about those who have a serious mental health condition or who are torture survivors.' He concluded, 'Where the UK Border Agency accepts that a person's health is likely to be injuriously affected by continued detention, they are normally released.'<sup>113</sup> However, as the results will demonstrate and UKBA's own audit has shown, individuals are not "normally" released at all.

## 9. UKBA performance in monitoring Rule 35

Importantly, quality control for implementing Rule 35(3) has been identified as lacking in most IRCs. "The central log of Rule 35 (potential torture of detainees) forms held in the on-site immigration office recorded that 12 forms had been received since November 2009 but only three had been responded to by the UKBA caseowner at the time of the inspection. There had been no follow-up by immigration staff until the first day of the inspection. There were no systems for monitoring receipt of monthly detention review letters or bail summaries." (HMIP Harmondsworth 2 - 5 Aug 2010)

Without quality control there is no mechanism to flag up where UKBA are failing detainees in their duties to produce Rule 35 responses. Furthermore, it has been found that healthcare services are failing to undertake this too. However, UKBA is responsible for monitoring subcontracted health services; it is their responsibility to identify where Rule 35 is not being implemented and to correct it. Monitoring has been found to be not in place and there is a failure to follow-up indicating a lack of accountability.

Examples of HMIP review recommendations on this topic include:

- ▷ *"UKBA and health care records of Rule 35 applications should be investigated and the findings acted on."* (Dover 24 - 28 May 2010)
- ▷ *"Accurate and complete Rule 35 report logs should be kept by the UKBA contact management and health care staff."* (Dungavel 21-25 June 2010)
- ▷ *"Further recommendation: The central log of rule 35 notifications and caseworker responses should include a copy of the notifications and responses."* Tinsley House 13-15 July 2009, later followed up by, *"Rule 35 procedures were not carried out effectively."* (Tinsley House 7-11 February 2011)

## 10. Lack of independent oversight

In light of evidence showing that UKBA has consistently failed to implement Rule 35 in acting on concerns of torture, there have been repeated requests made in the House of Lords and in HMIP IRC reports for UKBA to review the way in which Rule 35(3) is implemented.

This has led to the request for independent oversight by the Chief Inspector of HMIP and in the House of Lords. "...It is with that in mind that I asked the BIA [UKBA] to go further than a simple acknowledgement. Perhaps the solution would be to invite an independent person such as Stephen Shaw to carry out a quick audit of the procedures, to see whether the review mentioned by the Minister had adequately addressed the criticism made by the chief inspector, who gets to examine particular IRCs only every few years... The inquiry into procedures at Yarl's Wood highlighted the IND's failure to act when told of allegations of torture, a criticism that the Medical Foundation had been levelling at the Home Office for many months. The last report by the chief inspector, who had been the first to draw attention to the problem, related to February 2006." (HoL 23 November 2007 Lord Avebury.)

The response of Lord Bassam was that this was unnecessary due to HMIP inspections, "HMIP regularly inspects all removal centres and short-term holding facilities and therefore has ample opportunity to look at issues such as Rule 35 letters—and it does so often." (HoL 23 November 2007 Lord Bassam.)

It had to take the chief inspector of HMIP and repeated calls by Medical Justice and other NGOs to call for an independent audit before it would be considered. On 21 July 2008 HMIP confirmed that they were unable to provide a full in-depth audit when giving evidence to the JCHR: 'I am not really in a position to help you much on that, I am afraid, because we do not inspect the service, we inspect simply the centres. We are looking at what is happening on the ground. I think that is something you may need to raise with other witnesses.' (JCHR mins of evidence, Examination of witnesses.) Instead, HMIP recommended that UKBA undertake an audit; 'UKBA should undertake a comprehensive research audit of the workings of rule 35 with particular attention to whether it is providing the intended important safeguard.' (13/11/09 Yarl's Wood HMIP Detention Centre Report)

## First UKBA audit

Following the judgment of D and K, R (on the application of) v SSHD in 2006,<sup>114</sup> the then Head of Detention Services, Brian Pollett promised representatives of Medical Justice, to conduct an audit of Rule 35 operations. On 24 October 2006, Baroness Scotland stated in the House of Lords, 'The examination of processes for handling torture reports from centre doctors is under way.'<sup>115</sup>

An examination of the Detention User Group (DUG) Medical Subgroup (MSG) minutes serves to show the continued efforts by NGOs to raise their concerns about Rule 35. DUG is a forum for NGOs and UKBA Detention Services to discuss detention operational policy and practice. The sub group meets every quarter to discuss medical issues in detention and is chaired by a senior UKBA official. During these meetings, Medical Justice and other NGOs have consistently raised the problems associated with the Rule 35 process and the need for an audit.

In 2007, the audit was conducted by UKBA on 21 Rule 35 reports. The results were never published despite NGO efforts to see the data.

On 25/6/09, an action that arose from a DUG MSG meeting was noted as: "details of UKBA's audit of Rule 35 reports to be sent to Juliet Cohen (Freedom from Torture)". However, details were not sent and in the following meeting on 12/10/09, the following point was made: '1.3 ... there is no formal document – a sample of 21 cases were looked at to see what happened and what the character of the cases were.'

After further promises to release the data, Simon Barrett (the chair of DUG MSG) stated at a DUG meeting on 12/1/10 that the audit data had been lost: '1.1 ... The audit of the Rule 35 process had been commissioned in 2007 by Stuart Hyde, then Senior Director for the Enforcement and Compliance Directorate. Simon Barrett confirmed that efforts to locate details of the audit had proved fruitless.' Thus, since Brian Pollett's initial promise in July 2006 and Baroness Scotland's assertion that examination was underway in October 2006, it was only in January 2010 that UKBA representatives claimed it was lost.

## Second UKBA audit

At a similar time, UKBA was also promising to conduct a second audit. On 26/10/09, Phil Schoenenberger of Detention Services UKBA, was confirmed to be overseeing an audit of Rule 35. The audit would be based on an analysis of the responses over a period of two months from 1 November 2009.

On 21/9/10, following significant delay, Freedom from Torture (FTT) made an FOI request for the information but it was denied on the basis that the information would be published by the end of 2010. This never came and on 4/1/11, a further FOI was submitted by FTT and again rejected. On 4 February 2011, over 15 months later, the report was finally published. This is despite the fact that the report contained no substantive analysis and is 13 pages long.

## Second Audit Results<sup>116</sup>

216 Rule 35 reports were reviewed for the 2009 audit on Rule 35. Key findings and our conclusions are listed below.

- ▶ 65% of cases failed to receive a response within the 48 hour time limit, with:
- ▶ One third of the cases got no response at all.
- ▶ One third of the cases got a late response.

**Conclusion:** case owners fail in their requirements to respond to Rule 35 reports 65% of the time.

- ▶ 9% of the cases resulted in release. However, in these cases, the reason for release was not detailed.
- ▶ 91% of Rule 35 reports failed to secure release.

**Conclusion:** Most Rule 35 reports are rejected. Rule 35 reports do NOT provide a safeguard to torture survivors. Of the 9%, the fact that a person was released does not indicate that the person was accepted to have been a victim of torture. The exact reasons for release were not examined. It is therefore possible that none of the individuals were released through the Rule 35 process.

- ▶ Stage of case: 47% of the cases were refused and removed.
- ▶ 39% of the cases were refused and ongoing.

**Conclusion:** No substantive analysis was contained in the audit so UKBA were not able to demonstrate the quality of their responses or decisions.

The results of the audit are extremely disappointing. Very little analysis was conducted and where data was presented on release, no reasons were given: thus the 9% release figure was supplemented by the statement that release may not have been on the basis of torture. There was no analysis of the content of the reports or the quality of the detention review or the assessment of medical evidence. Without this information, the audit is essentially redundant.

The audit report demonstrates how little UKBA understand about the extent to which its systems are failing. For some time, Medical Justice has been demanding the raw data of this audit in order to see where and how the process fails. On 1 March 2011, Nicola Blackwood MP stated: 'To ask the Secretary of State for the Home Department whether the UK Border Agency plans to publish in full an unedited audit of forms completed in accordance with Rule 35 of the Detention Centre Rules on victims of torture and others with special illnesses and conditions'. Damian Green responded: 'The UK Border Agency audit report in relation to Detention Centre Rule 35 will be published in a full and unedited format in the near future.'<sup>117</sup> However, we are yet to see this and Simon Barrett, UKBA Chair of DUG MSG, maintained in the DUG MSG meeting on 16/1/12 that the published report is the "unedited" audit.

The audit was a very specific exercise that focused on reviewing response figures and timeframes for execution. However, as noted over the years of criticism, the problems of Rule 35 are not solely administrative. In order to

complete what the Chief inspector of HMIP requested, the audit should have taken into account the full process with far more detail in both quantitative and qualitative terms. Members of the DUG MSG also had demanded at the outset repeatedly that an analysis of substantive decision-making in the sample cases was needed. However, this was overlooked and UKBA did not consider this at all. This was criticised in the Home Affairs Committee on 5 April 2011 during an Examination of Witnesses as part of the report on *The Work of the UK Border Agency*.

**Q12 Dr Huppert:** Following on from Bridget Phillipson's question, earlier this year, in response to pressure from this Committee, you published the audit of Rule 35, about torture allegations, based on evidence that you collected in November and December 2009, so it was very late. It showed that there were a number of cases where Rule 35, about how to deal with people alleging torture, wasn't complied with—a significant proportion. It was also very thin, in that it didn't talk about the people where it was complied with, whether actually the decision was made correctly. It noted simply that the rules were there and things proceeded. Will you be doing some further work on this and what should we read into the fact that it took, I think, 14 months for the report to be released?

**Chair:** A brief answer.

**Jonathan Sedgwick:** A brief answer. We were also disappointed with the findings of that sample, and we are going to run it again. We don't believe that any asylum seeker who had been a victim of torture was removed from this country without having that claim properly considered, but we don't think our response was fast enough and we don't think our processes worked well enough. To your point, we don't think that the quality evaluation of our decision making was properly explored in the sample. So both of those things we will be setting right in the new sample that we will doing later on this year.

**Dr Huppert:** Which you will send to us soon, I hope.

**Jonathan Sedgwick:** Yes.<sup>118</sup>

This (third) promised audit has still not yet been conducted one year on. Actions and recommendations emerged from the second audit. At the time of this publication, little progress has been made. Below is a summary of some of the key tangible and measurable promises made and details whether they have been kept.

Commitment made	Achieved?
Development of training	No
Revised DSO	No
A further audit after 6 months.	No

As stated earlier, the dates of delivery for these documents have been pushed back on several occasions. The latest deadline for delivery, as promised on 16 January 2012, was meant to be March 31 2012. However, as stated earlier,

when this report went to print on 11 May 2012, none of these documents had yet been published.

Many of the recommendations made in the second audit centred around the creation of robust systems and clearer channels of communication as well as measures to improve accountability, such as improved recording and monitoring systems. However, a recent FOI highlights that these systems are also failing as information was not able to be provided, indicating an ongoing failure to hold and manage a central data system.

On 8/12/11, Medical Justice requested a breakdown of the numbers of Rule 35 reports submitted to UKBA as well as the numbers released across two time periods: 01/05/09-30/4/10 and 01/05/10 to present. However, the FOI was denied. The response dated 6/1/12 stated:

'I can confirm that we hold some of the information you have requested but have estimated that the cost of answering your request would exceed the £600 limit and we are therefore unable to comply with it. This is because for the period stated, the information requested was not held centrally and could only be obtained by examining individual records at disproportionate costs.'

On 9/1/12, two further FOIs<sup>119</sup> were submitted requesting the number of Rule 35 reports submitted.

The first asked:

1. For the period May 1 2010 until May 1 2011, how many rule 35 reports were sent by immigration removal centre healthcare staff to the UK Border Agency?
2. In how many of these cases, was release recommended as a result of the Rule 35 report?

The second asked:

1. For the period May 1 2011 until December 31 2011, how many rule 35 reports were sent by immigration removal centre healthcare staff to the UK Border Agency. If known, please provide the total amount as well as a breakdown of the numbers of Rule 35 (1), (2) and (3) reports.
2. In how many of these cases, was release recommended as a result of the Rule 35 report? If known, how many of those released were as a result of a Rule 35 (1); (2); or (3) reports?

However, these were also both denied on 31/1/12 for the same reason of cost. A follow-up email sent from the Enforcement and Crime Group of UKBA on 20/2/12 added further explanation as to why this information is unavailable: 'Since October 2011 centres were asked to provide weekly spreadsheets so that a central record could be kept. .... The spreadsheet does not record what part of Rule 35 the report refers to and whether release was recommended. To answer these questions we would again have to go back to each centre so that manual records could be checked.'

It is thus of great concern that UKBA still do not have central records of the numbers released through the Rule 35 process. Over 10 years since the inception of the Detention Centre Rules and despite much pressure from NGOs, independent inspectorates and official bodies, the UKBA still fails on even the most basic aspects of record keeping.

## Summary of findings – outstanding problems in implementing Rule 35

Despite years of criticism and damning findings, there has been a failure to follow up and rectify poor implementation. UKBA is responsible for this as the duty for the overall implementation of Rule 35(3) rests with them.<sup>120</sup>

The key issues plaguing the implementation of Rule 35 (3) include procedures that are not fit for purpose, poor record keeping, inadequate training, few responses with little or no explanation, ill-considered responses and no visible accountability. Looking at this as a process, all parts of it are flawed, from design, to implementation, to quality control, quality assurance, all the way to governance and accountability.

Furthermore, the final issue speaks to UKBA's failure to respond to criticism. As this review has shown, HMIP have repeated similar criticisms year on year and the associated UKBA Service Improvement Plans that details comments and actions emerging from the HMIP recommendations, remain superficial and/or unheeded.

In September 2011, HMIP published its most recent report on Yarl's Wood IRC. It found that staff still 'appeared to have little understanding of the purpose of this Rule 35'. 'Many Rule 35 reports (relating to fitness to detain and experience of torture) did not include sufficient information and many UKBA replies were poor. The process was not providing the intended safeguards for vulnerable detainees.' It was thereon recommended that

'Rule 35 reports should provide objective professional assessments – for example, commenting on the consistency between injuries and alleged methods of torture.' They noted that there was no centralised log to monitor monthly reviews and concluded: 'The Rule 35 process was not sufficiently robust.' The 2012 Harmondsworth report also contained further criticisms with reports described as "poor quality".

## Conclusion

Rule 35(3) is not and has not been implemented correctly since it first came into force. Failure is ensured, as information collection around implementation is historically and systematically poor; there is a black hole around the implementation of this process, especially around reporting and monitoring on the decisions made by UKBA caseowners. This leads to repeated requests for independent oversight. There is also a big issue around accountability of healthcare providers - UKBA is officially responsible so where healthcare fails there are few mechanisms in place to feedback/correct this.

Why are the problems ongoing and what are the obstacles to improving the process?

- ▶ Transparency and the availability of information
- ▶ Poor communication between IRC healthcare and UKBA
- ▶ Identifying who is accountable – UKBA case owners do not appear to be accountable and there seem to be no consequences to providing no/late responses
- ▶ Lack of oversight/independent audit
- ▶ Rule 35 exceptions – unclear policy
- ▶ Ongoing failure to learn lessons and follow up on recommendations

This box summary helps to explain the continuous and systematic failures. The beginning and the end of the process are both particularly problematic.

Activity	Problem	Recording procedure	Monitoring / Oversight	Who is responsible
Procedure: Identify victims of torture	Procedure does not ID victims of torture	Incomplete documents		UKBA caseowners and policymakers
	Staff unable to ID/support victims of torture	Not in place		Healthcare
Procedure: Produce a rule 35 Report	Wrong person fills out Rule 35 Report	Incomplete	Failure to pick-up/feedback on incomplete Rule 35 reports	Healthcare
	Form not sufficient to record information			UKBA policymakers
	Form not correctly/adequately filled-in			Healthcare
Procedure: Review rule 35 Report re: detention	No response	Incomplete	Failure to pick-up/feedback on failure to/late/incomplete responses	UKBA caseowner
	Late response			UKBA case owner
	Incomplete response			UKBA caseowner
	Ill-considered Response			UKBA caseowner

# Chapter 5 – Case Law

There are numerous reported cases where the courts have had cause to consider the legality of the detention of vulnerable individuals and victims of torture. Below are some of the most significant cases with a summary of their key findings of relevance to Rule 35.

## **R (on the application of D and K) v Secretary of State for the Home Department & Ors [2006] EWHC 980 (Admin) (22 May 2006)**

<http://www.bailii.org/ew/cases/EWHC/Admin/2006/980.html>

The leading case on the detention of victims of torture is R (on the application of D and K) v Secretary of State for the Home Department & Ors [2006], herein referred to as D and K.<sup>121</sup> This case concerned claims for damages for unlawful detention brought by two asylum seekers against the SSHD and private contractors due to their failure to abide by published policy and the terms of the Detention Centre Rules.

The Judge held that a failure to carry out medical examinations on detainees within 24 hours of their arrival at an IRC was in breach of Rule 34 of the Detention Centre Rules 2001 and therefore unlawful. Moreover a medical practitioner compiling a report for the purposes of the Detention Centre Rules should not be precluded from expressing a view that injuries on a detainee's body were consistent with allegations of torture made by that detainee. Thus, any such concerns as to torture as may be identified by the medical practitioner would at least be capable of constituting "independent evidence" of torture for the purposes of (what is now) chapter 55.10 of the EIG, meaning that there would need to be "very exceptional circumstances" for detention to be justified.

The judgment was highly critical of the prolonged failure of the Home Office and its private contractors to comply with the Detention Centre Rules and Operating Standards, which require that all detainees have a medical assessment by a General Practitioner within 24 hours of their arrival in detention. After noting these failures, the Judge found that had the system operated as it should, with D and K receiving medical examinations within 24 hours of their detention, Rule 35 reports would have been compiled which would in turn have constituted independent evidence of torture. Had such reports been made, Home Office policy prohibiting the detention of those with evidence of torture would then have required their release from detention.

The key findings were as follows:

35. *It thus is clear from all this that the making of a claim of torture does not of itself mean that the applicant*

*will not be detained. Independent evidence ordinarily is called for. Conversely, if there is sufficient independent evidence then ordinarily, and absent exceptional circumstances, an applicant will not be detained (...)*

50. *... any such concerns as to torture as may be identified by the medical practitioner would at least be capable of constituting "independent evidence" for the purposes of the Government's announced policy. Indeed if that were not so, it is difficult to see why so much emphasis has consistently been placed on the availability of – indeed, requirement for – such physical and mental examination....*
52. *... A concern as noted on an AOT form by, for instance, a relatively inexperienced nurse after an initial screening may be regarded as very different from a concern noted by an experienced doctor contained in a Rule 35(3) report in deciding whether to continue to detain. ...*
53. *... I consider that the existence of Rules 34 and 35 and the statement of Lord Filkin operate to displace any notion that in some way there is, as it were, an overriding burden on the detainee always himself to come up with the relevant "independent evidence". There may well be cases where an individual detainee can and should do that. But in other cases (whether for reasons of confusion, ignorance, language, lack of resources or otherwise) a detainee may be in no position to do so: at all events in the form of medical evidence. This in fact, as I see it, is precisely one of the reasons why Rules 34 and Rule 35 are framed as they are – the obligation being on the detaining authorities in this regard to provide the medical attendance which may in turn, in some cases, lead to a report capable of being independent evidence of torture.*
90. *(...) The Detention Centre Rules make no specific requirement of a two hour medical screening. That requirement derives not from legislation but (solely) from the Operating Standards. There is no definition in those Standards of the phrase "medical screening": nor do the Standards require that such "medical screening" be a physical examination undertaken by a doctor. But plainly it is at the least for the purpose of assessing whether the detainee has medical or psychological problems requiring immediate attention and also (and as made express) to assess the risk of self-harm and suicide. (...) Indeed, if Rule 34 is – as it should be – being properly applied in a detention centre, the initial two hour medical screening can properly be conducted on the understanding that there should in any event be an examination by a doctor within 24 hours: and it is to be taken that the Standards will have been drafted with this in mind. ...*

113. *That the AOT form in fact supplied in the case of K might not suffice to secure his release may have been a tenable viewpoint in circumstances where the AOT form contained no opinion or expression of concern that there may have been torture. (...) But it remains the case that the Oakington practice with regard to AOT forms did not operate to meet the rationale of Rules 34 and 35. Rule 35 (3), in particular, requires a report where the medical practitioner is "concerned" that there may have been torture. That language connotes a viewpoint – albeit of course one founded on medical examination – on the part of the medical practitioner. Since such a concern, if held, would at least be capable of constituting independent evidence of the claim, it should not, in my judgment, positively be prevented from being drawn to the attention of the Home Office.*

127. *(...) this case has served publicly to highlight a persistent and sustained failure to give effect to important aspects of the Detention Centre Rules and publicly to highlight a departure from published policy.* (...)

Thus, *D* and *K* highlighted the persistent and sustained failure of the SSHD and its private contractors to abide by published policy and implement Rules 34 and 35. The Judge stated that the obligation lay with the detaining authorities to provide the medical examination, which could thereon lead to a report capable of constituting independent evidence of torture. The failure to implement Rules 34 and 35 led to the SSHD having to pay damages for unlawful detention to the claimants in this and similar cases

Since 2006, there have been a number of other reported cases that have drawn attention to the prolonged failure of the SSHD and their contractors to comply with the requirements of the Detention Centre Rules 34 and 35. The key cases are presented thematically.

### ► **Unlawful detention on the basis of a failure to follow Rule 34/35 procedures (whereby a nurse rather than a doctor conducted the examinations)**

#### **PB [2008] EWHC 364 (Admin):**

<http://www.bailii.org/ew/cases/EWHC/Admin/2008/364.html>

The Judge held that the detention of PB was unlawful because in failing to ensure PB received proper medical examination, which could and should have revealed evidence of torture, Rules 34 and 34 had been breached. He found that had a proper medical examination taken place, a doctor would have identified that PB was a victim of torture and the Rule 35 report would have led to her release.

PB was a Cameroonian national who arrived in the UK on 4 December 2006 and claimed asylum on the same day. PB was initially refused asylum and the refusal paid no consideration of medical records that recorded the claimant's allegation of torture. UKBA also failed to consider referring PB to the Medical Foundation for the Care of Victims of Torture (now called Freedom from Torture) following the torture allegation.

There were admitted breaches of Rule 34 and 35, whereby a nurse rather than a doctor carried out the full medical examination and completed the Rule 35 AOT form. This failure was found to be unlawful.

24. *(...) Although Dr Cohen has substantial experience and expertise in the relevant skill of assessing attribution, I see no obvious reason why a competent GP, giving the claimant a thorough physical examination against the background of allegations of torture, would not have seen the scars and would not have reached the same, or a very similar, conclusion to that reached by Dr Cohen.*

25. *It seems to me also, having regard to the nature of the scars and the serious mistreatment to which they may well have related, that it was more probable than not that a report would have been made under rule 35(3). Given that any such report would have been capable of constituting independent evidence of torture, I believe also that having regard to the nature of the scars and the gravity of the mistreatment to which they may well have related, the putative rule 34 examination and rule 35 report would, on a balance of probabilities, have brought about the claimant's release from detention in the absence of any exceptional circumstances justifying such detention. No such circumstances are relied on by the defendant and I accordingly hold the detention, after a short period sufficient to have allowed a proper procedure to be followed, to be unlawful.*

The Judge went on to state that the Home Office failed to also follow its own policy with regard to referring identified victims of torture to the Medical Foundation for Victims of Torture.

#### **PB, R (on the application of) v Secretary of State for the Home Department [2008] EWHC 3189 (Admin)**

<http://www.bailii.org/ew/cases/EWHC/Admin/2008/3189.html>

At this second hearing the Judge was required to determine how much compensation should be awarded to PB for the six month period of unlawful detention he had found at the previous hearing. The claimant was awarded £32,000 basic damages for loss of liberty and a further £6,000 in aggravated damages.



## ► Failure to conduct medical examination within 24 hours; failure to respond to a Rule 35 report; failure to consider independent reports of torture and mental illness in detention reviews

### T, R (on the application of) v Secretary of State for the Home Department [2010] EWHC 668 (Admin) (03 February 2010)

<http://www.bailii.org/ew/cases/EWHC/Admin/2010/668.html>

In this case, the claimant challenged the legality of his detention on the basis that it was contrary to the Detention Centre Rules 2001 and Chapter 55.10 of the EIG, under which persons who are mentally ill and persons where there is independent evidence that they have been tortured should normally only be detained in very exceptional circumstances. The claimant was a Zimbabwean national who was arrested, detained and severely beaten by the authorities for his political affiliations with the Movement for Democratic Change (MDC).

The claimant did not receive an examination by a medical practitioner within 24 hours of his detention contrary to Rule 34(1). He later had one and this led to a Rule 35 report detailing his scarring as a result of his alleged torture. However, no response to the report was ever provided by UKBA.

The claimant had reported his torture and mental health problems including PTSD in his asylum screening interview. Further, he had an independent medico legal report outlining his mental illnesses, which included complex PTSD and Severe Depressive Episode. However, all but the final detention review made any reference to this. On this point, the Judge stated:

73. *The first evidence of the defendant taking into account the claimant's medical illness when considering the appropriateness of the claimant's detention is the detention review of 20 January 2010, the first day of the hearing of this case. In that detention review, which I have quoted earlier, it was considered that the risk to the public outweighed the mental illness. Apart from that last minute consideration, made in the light of these proceedings, none of the progress reports or the detention reports during the claimant's detention of almost ten months even considered the appropriateness of detention in the light of the claimant's mental illness, let alone the evidence in the reports of Dr Sbaiti and Dr Katona relating to torture. There was a litany of failures and breaches of policy by the defendant which, in my view, were significant and serious. All the more so when there was clear evidence in Dr Katona's report and Dr Sbaiti's report that the claimant's continued and open ended detention was aggravating his PTSD symptoms and increasing the*

*risk of further suicide attempts. In my judgment, it would need very compelling circumstances indeed to justify the claimant's continued detention in the light of that evidence. That is, no doubt, why Chapter 55.10 of the EIG provides that the detention of the mentally ill, or of those where there is independent evidence of torture, is normally considered suitable in only "very exceptional circumstances".*

The judge concluded that the SSHD had acted in breach of the Detention Centre Rules and policy guidance by not carrying out the medical examination within 24 hours of admission and thereafter failed to review his detention on the basis of independent evidence of his torture and mental illness.

In reference to Chapter 55 of the EIG, the Judge considered the requirement for there to be "very exceptional circumstances" justifying the detention of victims of torture. In this case, the risk of re-offending and the risk of absconding were considered and these risks were not found to outweigh detention. The Judge ordered the release of the claimant, stating at paragraph 80:

80. *Having regard to all the considerations to which I have referred, I have come to the conclusion that the balance comes down in favour of the claimant. For the reasons I have given, I do not consider that there are "very exceptional circumstances" justifying the detention of the claimant. There were, as I have said, significant and serious failures and breaches of policy by the defendant in this case when considering the ongoing detention of the claimant which, in my judgment, have caused his detention to be unlawful, because it cannot be justified by the existence of "very exceptional circumstances". I would therefore grant the claimant a declaration that his detention is unlawful and has been so since the defendant's receipt of Dr Katona's report at the beginning of October 2009.*

## ► The Duty rests with the State to ascertain facts relating to torture

### European Court of Justice: Case of R.C. v Sweden

[http://www.asgi.it/public/parser\\_download/save/cedu\\_41827\\_09032010.pdf](http://www.asgi.it/public/parser_download/save/cedu_41827_09032010.pdf)

The European Court of Human Rights has considered medical evidence in torture cases. In R.C. v Sweden (Application no. 41827/07), determined on 9 March 2010, the Court considered the case of an Iranian who claimed he would face a real risk of being arrested and subjected to inhuman treatment and torture in violation of Article 3 of the Convention on return to Iran. The claimant asserted that the Migration Court of Appeal (*Migrationsöverdomstolen*) had failed to take into account the medical certificate testifying to his torture injuries. The Court held, firstly, the important role medical evidence may have in corroborating an individual's account of ill

treatment; and, secondly, that the duty is on the State to ascertain all the relevant facts in circumstances where the individual may be a victim of torture. The relevant paragraphs are quoted below:

53 *Firstly, the Court notes that the applicant initially produced a medical certificate before the Migration Board as evidence of his having been tortured (see paragraph 11). Although the certificate was not written by an expert specialising in the assessment of torture injuries, the Court considers that it, nevertheless, gave a rather strong indication to the authorities that the applicant's scars and injuries may have been caused by ill-treatment or torture. In such circumstances, it was for the Migration Board to dispel any doubts that might have persisted as to the cause of such scarring (see the last sentence of paragraph 50). In the Court's view, the Migration Board ought to have directed that an expert opinion be obtained as to the probable cause of the applicant's scars in circumstances where he had made out a prima facie case as to their origin. It did not do so and neither did the appellate courts. While the burden of proof, in principle, rests on the applicant, the Court disagrees with the Government's view that it was incumbent upon him to produce such expert opinion. In cases such as the present one, the State has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture. The Court notes that the forensic medical report submitted at its request has documented numerous scars on the applicant's body. Although some of them may have been caused by means other than by torture, the Court accepts the report's general conclusion that the injuries, to a large extent, are consistent with having been inflicted on the applicant by other persons and in the manner in which he described, thereby strongly indicating that he has been a victim of torture. The medical evidence thus corroborates the applicant's story.*

55. .... The question, therefore, to be considered is whether the applicant would run a real risk of being subjected to such treatment in the event of his return to Iran. Having regard to its finding that the applicant has discharged the burden of proving that he has already been tortured, the Court considers that the onus rests with the State to dispel any doubts about the risk of his being subjected again to treatment contrary to Article 3 in the event that his expulsion proceeds.

### ► **Failure to conduct a Rule 35 report** **E (v) Home Office, 10 June 2010, Liability and Quantum Judgments**

This case concerned a Cameroonian claimant who had been raped in prison by prison officials in Cameroon. The claimant claimed damages for false imprisonment

as a result of having been put on the detained fast track (DFT) process in 2006. This court found that the detention was unlawful; that UKBA was at fault with their Rule 35 process; and that Yarl's Wood had "systemic failures" in implementing Rule 35. Damages were awarded.

In the Rule 34 examination, it was noted that the claimant had scars from a cigarette burn and the Judge held that the doctor showed a concern in his notes that the claimant was a victim of torture; however, a Rule 35 report was never compiled. At paragraph 37 of his judgment, His Honour Judge Collins states:

37. *It is clear from those records that the doctor was concerned, and rightly concerned, that the Claimant might have been tortured and there is no explanation as to why he did not make a Rule 35 report. Accordingly, it was potentially a serious dereliction of duty by the doctor although I suspect the doctor may not have been personally responsible. The failure appears to be a systemic one at Yarl's Wood in understanding what Rule 35 required and ensuring that it was complied with. Insofar as it is said to be a physical and mental examination, it was fairly superficial in any event.*

The Judge continues:

41. *It is the Secretary of State's policy not to detain persons who claim that they have been tortured where that claim is supported by independent evidence in the absence of special circumstances and the Secretary of State has to stick by his policy. A proper Rule 34 examination should have produced that independent evidence and the question is what would have happened if that evidence had been in the hands of a decision-maker on the 3rd March? It is sufficient to say that the Defendant has simply not even begun to satisfy me that the Claimant would have been detained in any event. There is no reason whatsoever in any of the evidence to suppose that a competent examination under Rule 34 would have come to any conclusion other than that the cigarette scar was highly consistent with the claim of torture and that that claim was supported by evidence which was compelling on any basis. It seems to me that there is no evidence which has been placed before me to suppose that a responsible official considering a proper Rule 35 report on the 3rd March would have done anything other than act in accordance with the Secretary of State's policy, which would have been to release.*

The Judgment on quantum dealt with the question of how much compensation should be paid to E for her unlawful detention at Yarl's Wood Immigration Removal Centre from the 28th February 2006 to the 29th March 2006.

Judge Collins reiterated the absolute failure in the Rule 35 process, thereon awarding damages of £57,500 (including £25,000 exemplary damages<sup>122</sup>) for a period of one month's unlawful detention.

19. *I said then, and I do not shrink from saying now, that it was outrageous that in February 2006 there was no effective system for complying with Rules 34 and 35, in particular Rule 35, of the Detention Rules. The doctor who examined the Claimant did not make a report, as he was required to do under Rule 35, on the Claimant, having regard to what was obviously his concern that she had been tortured. The pathetic apology for a Rule 35 report that was, in fact, submitted took over a week to arrive and there is no indication that anyone took it into account at all.*
20. *Bearing in mind the undisputed primacy of the interests of those who claim asylum in this country after being the victims of torture elsewhere, the failure to have an adequate system for dealing with Rule 35 cases, notwithstanding a warning by the Inspector of Prisons, was as grave a failure on the part of the Home Office and its contractors as can be imagined in the context of this sort of case.*

► **Failure to follow Rules 34 and Rule 35 Process; liability for breaches of Detention Centre Rules lies with SSHD**

MT on the application of R v SSHD, GSL UK Ltd and Nestor Healthcare Services plc [2008] EWHC 1788 (Admin)

<http://www.unhcr.org/refworld/pdfid/489c35722.pdf>

This case involved a national of DRC who claimed to be a victim of sexual torture as a result of her husband's political activities. She was detained under the DFT process and the lawfulness of this detention was examined. The claimant argued that the private company failed to comply with the statutory requirements for medical examinations laid down in secondary legislation. Further, once the claimant notified the SSHD of her account of torture, her detention continued.

In this case, Rule 34 was breached, in that the claimant did not receive a medical examination within 24 hours, as well as Rule 35. Indeed, when the claimant did have a medical examination and disclosed rape and associated gynaecological problems, the medical practitioner failed to complete a Rule 35 AOT form. However, a breach of the Detention Centre Rules does not automatically render detention unlawful: the Judge was unable to find on the balance of probabilities that if a Rule 34 medical examination had been carried out, a Rule 35 report capable of constituting independent evidence of torture would have been produced.

The Judge considered who was liable for breaches of the Detention Centre Rules. He found that responsibility would fall on the SSHD rather than her subcontractors.

The Judge concluded at paragraph 54:

54. *... The second is that where public services are contracted out a public authority may be liable for the failure to perform them if there can be said there is a breach of a non-delegable duty or if the breach has been specifically instigated, authorised or ratified by the public authority. ... While I have concluded that the Secretary of State is responsible for a breach of statutory duty by the third defendant – the failure to conduct a medical examination – I am not persuaded that that breach caused the claimant's continued detention. Consequently, the Secretary of State is under no liability in that respect of this claimant's detention in the fast track process.*

► **Medical practitioners must be able to identify signs of torture to comply with Rules 34 and 35**

R (RT) v Secretary of State for the Home Department [2011] EWHC 1792 (Admin)

<http://www.bailii.org/ew/cases/EWHC/Admin/2011/1792.html>

In this case, RT declined consent to a Rule 34 examination. However, there was no evidence that the purpose of the examination had been explained to him – that is, so that the doctor could report to UKBA on signs of torture or other factors that might make detention inappropriate. The Judge found that had a Rule 34 examination taken place, a Rule 35(3) report would have been generated which should have led to RT's release. The onus was on UKBA to ensure that the purpose of the Rule 34 examination was explained to the detainee and the failure by the contractor in this case to do led to a finding that RT's detention was unlawful.

The SSHD sought and was refused permission to appeal. In the refusal of permission, a Court of Appeal Judge held that the medical practitioner must be able to identify signs of torture in order to comply with Rules 34 and 35. The Rt. Hon. Sir Richard Buxton stated: *'If it is indeed the case ... that the examinations are carried out by persons incapable of recognising and looking for indicia of torture, then the examinations cannot be said to comply with the requirements of rules 34 and 35.'*

Thus, together with *D and K*, it is made clear that detainees who later prove that they are victims of torture will have claims for damages against UKBA. The case also highlights that full information as to the purpose of Rule 35 reports and the role it plays in ensuring a review of their detention. This information should be provided to the detainee in order to secure informed consent.

## ► Treatment of independent evidence of torture

### AM, R (on the application of) v Secretary of State for the Home Department [2012] EWCA Civ 521 (26 April 2012)

<http://www.bailii.org/ew/cases/EWCA/Civ/2012/521.html>

In this case, the legality of the claimant's detention was challenged on the basis of the decision to detain and Section 55.10 that states that those with independent evidence of torture should not be detained unless there are very exceptional circumstances. It was ruled that the SSHD was in breach of her policy and liable for the tort of false imprisonment of AM.

The Judges held that a scarring report did amount to independent evidence of torture: it did not cease to be such evidence because the explanation for the scars came, in part, from the individual's own account. In paragraph 30, the following is noted:

*(...) If an independent expert's findings, expert opinion, and honest belief (no one suggested that her belief was other than honest) are to be refused the status of independent evidence because, as must inevitably happen, to some extent the expert starts with an account from her client and patient, then practically all meaning would be taken from the clearly important policy that, in the absence of very exceptional circumstances suggesting otherwise, independent evidence of torture makes the victim unsuitable for detention. That conclusion is a fortiori where the independent expert is applying the internationally recognised Istanbul Protocol designed for the reporting on and assessment of signs of torture. A requirement of "evidence" is not the same as a requirement of proof, conclusive or otherwise. Whether evidence amounts to proof, on any particular standard (and the burden and standard of proof in asylum cases are not high), is a matter of weight and assessment.*

## ► Failure to apply the policy contained in the EIG (mental illness and exceptional circumstances)

### OM (Algeria) v SSHD [2010] EWHC 65 (Admin)

<http://www.bailii.org/ew/cases/EWHC/Admin/2010/65.html>

In the case of OM (Algeria), it was held that the claimant's detention was unlawful on the basis that the SSHD failed to conduct adequate detention reviews that applied the correct tests. The claimant had a long history of mental illness and it was necessary to weigh OM's mental illness against his various criminal convictions or "very exceptional circumstances", and whether they outweighed the factors against detention.

However, the detention reviews failed to make any

mention of his mental health for a whole year. After a year, it was only mentioned when the claimant had an adverse reaction to medication and was placed on a "raised" risk category. In paragraph 37, the Judge stated: "...none of the monthly reviews purports to balance the factors pointing to detention against the claimant's mental condition, in the way required by paragraph 55.10 of the Guidance'.

Thus, the failure to conduct a real assessment in the manner required by the EIG meant that there was no balancing of the level of the claimant's mental condition against the level of risk.

In paragraph 45, the Judge concludes:

*'(...) It may be that there could have been justification for the claimant's detention, but the Secretary of State has not been able to justify the detention according to the tests he has said are appropriate for cases of this sort. In my judgement the Secretary of State has, by failing to carry out the test prescribed for the detention of the mentally ill, and by failing to appreciate the nature of the claimant's challenges to removal, failed to establish that the claimant's detention was other than arbitrary. It follows that, for the period in question, it was unlawful.'*

## ► Failure to correctly apply exceptional circumstances policy with regard to mental illness

### R (on the application of AA (Nigeria)) v Secretary of State for the Home Department [2010] EWHC 2265 (Admin)

<http://www.bailii.org/ew/cases/EWHC/Admin/2010/2265.html>

AA was a failed asylum seeker from Nigeria. Having completed his custodial sentence in September 2009, he was detained under immigration powers and remained at HMP Chelmsford. After AA was served with a deportation order, his mental health deteriorated. He made five suicide attempts by ligature and he was consistently assessed as a high risk of suicide by those treating him. He was assessed as suffering from depression and symptoms of PTSD. At times he was on constant watch because of his high risk of suicide.

Internal UKBA emails disclosed in the course of the proceedings revealed disquiet at AA's continued detention at HMP Chelmsford. One email stated, "I do not think we can justify continued detention" and another "We must get him out of HMP ASAP". On 26 April 2010 a consultant psychiatrist emailed UKBA and stated that AA's mental state was not such as to require transfer under Section 48 of the Mental Health Act 1983 but recommended that he be transferred to an IRC. An UKBA email disclosed in the proceedings reported that it was impossible to find a space in an IRC because of the large number of mentally ill detainees in the detention estate.

The detention reviews of October 2009 to March 2010 sought to justify AA's detention by reference to the risk he posed to himself. The first time that paragraph 55.10 of the EIG was referred to was in the April 2010 detention review, after the judicial review proceedings had been initiated.

The Judge found that AA's detention had been unlawful from the outset and was unlawful until his release (25 September 2009 to 20 July 2010). In construing paragraph 55.10 of the EIG, Judge Cranston cited what he had said at [51] and [55] in *Anam v Secretary of State for Home Department* [2009] EWHC 2496.<sup>123</sup> He noted that "exceptional circumstances demands both a quantitative and qualitative judgment" [51] and in [55]:

*The upshot of all this is that although a person's mental illness means a strong presumption in favour of release will operate, there are other factors which go into the balance in a decision to detain under the policy. The phrase needs to be construed in the context of the policy providing guidance for the detention of all those liable to removal, not just foreign national prisoners. It seems to me that there is a general spectrum which near one end has those with mental illness who should be detained only in "very exceptional circumstances" along it – the average asylum seeker with a presumption of release – and near the other end has high risk terrorists who are detained on national security grounds. To be factored in, in individual cases, are matters such as the risk of further offending or public harm and the risk of absconding. When the person has been convicted of a serious offence substantial weight must be given to these factors. In effect paragraph 55.10 demands that, with mental illness, the balance of those factors has to be substantial indeed for detention to be justified.*

The Judge's approach on how a breach of policy bears on the legality of detention is noteworthy for its clarity: he held that detention in breach of policy will be unlawful unless the SSHD can prove that the decision to detain was inevitable – see [32]:

*Where there is a failure to apply a policy such as that set out in the Enforcement Instructions and Guidance, paragraph 55.10, the detention will be unlawful in public law. A declaration to that effect can be granted. In this case that would be because a failure to take a decision to detain in accordance with the applicable policy would itself mean that detention was unlawful, a lawful decision to detain being a prerequisite to detention. The exception, however, is if the decision to detain was inevitable: *R(WL (Congo)) v Secretary of State for the Home Department* [2010] EWCA Civ 11; [2010] UKHRR 366, [89]; see also *OM (Algeria) v Secretary of State for the Home Department* [2010] EWHC 65 (Admin). That approach is consistent with orthodox public law principles that if a public authority is to contend that a breach of principles has no material impact, so that a remedy is to be denied the claimant, it must demonstrate that the same decision would still have been reached on other grounds: e.g., *Simplex GE Holdings v Secretary of State for the Environment* [1989] 57 P&CR 306.*

The Judge found that the SSHD had not applied the policy in paragraph 55.10 of the EIG as she had not addressed whether there were very exceptional circumstances that could justify detention pursuant to that policy. The Judge went on to find that if the policy had been applied "it is difficult to see how the claimant would not have been released" and in any event AA's detention was not inevitable.

Importantly, the Judge roundly rejected the SSHD's attempts to justify the Claimant's detention by reference to his own wellbeing because this would fall outside of the statutory purpose of Immigration Act detention, which is removal rather than protecting people from themselves (as noted in para [40])

It is a matter of grave concern that UKBA ignored the clear terms of their own policy and failed to release someone as mentally unwell as AA. The internal emails disclosed during the course of the litigation referring to the large number of mentally ill detainees in the immigration detention estate suggest a problem that has become endemic.

AA's experience also points to UKBA continuing to operate a practice of blanket detention in respect of foreign national prisoners. AA was convicted of an offence of dishonesty; his risk of harm was low; his risk of re-offending was low; and UKBA understood the seriousness of his mental health problems: if UKBA will not release in those circumstances it is difficult to envisage circumstances in which it would.

## ► Detention amounted to a breach of Article 3 of the ECHR

### R (BA) v Secretary of State for the Home Department [2011] EWHC 2748 (Admin) (26 October 2011)

<http://www.bailii.org/ew/cases/EWHC/Admin/2011/2748.html>

It is important to note this decision and *R (S) v SSHD* [2011] EWHC 2120 (Admin) detailed below. In both cases, it was ruled that the SSHD has unlawfully detained individuals and that the circumstances of their detention amounted to inhuman or degrading treatment in breach of Article 3 of the European Convention on Human Rights (ECHR).

In both cases, the individuals were suffering from severe mental illnesses. The cases highlight failures by UKBA to follow its policy that the mentally ill should be only be detained very exceptionally as well as inadequate healthcare for mental illness in the immigration detention estate

The detention of BA was found to be unlawful between 21 June and 7 October 2011. Prior to being detained for immigration purposes, BA had been in prison where his mental health had deteriorated and had also been

admitted to hospital under the Mental Health Act 1983 twice. UKBA detained BA upon his discharge from hospital on 1 February 2011 and at this time had been warned by his responsible psychiatrist that he would be likely to deteriorate in prison and that signs of deterioration included him refusing food and fluids.

During his time in detention, there were a number of shortcomings in his clinical care at Harmondsworth, including a failure to monitor BA for the first two months of his detention and a failure to allow him to see a psychiatrist until 21 May 2011, despite a GP's recommendation. Further, there was significant delay in the assessment of his mental state for the purposes of transfer under the Mental Health Act and in arranging the transfer itself, which was only achieved following the intervention of the Court.<sup>124</sup>

During his time in detention, two independent doctors saw him, one noting BA was showing signs of relapse, including anxiety, depression and signs of psychosis and the other later warning that BA required urgent psychiatric treatment outside of immigration detention and warned that continued detention carried "a real risk that he could die" (6 July 2011).

On 4 July 2011 the healthcare manager at Harmondsworth had already informed UKBA that BA was unfit to remain in detention. By 28 July 2011 the healthcare manager considered that BA could die imminently and was preparing "an end of life care plan" for him.<sup>125</sup> Despite all of the information UKBA had about BA's mental illness and the risks of continued detention David Wood, the Director of Criminality and Detention at UKBA, maintained his detention on two separate occasions in late July and early August 2011 when he was asked by junior officials to consider authorising release.<sup>126</sup>

BA was transferred to a Hillingdon Hospital (near Harmondsworth IRC) on 6 August 2011. In late September 2011, he was ready to be discharged but the hospital warned that he would be likely to deteriorate if he returned to detention. Despite all that had happened before and the clear medical advice, UKBA decided to return BA to Harmondsworth. Moreover, despite the ongoing judicial review proceedings, UKBA had breached the order made on 26 July 2001 and had transferred BA back to Harmondsworth.<sup>127</sup>

Similar to the case of OM (Algeria), these cases serve to highlight the failure to consider whether there are "very exceptional circumstances" justifying detention. In the decision of BA, the Judge noted concern<sup>128</sup> about the criminal casework policy in the EIG, wherein if a detainee has committed a serious offence, the policy directs caseworkers to continue detention even in the face of compelling evidence of a serious mental illness, which cannot be satisfactorily managed in detention.

Whilst this case is not torture related, the concerns raised in the judgments are of relevance to the remit of this

investigation. In finding a breach of Article 3 in paragraphs 236-238, the Judge in the case of BA stated:

*"In my judgment there was a deplorable failure, from the outset, by those responsible for BA's detention to recognise the nature and extent of BA's illness... I... consider that there has been a combination of bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare. The documents disclosed by the Secretary of State have also shown, on one occasion, a callous indifference to BA's plight..."*

This damning judgment cannot be taken lightly. Many of the issues highlighted by the Judge have also been uncovered in the course of this investigation.

### ► Detention amounted to a breach of Article 3 of the ECHR

#### R (S) v SSHD [2011] EWHC 2120 (Admin) (5 August 2011).

<http://www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html>

On 5 August 2011, the High Court ruled that the SSHD, through UKBA, unlawfully detained a man with severe mental illness for a period of five months between April and September 2010 and that the circumstances of his detention at Harmondsworth IRC breached article 3 of the European Convention on Human Rights (ECHR).

The Claimant, "S", had a history of serious ill treatment and abuse prior to arriving in the UK which had been accepted by a number of medical experts. After serving a prison sentence, he was placed in a psychiatric hospital and in both these sets of medical records, it was documented that detention had caused deterioration in his psychiatric state, precipitating psychotic symptoms and incidents of serious self-harm.

In deciding to detain S, UKBA, inexplicably, stated that there was "no evidence" that he was mentally ill. The failure at the outset to understand and appreciate the nature and degree of S's mental illness was repeated by the officials responsible for reviewing and authorising his detention until his release on bail by the High Court on 29 September 2010.

Within days of arriving at Harmondsworth, S began to present with psychotic symptoms and also began to self-harm. By early June 2010, he had been assessed by a psychiatrist as unfit to remain in detention and, once again, required treatment in a psychiatric hospital. However, by the end of July 2010 UKBA had done very little to progress S's transfer to hospital and he had deteriorated to the point that he lacked capacity to make decisions in his own best interests. He was presenting with psychotic symptoms and there were further serious episodes of self-harm. Eventually, on 28 July 2010, the High Court ordered UKBA to take steps to arrange for S to

be transferred to a psychiatric hospital. Upon discharge in late September 2010, UKBA again attempted to detain him but this was stopped by a High Court intervention that released S on bail.

His detention breached UKBA's detention policy<sup>129</sup>, in that the officials responsible for authorising detention failed to understand and take into account the evidence of S's mental illness.<sup>130</sup> Further, the Court found that UKBA's "... policy was not properly understood by those authorising detention and was certainly not properly applied and that the decision and subsequent reviews failed to both understand and assess the impact of detention on S's mental condition."<sup>131</sup> The Court specifically found that the evidence showed that S presented a risk to himself and not others.

By detaining S, the UKBA had breached the negative and positive obligations under article 3 of the ECHR. With regard to the negative obligation on the state, the Court found that the circumstances of S's detention at Harmondsworth IRC amounted to inhuman or degrading treatment.<sup>132</sup> The Court also found that the UK Border Agency had not put in place appropriate measures to ensure that S was not subject to inhuman or degrading treatment, and such measures that were in place were not treated with the "appropriate level of seriousness or urgency"<sup>133</sup> thus breaching positive obligations.

At paragraph 212 the Court said: *'... I find that the treatment of S, both in the fact of detention, and its continuation despite S's deteriorating condition, and both the mental and physical manifestations of S's condition were sufficiently severe to fall within the Article 3 prohibition. S's pre-existing mental condition was both triggered and exacerbated by detention and that involved both a debasement and humiliation of S since it showed a serious lack of respect for his human dignity.*

### ► **Detention of mentally ill persons; Detention amounted to a breach of Article 3 of the ECHR**

#### **R (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>

In April 2012, the High Court found that the SSHD had acted unlawfully in August 2010 in making changes to the Home Office policy for detaining those with mental illness in immigration detention. The Judge 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 judicial review, which was brought by a detainee with paranoid schizophrenia, found that the claimant had 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.

This is therefore the third time in under a year that the Home Office has been found to have treated an immigration detainee in an inhuman and degrading manner.

### ► **Failure to follow published policy may render detention unlawful**

#### **Lumba (Congo) and Mighty (Jamaica) v Secretary of State for the Home Department [2011] UKSC 12, 2 WLR 671 And Kambadzi v Secretary of State for the Home Department [2011] UKSC 23**

[http://www.supremecourt.gov.uk/decided-cases/docs/UKSC\\_2010\\_0063\\_Judgment.pdf](http://www.supremecourt.gov.uk/decided-cases/docs/UKSC_2010_0063_Judgment.pdf)

[http://www.supremecourt.gov.uk/decided-cases/docs/UKSC\\_2009\\_0022\\_Judgment.pdf](http://www.supremecourt.gov.uk/decided-cases/docs/UKSC_2009_0022_Judgment.pdf)

The case of Lumba and Mighty exposed a Home Office secret policy that enabled a near blanket ban on the release of foreign nationals once their criminal sentence had expired. The Supreme Court ruled their detention unlawful on the basis that a blanket policy was used and that this policy was not a published policy but in fact contrary to the actual published policy. The case also revisited the *Hardial Singh* principles, fully endorsing four of them<sup>134</sup> and adding a few refinements.<sup>135</sup> Nominal damages were awarded.

This case may have relevance in the future with regards to Rules 34 and 35, although this is yet to be seen. It has served to highlight that the UKBA must have clear published policies on the use of detention and only follow these in order for detention to be lawful. Further, a failure to follow published policy with regards to the decision to detain is capable of making detention unlawful.

As shown above, D & K v SSHD, PB v SSHD and MT v SSHD have highlighted a failure to conduct a medical examination on admission would not in itself render detention unlawful. An individual may have an unlawful detention claim if it could be shown that the examination would have resulted in release under the policy. The Judge in RT found that in such circumstances breach of the Detention Centre Rules was a breach of a public law duty, in the sense described by the Supreme Court in *Lumba* and *Kambadzi* that would render detention unlawful.

The cases cited in this chapter serve to highlight the ongoing failures of the SSHD to meet its own policy in several cases. This supports findings made in the earlier chapter examining the history of policy objections. What follows is a presentation of primary data results collected with the aim of assessing the functioning and effectiveness of the Rule 35 (3) process.

# Chapter Six – Questionnaire Results

***'Detaining people who are trafficked and tortured is wrong... we need help... not to be tortured again, please stop detaining people who have been trafficked and tortured.'***

## Profile of Respondents

Of the 50 individuals contained in the sample, 46 returned a questionnaire. This is a 92% response rate. The data results indicate that the profile of the individual is not a determining factor of one's experience. Rather, trends emerge as a collective with all detainees reporting similar experiences.

14 of the respondents were women while the majority (32) were men. Whilst there were a few gender-specific comments made, either regarding pregnant or trafficked women in detention, gender did not appear to affect the results. The one trend observed was in the general comments section. Whereas men spoke of their personal experience, over half of the women spoke of their experience and/or the experience of detainees in general, often wishing that others do not have this experience of detention in the future.

For example, one woman wrote: *'The experience in the detention centre is unforgettable... being locked up for a year behind walls... it is not fair, it damages people... Please stop detaining people. It is not good. It damages people.'*

Of the 46 respondents, 13 were still in detention at the time of completing the questionnaire. There is no notable trend emerging from this subset. Rather the findings of this group are representative of the general trends observed. Many of the comments spoke of the negative mental impact detention was having on them with a feeling of hopelessness. One detainee who was being detained in Harmondsworth wrote: *'Every day I am in detention, I want to die and I wish I can be released from this prison as soon as possible.'*

## Results from the Questionnaires

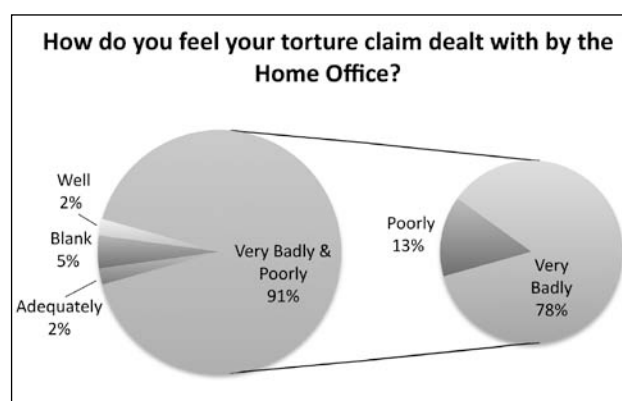
The results are reported using the data from the 46 returned questionnaires. 44 of 46 said that they told the Home Office that they were victims of torture. One individual failed to respond to this question. The remaining one individual stated 'No'. Upon cross-referencing this answer with this individual's immigration case file, it emerges that they did disclose being a victim of torture during the SEF/asylum interview.

In response to the question, 'Were you asked by the

detention centre healthcare team that you were a victim of torture?', 13 reported 'No' whilst the remaining 33 stated 'Yes'.

By comparison, only two individuals stated 'No' while 43 stated 'Yes' in response to: 'Did you tell healthcare that you were a victim of torture?' (One left it blank). For those who reported 'No', one added a comment to explain why not, qualifying their answer by explaining that they were not asked.

## How do you feel that your claim of torture was dealt with by the Home Office?



The vast majority (91%) believed their claim of torture was dealt with poorly or very badly by the Home Office. The one individual who believed their claim was dealt with well now has refugee status.

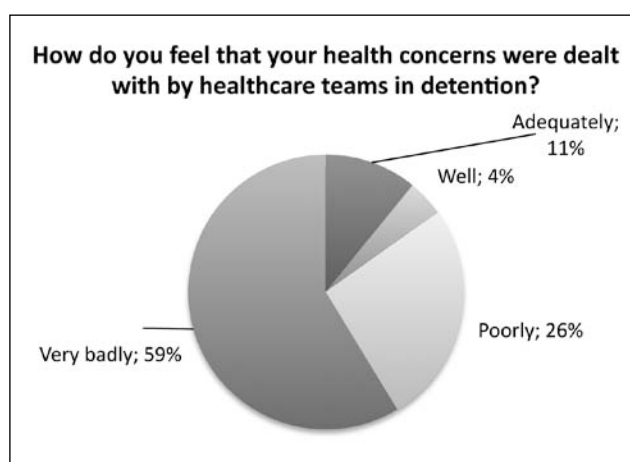
Similar themes were covered in the comments.

- 1) Decisions to detain are made without giving individuals the opportunity to explain their ordeals  
*'Never given a chance to explain my ordeal before being detained.'*
- 2) Detention is continued despite evidence of torture  
*'I was detained for 3 months after I informed the Home Office that I was a victim of torture, even after filling a Rule 35 report.'*
- 3) Decision on claims are made without consideration of evidence of torture  
*'The home office Officer decides without consideration whether I am a victim of torture.'*
- 4) Incompetence of Home Office staff  
*'The incompetence of the Home Office in dealing with case is so appalling for a developed country, as England has human rights laws.'*



- 5) Credibility: the perceived disbelief that caseowners have of people's experiences  
*'The Home Office did not believe me even though I had scars on my body to prove it.'*  
*'It confuses me why the HO dismisses my horrible experiences that I went through... It sometimes makes me feel they won't help me in any way... my caseworker tried to say I made it up... Why would I have scars on every inch of my body if I made it up?'*
- 6) Individuals feel they are treated very badly and ignored  
*'I feel very bad and that animals are treated better.'*

**How do you feel that your health concerns related to your experience of torture were dealt with by healthcare teams in detention?**



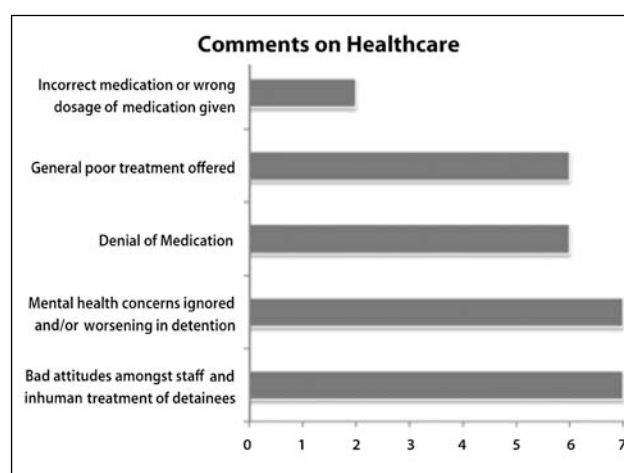
Perceptions of how victims of torture are dealt with by healthcare care teams in detention were slightly better than by the Home Office. However, results are still overwhelmingly negative with health concerns dealt with poorly or very badly in 75% of cases. In five cases, individuals expressed that their health concerns were managed adequately. However, one qualified this by stating: *'I received some counselling and medication for depression but [my] medication was sometimes the wrong dosage.'* This statement indicates a low threshold for what is perceived to be "adequate" healthcare.

21 individuals added comments regarding the management of their health concerns by the detention centre healthcare teams. The following five key trends were observed:

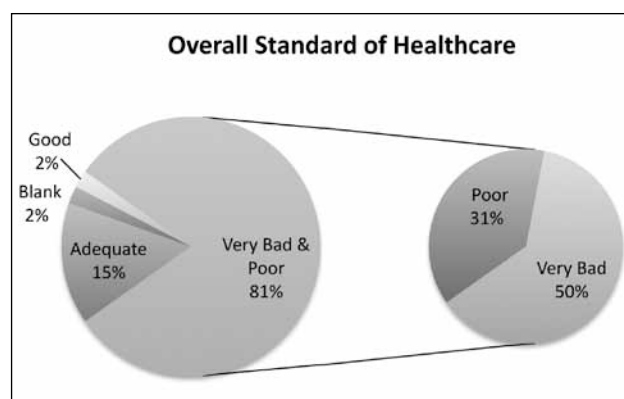
- 1) Bad attitudes amongst staff and inhuman treatment of detainees (7 individuals cited this)  
*'...staff were rude and unhelpful... They don't care if you are a torture victim, they treat you like you are a burden on them.'*  
*'They said go back to my country and I don't have any mental health problem.'*
- 2) Mental health concerns ignored and/or worsening in detention (7 individuals)

*'They don't have the right treatment for me, even my anti-depressant medication I don't really get all the time and this made me self-harm.'*

- 3) Denial of Medication (6 individuals)  
*'Most of the time my drugs were not given'*  
*'I was shocked they denied me medication'*
- 4) General poor treatment offered (6 individuals)<sup>136</sup>  
*'The health care teams in detention don't listen to me or understand what I have been through in my life. Their only concern is increasing my dose... not really assessing if what I am taking is helping me.'*
- 5) Incorrect medication or wrong dosage of medication given (2 individuals)  
*'...medication was sometimes the wrong dosage.'*



**Overall Standards of Healthcare**



The majority of respondents believed the overall standard of healthcare was very bad (50%) followed by poor (31%). Only one individual thought it was of a 'good' standard and another individual noted that quality differs across centres: *'Colnbrook was very bad, Oakington was adequate.'*

The majority of comments covered two themes:

- 1) A reluctance to give proper standards of care: this includes only acting when there is an emergency;

no proper medical check-ups; long queues for medication; and long waiting times, for example, to see psychiatrists.

*The healthcare services ... did not take detainees seriously when they were unwell... they wait until your condition is much worse before they refer you for treatment.*

*The healthcare team only act when they see a detainee collapsing or nearly passing out which is quite sad.*

People spoke of the experiences they witnessed as well as their own:

*Healthcare – they do what they think is good for them, not for detainees. [I] have seen so many people suffering and they were not given any help by the healthcare.'*

*I have seen that detainees that have been left ill over night, vomiting and some passing out with no medical attention for days'*

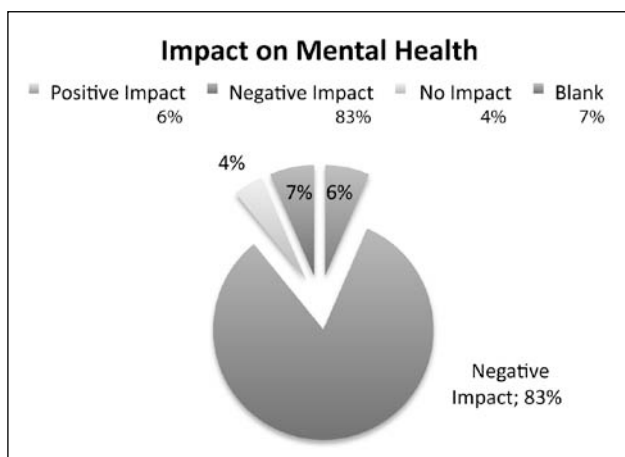
- 2) Detainees were ignored and poor attitudes amongst healthcare staff: staff were described as 'awful', 'stropky', 'rude and unhelpful' with 'deplorable attitudes'.

*They don't care and don't think we deserve to be looked after. In their words, "Why waste NHS money on people who are about to be deported?"*

*'Deplorable attitude to detainees.'*

These findings echo the results from the question about how their health concerns were dealt with. Other comments included that the clinical environment was not clean; incorrect food was given to pregnant women; poor complaints procedure and interpreters were not available.

### What was the impact of being in detention on your mental health?



83% of individuals reported experiencing a negative impact on their mental health from detention. One individual, who left the space blank, stated: "it is difficult for me to remember". However, as will be noted in the Discussion later, there is a scientific link between trauma associated with torture and problems with memory, recall and denial.

It must be noted that in the space for comments,

anomalies are observed. One individual who stated "positive impact" wrote in the comments "physically and mentally ill". Both individuals who reported that detention had "No impact" on their mental health also provided contradictory further comments. For example, one wrote: 'I was so depressed in detention... it reminded me of torture in Cameroon.'

The impact on mental health was reported to manifest itself in a number of ways: nightmares, suicidal ideation, hallucinations, paranoia, loneliness, depression, anxiety, emotional stress, memory loss, loss of confidence, fear, frustration and mood swings.

Common themes emerged from individuals' comments are as follows. These are:

1. Detention brought back memories of torture
2. Emotional mistreatment
3. Psychological symptoms
4. Fear of return provokes re-traumatisation

### 1. Detention brought back memories of torture / Detention is torture in itself

*'The detention centre room and the noises were similar to the noises and sounds where I was tortured so it made me feel like I was in the same place.'*

*'It has worsened my condition, I feel like I have been tortured again. I am scared, want to be in the dark all the time, can't talk to people, or make friends, nightmares every time I close my eyes, flashbacks, thoughts of harming or killing myself because I don't think my life is worth living.'*

*'I was tortured psychologically, emotionally and mentally. My health deteriorated and I now suffer from anxiety and depression ... I felt nobody was there for me and I wanted to die.'*

*'I had so many intrusive thought and nightmares, being locked up brought those bad memories of what I had gone through in Uganda back. I had a mental breakdown.'*

### 2. Individuals reported emotional mistreatment at the hands of detention centre staff

*'Staff treated detainees as criminals'*

*'My health has rapidly deteriorated over the year I have been kept here and nobody seems to care'*

### 3. Psychological symptoms and Suicidal ideation

*'I became mentally disorganized, stressed. I was traumatized, depressed, lost my confidence, my memory, my rights, were taken away, I actually lost my life'*

*'The way I think changed... don't know who to trust... I cry all the time. I am mentally changed.'*

*'In addition to all the fears and stress I had in my country, being a detained in the UK damaged me mentally and physically.'*

*'Surviving torture and surviving detention is equally hard experience. I won't forget either as they are like wounds in my heart. I could talk to anyone about it.'*

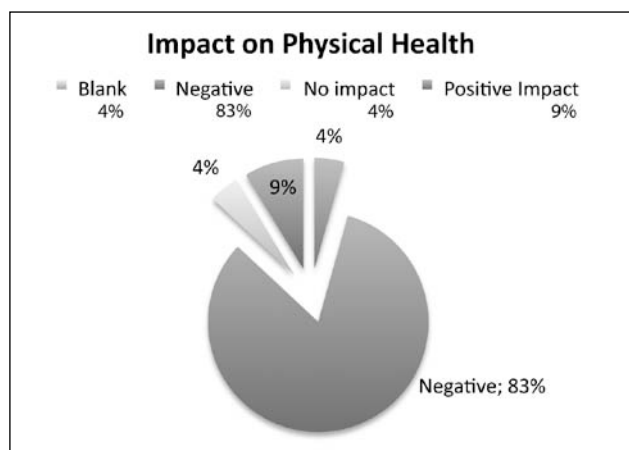
*'Suicidal thoughts increased.'*

#### 4. The fear of return provokes re-traumatization

*'I am scared to go to Sri Lanka. They have told me they have booked a ticket... it has highly affected my mental health.'*

*'I had one question in my mind everyday... am I criminal man, to be sent to this prison? To be locked every time they want? If they send me back I will be killed after mental and physical torture like the first time... I was scared.'*

#### What was the impact of being in detention on your physical health?



Respondents reported similar results with regards to the impact of detention on physical health, with 83% reporting a negative impact. Likewise, contradictory comments were found in three of the six responses reporting "positive" or "no impact", with comments reporting on the various physical illnesses and ailments suffered in detention.

The reported impact of detention on physical health was varied and responses included: weakness, headaches, dizziness, weight loss, hair loss, back and joint problems, skin infection, abscess, diarrhoea, skin, eye and dental problems. The negative impact on physical health was also noted to be related to allegations that medication was withheld, as well as injuries sustained during control and restraint. Other responses included more mental health related problems such as self-harm, loss of appetite, loss of motivation and loss of libido. Indeed, the majority of comments related back to individuals' mental health and how this in turn impacted on their physical health. For example:

- ▶ *'My mental health problems have greatly affected my physical health. I don't feel motivated at all to do anything.'*
- ▶ *'I am too weak and lazy to do things, I don't get enough sleep... I feel like a different person, can't get involved and do things like every other person... pains, headaches, feeling dizzy and faint when I stand up.'*
- ▶ *'I never had any appetite and I couldn't sleep at night which made me always tired and weak.'*
- ▶ *'My physical health was not good as my mind was never settled...'*

This was qualified by detention feeling like a second torture, the lack of care from staff, the lack of freedom of movement, the lack of peace and finally, the lack of information coupled with fear of the future. For example, one individual stated that detention: *'Reminded [me] of capture and torture - increased self harm.'*

#### Other comments

Respondents were offered the opportunity to write any further comments they may have about their time in detention. Despite being an open question, individuals shared similar experiences and concerns and the results echoed the findings from the previous responses.

The following five key themes were identified:

### Five key themes

Torture	<ul style="list-style-type: none"> <li>● 1. Detention = second torture</li> <li>● 2. Fail to identify torture victims</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>● 3. Inhuman treatment</li> <li>● 4. Inadequate healthcare</li> </ul>
Impact	<ul style="list-style-type: none"> <li>● 5. Damages mental health</li> </ul>

## 1. Detention was a second torture

*'The detention centre was the second torture that I had... the first was in DRC and was physical, the second one was psychological'*

*'My time in detention was a nightmare... I found myself having the worst flash backs [of my time in] prison in Cameroon... It was the same event repeating itself twice in detention... I am traumatised... When I see uniformed people I get so frightened. My health is getting worse. My time in detention is something I won't wish my enemy to experience. The whole atmosphere is one of panic.'*

*'I was so depressed in detention... it reminded me of torture in Cameroon, they beat me and caused nerve injury to me.'*

*'I am traumatized from torture from my country and now feel I am being punished again ...'*

## 2. Failure to identify, treat and/or release victims of torture

*'It was really tough when the Home Office made a decision to put me in prison for 6 months after I explained my situation in Iran, that it was about my torture, my mental and physical health. I ran away from country and left my family because I was tortured by the government in a jail and I knew in country there is no human rights law. I came to the UK because I heard it was safe and free...'*

*'The home office should always take time to listen to torture victims before sending them to detention... torture victims should not at anytime be detained because it leads to intrusive thoughts and nightmares and mental breakdown.'*

## 3. Inhumane treatment and criminalisation of detainees; uncaring staff with a poor attitude

*'I was just another asylum seeker in their eyes, they don't care where you are from, what you have been through, they treat you like a prisoner. I couldn't get the right help from healthcare staff which was a talking therapy. I still can't believe I survived it.'*

*'I wonder how a first world [country] can behave the way they do especially to people with terminal diseases.'*

*'Life became meaningless, there was a lot of fear at all times ... there was nothing promising, I became stressed out, depressed, traumatised and developed an inferiority complex. I couldn't express my self, life became meaningless...the officers had no respect, they would enter our rooms without knocking, when you were naked or on the toilet, embarrassing you.'*

*'I wish no-one to be in that place, the staff are racist ... there are no human rights there... it is not fair.'*

## 4. Inadequate healthcare and health concerns dismissed: includes lack of continuity of care, movement around centres disrupting medication, medication withheld, poor mental healthcare provision

*'Detention centres should be a place for criminals not for immigrants fleeing persecution in their countries of origin after being tortured... I was given the wrong medication whilst in detention... I was given malaria tablets that are unsafe in pregnancy...Regardless of someone's status, people should be protected, unborn children should be protected and have enough information about harmful medication.'*

*'Poor organization, moved without medication, difficult to arrange to take someone out of detention with a serious illness.'*

## 5. Psychological impact of detention, including self-harm and suicidal ideation

*'My detention was hell... I wouldn't wish that on any person. It made me feel worthless, useless and that I had no future, which is why I attempted suicide on 4 occasions during my detention... The damage done to me remains with me. Detention broke my heart ... took everything from me.'*

*'Detention is another soft name for prison, with time, one gets mentally affected. I was worrying all the time... I could never sleep, I woke up with nightmares'*

*'Everyday I am in detention I want to die and I wish I can be released from this Prison as soon as possible.'*

*'The experience in the detention centre is unforgettable... being locked up for a year behind walls... it is not fair it damages people... my mental state is not good... I am on very strong medications... Please stop detaining people. It's not good. It destroys people.'*

## Conclusion

The results of the questionnaires show the poor treatment of victims of torture who are held in IRCs and the negative impact this has on their mental health. The inadequacies of healthcare in detention coupled with the poor attitudes of staff add to the trauma of being detained.

In the words of one individual:

*'No [any other] human being should be treated like that, you suffer in the hands of those who you think will offer support and keep you safe. There are so many victims of torture in there but the system does not even have time to detect that from the detainees. People do suffer from their origin country and flee to face another torture. Detention in my point of view, it is a torture itself.'*

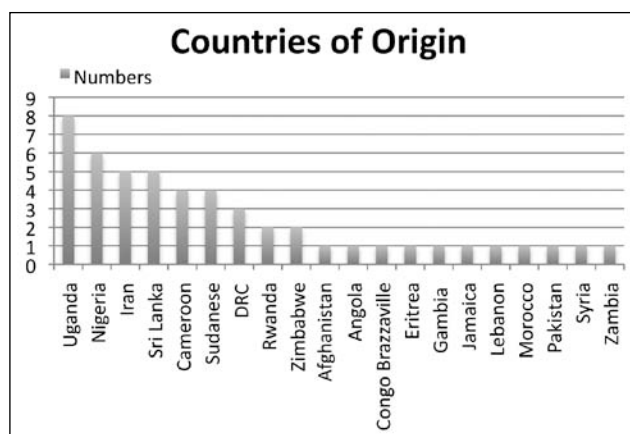
# Chapter Seven – Data Results

This section details the results from the data gathered from the immigration files and healthcare notes. Please refer to the *Methodology* for information about data gathering techniques. Results are presented thematically as follows:

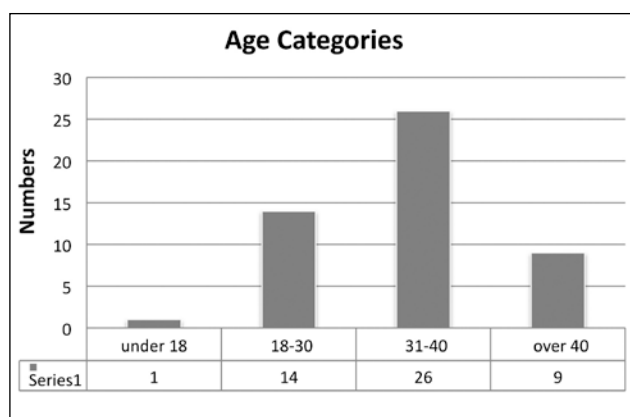
- Profile of Participants
- Screening
- Rule 35 Reports
- Rule 35 Responses
- MLRs
- Mental Health Provision
- Health Outcomes

## Profile of the Participants

50 individuals took part in this study. They came from a wide range of countries, the most common of which were Uganda (8), Nigeria (6), Iran (5) and Sri Lanka (5).



The ages of the participants ranged from 16 to 55 years old. The youngest, aged 16, was age disputed on arrival, has now been released from detention and is awaiting the results of her initial decision.



As the chart shows, the most popular age category was 31-40. This category can be broken down with 14 people aged between 31 and 35 and 12 people aged 36 to 40 years old.

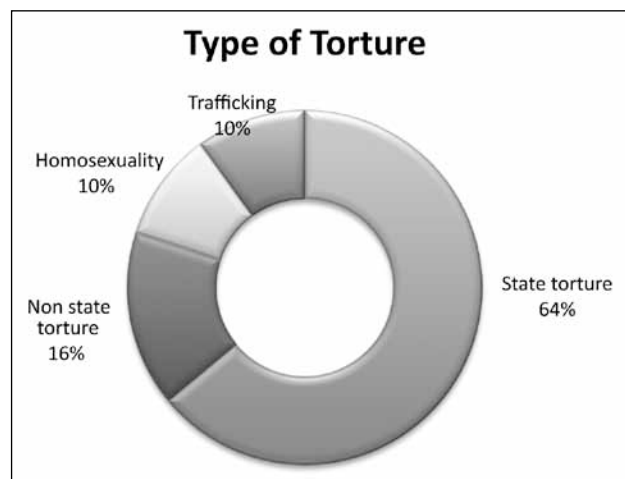
72% of participants were male and 28% were female. The most common nationalities for women in the study were Ugandan (6) and Nigerian (3).

## Types of Claims

All cases involved torture although the reason for which and the actors involved varied. The vast majority of individuals suffered torture at the hands of the state or groups vying for state control.

The breakdown is as follows:

- ▶ Tortured by state agents/officials (32) (the vast majority of whom for reasons of perceived/actual involvement in opposition politics)
- ▶ Tortured by non state agents (8) (for example, for avoiding forced conscription or for reasons of ethnicity/ religion)
- ▶ Tortured on the basis of homosexuality (5)
- ▶ Trafficking (5) – one claim was also based on homosexuality



## Methods of Torture

The 50 individuals in the sample endured various methods of torture. For example, beatings with various objects including: gun butts; bats or batons; sticks; cable wires; or metal objects as well as whippings. Individuals also reported the beatings taking place to particularly sensitive parts of the body such as genitalia, the neck or the soles of the feet.

Other methods of torture included:

- ▶ Falaka “foot whipping”
- ▶ Suspension
- ▶ Stabs or cuts to the body with machetes, knives, barbed wire etc.
- ▶ Burns with chillis, hot iron bars, cigarettes or hot oil
- ▶ Water torture (e.g. mock drowning)
- ▶ Electric torture (e.g. shocks to genitalia)
- ▶ Chemical asphyxiation
- ▶ Forced to drink urine
- ▶ Nail extraction and finger breaking
- ▶ Food deprivation, sleep deprivation and forced labour

16 out of 50 individuals in the sample suffered rape or instrumental rape. 11 were women and 5 were men. Of the rape cases, 5 were trafficking cases, 10 were part of wider torture at the hands of state officials and one was a forced marriage/homosexuality case. All of the women (3) from Nigeria were trafficked to the UK.

All the individuals seeking asylum from Iran were men. All of them suffered torture at the hands of state officials for actual or perceived opposition political activities. 3 of the 5 men from Iran suffered instrumental rape when held in detention in Iran. All who reported on their torture shared the common experience of suspension and beatings. Torture seemed more precise in Iranian cases with specific methods being used such as electric torture and nail extraction.

By comparison, 4 of the 5 Sri Lankans in the sample reported the use of burning more often, either with chillis, hot rods, iron bars or cigarettes.

### **Ongoing Effects of the Torture**

All participants in the sample suffered physical and/or mental after-effects of the torture they endured. These were documented by independent Medical Justice doctors following an examination at the IRCs. The physical effects of the torture were manifested in different ways often dependent on the methods of torture they were exposed to.

Falaka, the whipping or beating of the feet, often left individuals with enduring pain on walking. Individuals who underwent beatings or electrocution to their genital areas often suffered chronic testicular pain. Others were left with chronic pain in the areas they were beaten the most – for example, individuals who had been tied up, suspended and whipped or beaten, tended to experience ongoing back pain.

Those who were beaten around the face were left with a variety of after-effects. These include damage to their eyes, a fractured skull, deformity to the nose and lost teeth.

Scarring was common. Dependent on the type of injury sustained, scars differ. For example, being burnt with cigarette butts may leave circular scars, which tend to be uniform in size, may have dark edges and pale bases, and sometimes a ‘target’ centre.

The effects of rape not only meant some people contracted various types of sexually transmitted infections (STIs) but also those who experienced anal rape often continue to have rectal bleeding and/or pain on defecation, a constant reminder of their trauma.

The vast majority of the sample experienced ongoing mental health problems. This included meeting the diagnostic criteria for PTSD, major depressive disorders and psychotic disorders. The majority, 64%, of the sample were diagnosed with PTSD.

### **Victims of Sexual violence**

There are UK national guidelines on the management of victims of sexual assault written by the British Association for Sexual Health and HIV (BASHH).<sup>137</sup> 28% of the sample revealed history of sexual trauma to the healthcare team at some stage (2 did not). However, there was no evidence that these guidelines or any protocol was followed when a detainee declared a history of rape or sexual assault.

One breach of these guidelines was that no sexual health screening was offered to the detainees. Only one detainee with a history of sexual violence received HIV testing as they requested it themselves. Specific counselling for sexual trauma was also not routinely offered or available.

### **Detained fast track**

In March 2000, the detained fast track (DFT) process was established and thereafter the Detained Non-Suspensive Appeals (DNSA) process.<sup>138</sup> The UKBA guidance on this process states in para 2.2:

‘any asylum claim, whatever the nationality or country of origin of the claimant, may be considered suitable for DFT/DNSA processes where it appears, after screening (and absent of suitability exclusion factors), to be one where a quick decision may be made. This assessment must be made on a case by case basis.’<sup>139</sup>

14 victims of torture in the sample were at some point placed on DFT or DNSA. The following is a breakdown of the profiles of individuals:

- 5 were women and 9 were men
- 4 were victims of rape or instrumental rape (3 of which were women and one was male)
- 5 people came from Uganda and one from each of the following countries: Afghanistan, Cameroon, Congo Brazzaville, Gambia, Iran, Jamaica, Nigeria, Pakistan, Sri Lanka

The cases involved the following claims:

- 6 were state torture cases
- 3 were non state torture cases
- 3 were homosexuality cases
- 2 were trafficking cases

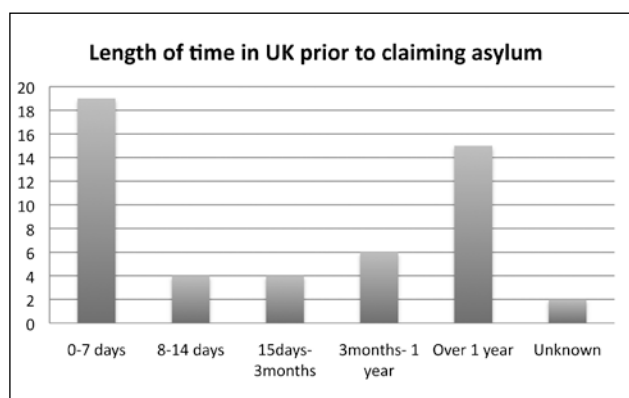
### Third Country Cases

The Dublin II Regulation (Regulation 2003/343/CE) provides for the identification of the Member State responsible for examining an asylum claim. It enables EU states to return as asylum seeker to the country through which the asylum seeker first entered the EU.

6 individuals were third country cases. All were male. 2 came from Sri Lanka, 2 from Iran and one from Sudan and Syria. Of these, 3 now have status in the UK and 3 still have their cases pending and have been released from detention.

### Details of time in detention

The majority of individuals in the sample claimed asylum within one week of arrival, with 10 individuals claiming on the same day as arriving.<sup>140</sup>



23 people were detained within 14 days of claiming asylum (and/or were already held under immigration powers before claiming asylum). Of those, 12 were detained on the same day as claiming asylum. A number of individuals in the sample had also completed criminal sentences, the majority of which were for immigration related offences. However, all dates of detention used and recorded are for those held under Immigration Service (IS) powers.

All 50 individuals were held under IS powers at some point during the period of May 2010 and May 2011. 48 of the 50 have now been released from detention with 2 still being held in detention at the time data gathering was complete (1/1/12). One of these individuals has not been in an IRC as yet, but is being held under IS powers in a prison having completed his custodial sentence.

Of the 50 individuals in the sample, the minimum length of time spent in detention was 3 days and the maximum

was 1032 days.<sup>141</sup> The average length of time spent in detention for the victims of torture in this sample was 226 days.<sup>142</sup>

Using the rate of £102 per day, as noted by Damian Green in October 2011 as being the average cost of detaining someone per day,<sup>143</sup> the average cost of detaining each of the individuals in the sample based on the average 226 days, was £23,052.

Whilst all the women in the sample were held in Yarl's Wood, the men were held in a number of IRCs. What is striking about the data is the number of times individuals are transferred between IRCs during their time in immigration detention. Men were held in up to 5 different centres with the average number of places of detention being 2.2 per person.

One individual was held for a total of 37 days and in this period was sent to four different IRCs. Another was in detention for 60 days and was also sent to four different IRCs. A final person spent a total of 133 days in detention transferred on 4 occasions across 3 different IRCs.

When taking the decision to detain, the EIG sets out in paragraph 55.1.3 that detention should be used sparingly and for the shortest period necessary and in paragraph 55.1.1 that detention must accord with published policy. The average time in detention of the individuals in this sample was 226 days and in the vast majority of the cases where Rule 35 reports were conducted, the process departed from published policy in some way.

### Outcomes

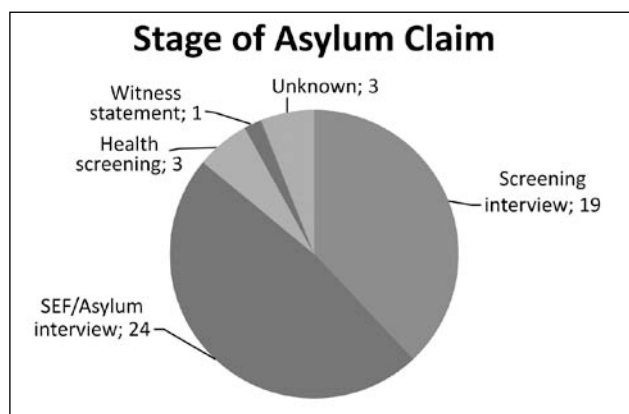
- ▶ 14 of the 50 now have leave to remain.
- ▶ 48 out of 50 have been released from detention. All individuals who had a Rule 35 report have since been released from detention, except one.
- ▶ Only one individual was released through the Rule 35 process.
- ▶ None of the 50 have been removed.
- ▶ Of the 44 Rule 35 reports conducted that did not result in release, the average time of release from time of Rule 35 report to gaining TA/bail was 190 days. The maximum time was 814 days (still in detention) and the minimum was 9 days.
- ▶ A minimum of 17 individuals in the sample are in the process of pursuing civil claims involving unlawful detention.

## Screening

### (i) Asylum Screening

#### Disclosure of torture

19 individuals disclosed that they had been tortured during their initial screening interview. During the screening interview, there is no direct question relating to torture, although the majority of people who mentioned it at this stage did so either when talking about the basis of their claim or when describing their medical conditions. This is a high proportion of individuals given the wealth of information in the public domain outlining the difficulties of disclosing traumatic experiences.



A further 24 individuals disclosed their experiences of torture during their asylum interview or in their self-evidence form (SEF) form. 3 individuals first stated it during their health screening at the IRC and one disclosed it in their witness statement. For the remaining 3 people, the records held on them were incomplete, with key documents such as the screening interview missing and so it is difficult to ascertain when they first disclosed torture.

The results highlight that victims of torture are routinely placed in detention including the detained fast track (DFT) despite stating they are victims of torture in their screening interview. Of the 14 individuals who were routed on to the DFT process, 6 of them stated in their initial screening interview that they had been victims of torture. Of these 14 individuals, 12 had Rule 35 reports completed and one of these reports led to release.

Chapter 55 of the EIG outlines persons considered unsuitable for the DFT process. This includes the following categories, which were found in our sample:

- ... the applicant is a potential victim of trafficking ...
- Those in respect of whom there is independent evidence of torture<sup>144</sup>

However, this policy is somewhat irrational given that at the point at which individuals are designated onto the DFT process, they are highly unlikely to have this evidence available or even have a legal representative. As recently

noted by Detention Action, the screening process to identify vulnerable individuals is inherently flawed: 'The difficulties of effective screening mean that it is not in practice possible to distinguish straightforward claims and the lateness of a claim is no reliable indicator that it will be unfounded.'<sup>145</sup>

The DFT process has come under fire since its inception for a number of reasons including the accelerated timescales, poor screening, the often complex claims which are routed in yet are not "straight-forward", and the inability of individuals to gather evidence such as medical reports in the rigid timeframes.<sup>146</sup>

Concerns regarding the DFT process were also raised in the UNHCR's fifth Quality Initiative Report in March 2008. The concerns noted included an incorrect approach to credibility assessment, a high prevalence of speculative arguments and that an excessively high burden of proof was being placed on applicants.

'The Office further notes concern regarding the assessment of claims of torture and ill treatment in the DFT. There is limited understanding of the purpose of medical evidence in decision making evidenced by frequent use of standard wording to the effect that medical evidence would not assist the applicant in substantiating a claim of ill treatment: UNHCR has also observed some cases of DFT decision makers making medical judgments in decisions. Decision makers are not qualified to make such assessments and UNHCR considers it clearly inappropriate for them to do so.'<sup>147</sup>

Furthermore, Human Rights Watch noted the deficiencies in the screening of applicants and found that in 2008, around 26% of female applicants were taken out of the DFT process, suggesting they had been inappropriately detained owing to screening failures.<sup>148</sup>

In February 2012, the Chief Inspector of UKBA found that of 114 detained fast track cases sampled, 30% were taken out of detention at some stage and 27% of these were released before a decision on their asylum claim had been made. Most of these people (44%) were released due to health issues and evidence they were victims of torture or trafficking, and 32% were released because of difficulties in obtaining travel documentation for removal. This demonstrates the inadequacies of the DFT, in particular for vulnerable individuals and torture survivors.<sup>149</sup>

### (ii) Healthcare Screening

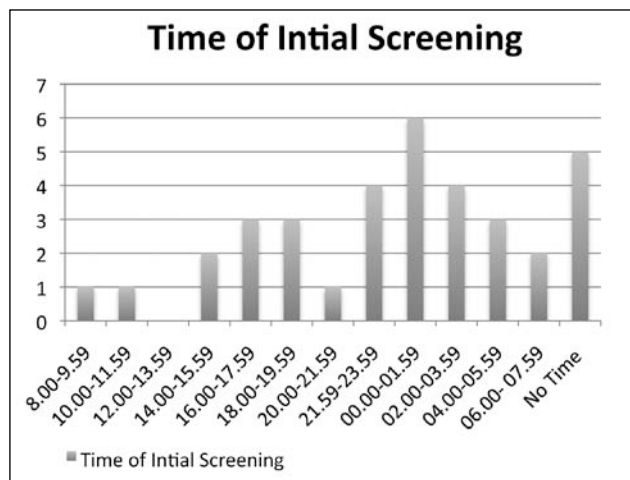
UNHCR advises that identification of survivors of torture and violence should be completed at the earliest possible stage of the asylum process.<sup>150</sup> The initial healthcare screening and Rule 34 assessment are the most crucial stages for IRC healthcare staff to identify victims of torture and raise clinical concerns.

There is chronic failure in the healthcare screenings. The results suggest that the key problems in screening



individuals are: a) times b) interpreters and c) quality of information gathered.

### Time of Initial Health Screening by Nurse<sup>151</sup>



A nurse completed the initial healthcare screening within 2 hours of arrival. As shown in the graph above, the majority of screenings took place at night, with the modal time between midnight and 4am. Notably 23% of the screening documents had no time recorded, demonstrating poor record-keeping.

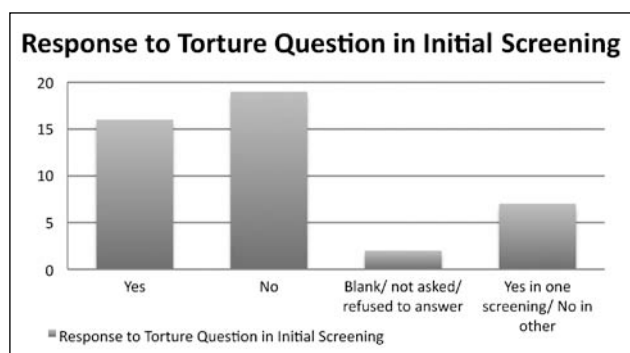
### Language Barriers and Use of Interpreters for Initial Medical Screening

The first language of the detainee was documented in 30% of screenings. 70% had no first language documented. Where the information was available, 63% of the screening documents noted the level of English language ability of the detainee, for example recording "poor" or "good" somewhere on the screening/ reception documents.

It was recorded that an interpreter was offered on 8 of the screening documents but all were "not needed" or declined by the detainee. None of the 44 screening documents recorded that an interpreter or "Language Line" (telephone interpreting services) were used.

From reviewing the full medical notes and MLRs, it was clear that at least 8 detainees did have a significant language barrier and required an interpreter for medical interviews at a later stage.

### Was Torture declared at Initial Health Screening?



All health screening forms contained a question about whether the detainee had been a victim of torture. An example is shown in the Figure below of a screening proforma.

Only 32% of the sample answered "yes" to this question. This low figure is probably owing to combination of late night screening, language barriers and detainees' reluctance to disclose. A further 14% answered 'yes' in one health screening and 'no' in another. Often no further details of the torture were documented.

It was also unclear whether the nursing staff knew what was included under the definition of torture. For example, one screening document recorded 'no' to the question of torture but also documented underneath that the detainee had been a victim of human trafficking and rape. A Rule 35 form was not prompted for this detainee at this stage and was only completed at a later date.

There was no documentation on what measures were taken to ensure the detainee understood the question or its implications. This raises questions about the reliability of the health screening process in identifying victims of torture. The factors that may undermine the screening process are discussed below.

The results show that professional interpreters were not being routinely used for the initial health screening process. At least 8 detainees had a significant language barrier, which meant communication would have been unfeasible. It is also likely that a larger proportion of the detainees had more subtle linguistic difficulties impeding communication of complex issues such as mental health problems or a history of torture.

There were also examples in the medical notes of fellow detainees acting as interpreters for medical consultations on occasions. The lack of consistent usage of professional interpreters and reliance on broken English or a fellow detainee is of concern and would be especially inappropriate in highly sensitive situations, such as the disclosure of torture or in the assessment of sexual violence.

Several systematic reviews have shown use of professional interpreters, rather than ad hoc translators (such as staff or other detainees), can improve communication and increase disclosure of psychological symptoms among asylum seekers.<sup>152</sup>

Of those where times are noted, the majority of the healthcare screenings took place in the middle of the night between midnight and 4am, with the most common category being between 2am and 3.59am. After what must be a highly traumatising day, (which may have involved arrest, a dawn-raid (or “enforcement visit”), the possible use of force, separation from family and medication left behind), it seems unreasonable to expect individuals to be screened at these times.

This finding was corroborated by the 2008 CSIP report on ‘Healthcare in Private Immigration Removal Centres’, which also found that transfers to, from and between IRCs frequently occurred at night due to the escort contractor responsible for moving detainees being needed to move detainees during the day to courts, external appointments or for immigration interviews.<sup>153</sup> Detainees often arrived following a dawn raid or having been detained in short term holding facilities or police cells and may have been in transit for some time. Detainees arriving in these circumstances were likely to be overtired and stressed on arrival.

The 2006 Inquiry into the quality of healthcare at Yarl’s Wood also noted that initial healthcare screenings were very brief, lasting typically less than 10 minutes whereas they should take around 30 minutes.<sup>154</sup> In 2011, an HMIP inspectorate report described a typical screening interview; “The interview took place in the treatment room and was regularly interrupted by nurses collecting medication and records, the telephone and the noise of the printer/fax. The overall environment was unsuitable for sensitive discussion.”<sup>155</sup>

As there is no absolute requirement for a detainee to agree to a Rule 34 assessment it is possible for someone to be detained and never have anything more than the initial brief 10-minute screening with a nurse.

**If a history of torture was declared at screening, did this prompt a Rule 35 at the time of screening?**

<b>Rule 35 prompted by Screening?</b>	<b>N=23</b>	<b>%</b>
YES	15	65
NO	8	35

On most forms there was a prompt to complete a Rule 35 form if the detainee declared a history of torture. See the screening proforma example above. Of the 23 detainees who did declare a history of torture in one of the healthcare screenings, only 15 (65%) had a Rule 35 completed at this initial screening stage by either a nurse or a doctor.

For the remaining 8 detainees (35%) a history of torture was noted but this failed to prompt a Rule 35 report, clearly contravening policy. In 3 cases, reasons for not completing a Rule 35 were documented, including “detainee too tired” and “declined to file V.O.T”. For these detainees who requested not to complete the Rule 35 forms, the screening times were 3:30am, 5:35 am and 2:55am. In cases such as these, detainees should be left to sleep and IRC healthcare should instead conduct one the following day, clearly explaining the function and purpose of a Rule 35 report. For the other 5 detainees who did declare a history of torture it was unclear why Rule 35 forms were not completed at this stage.

**Torture Victims without a Rule 35 Report**

In total, ten individuals, all of whom were victims of torture, were not identified by the Rule 35 process and did not have a report done. However, one of these people has not yet been transferred out of prison despite being held under IS powers following the completion of his custodial sentence, and the Rule 35 process does not apply to prisons.

Of the remaining 9 individuals, one of these individuals disclosed torture during their asylum screening interview and the remaining 8 during their SEF or asylum interview. These 9 individuals were in detention from a minimum of 3 days to a maximum of 421 days. The average length of time of these 9 individuals was 101 days in immigration detention.

**Rule 34 Assessments**

Following screening by the IRC nurse, the detainee should have an option to see an IRC GP doctor for a more detailed assessment, in accordance with Rule 34 of the Detention Centre Rules 2001. Documentation of the Rule 34 forms was reviewed, which is form based, normally 1-2 pages. (Please see Appendix for a template form.)

The failure to conduct a Rule 34 medical examination within 24 hours of admission was examined in *D & K v SSHD*.<sup>156</sup> It was found that the Home Office failed to abide by its published policy whereby medical attendance within 24 hours could, in the applicable cases, trigger a Rule 35 report, capable of constituting independent evidence.

Rule 34 documents were available for 31 detainees. For 8 detainees it was recorded that they declined a Rule 34 assessment. For the 5 remaining detainees there was no Rule 34 available in the healthcare notes, however the reason was not apparent. Reasons could include not understanding the need for an assessment; failing to attend owing to tiredness following a late arrival at the centre; or reluctance on the part of the detainee due to mistrust.

In general, Rule 34 assessments were brief with little information recorded on them. Few had comprehensive physical and mental health assessments documented. Some assessments documented only “appears fit and well” when the detainee had complex history of torture, mental and physical conditions.

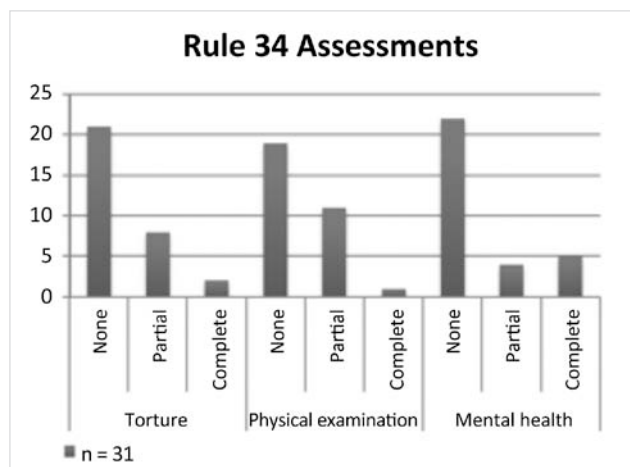
Only two Rule 34 assessments contained any reference to scars. This was despite 45 of the 50 detainees (90%) having some form of scarring relating to their history of torture as recorded in their MLRs. Three detainees had radiological evidence of old fractures from torture. In one example, the screening nurse recorded “extensive scarring” but the GP made no mention of this in the Rule 34 physical assessment.

The IRC doctors are not expected to document scarring to the standard of an MLR but it would be reasonable for extensive scarring to be documented in a routine physical examination for example.

When evaluating the Rule 34 assessments the level of detail in notes was grouped as none, partial or complete. If the GP simply recorded the detainee’s past medical history or recorded only “fit and well” with no other documentation of an examination this was considered to be incomplete and recorded as “none”.

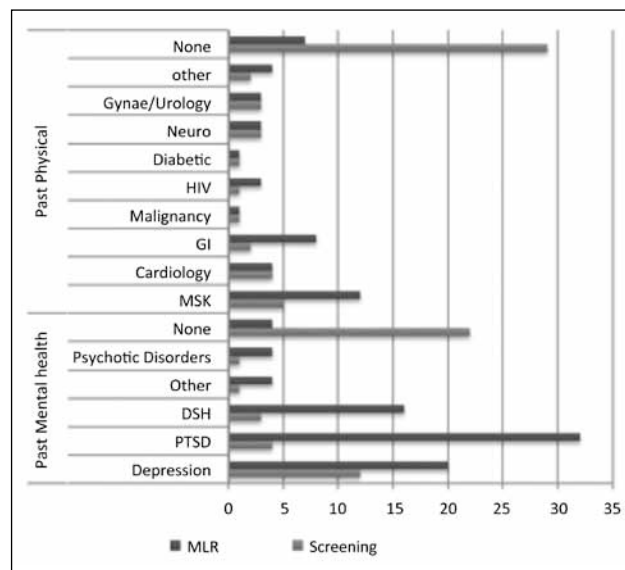
“Partial” applied if some relevant medical positives were documented such as examination of the abdomen if the patient complained of abdominal pain. “Complete” suggested a more detailed examination, for example, where there was a detailed description of scars or a completed mental state examination. It was also recorded whether there was any description of torture in the Rule 34 documents. The table below shows that only one individual had a “full” physical examination and only 5 had a “full” mental examination.

		n = 31	%
Torture	None	21	68%
	Partial	8	26%
	Complete	2	6%
Physical examination	None	19	61%
	Partial	11	35%
	Complete	1	3%
Mental health	None	22	71%
	Partial	4	13%
	Complete	5	16%



## Accuracy of Screening Process

### Diagnosis recorded at Screening/ Rule 34 Assessment compared to MLRs



The above table shows a comparison of different rates of diagnosis recorded at the initial screening or Rule 34 assessment compared to diagnoses recorded by the independent doctor completing the MLR.

There was a striking disparity between rates of diagnosis for all mental health conditions in MLRs compared to Rule 34 assessments. This was particularly evident with regards to depression and PTSD. A diagnosis of PTSD was recorded on only 4 screening documents compared to 32 diagnoses made by independent doctors in MLRs.

There are multiple possible reasons for this disparity. Rule 34 assessments are brief and less comprehensive compared to MLR assessments and IRC doctors are not trained to assess and document the sequelae of torture. MLR assessments are more likely to take place with an interpreter present. Detainees themselves may be more willing to disclose information to an outside doctor. MLRs also took place after a period of detention and therefore mental health conditions such as PTSD and depression may have become more pronounced during the detention process.

## Screening and medication

Upon arrest or upon detention, individuals are often separated from their medication. There were multiple examples of detainees’ medication being disrupted during the course of the detention due to poor screening.

The healthcare screening relies mainly on declaration by the detainee. IRCs should also obtain previous medical records for example from the detainees’ previous GP. However in practice this was not routinely done. This may have been because detainees did not have a GP or because the screening process was at night when the staff were unable to contact the GP practice. This meant that

important past medical history was not always recorded accurately and was particularly important for prescribing the correct medications for detainees. Furthermore healthcare notes were not always transferred from one IRC to another with the detainee. They were sometimes transferred at a later date or not at all. In practice, it was the detainee who provided all medication history as shown in the example below.

<p><b>Current Medication</b></p> <p>Can't Remember</p>
<p><b>Any Disabilities</b></p> <p>NO</p>

In several MLRs, the failure to provide medication and/or appropriate care for detainees was noted. For one patient, an external NHS consultant wrote to the healthcare team at the IRC noting that: "Appropriate treatment was prescribed, but the immigration centre health services failed to ensure that this medication was provided for him during his transfer between various IRCs.... In addition, the health care services of the IRCs failed to refer Mr X for follow-up of his condition, and he had to make these arrangements himself"

The below document shows an example of antidepressant medication being stopped abruptly because it was not prescribed. It also demonstrates the anguish felt by the detainee who was clearly concerned about this.

Date	Comments
02.05	Came for next meds, demanding his Doxepin, advised was only prescribed for 7 days and discontinued 6/9. GP appointment unavailable until next week, very unhappy says next cope. ? for urgent review to his GP please. (Sign ed)

For another detainee with a history of depression on regular antidepressants, no medication was prescribed on arrival in detention, as he was unsure of the name of his tablets. There was no indication in the notes that any effort was made to find information from his previous GP to allow the detainee to get a new prescription. His medication was therefore stopped abruptly on arrival into detention. Note the British National Formulary (BNF) advises against stopping selective serotonin re-uptake inhibitors (SSRI) antidepressants (the antidepressant the detainee was on) suddenly, as this can precipitate severe withdrawal symptoms including gastro-intestinal disturbances, headache, anxiety, dizziness, paraesthesia, electric shock sensation in the head, neck, and spine,

tinnitus, sleep disturbances, fatigue, influenza-like symptoms, and sweating.<sup>157</sup> From the notes it appears that a detention centre doctor did not see him for 15 days after this initial screening.

## Rule 35 Reports

A claim of torture does not in itself mean an individual will not be detained. Instead, independent evidence, for example, in the form of a Rule 35 report may constitute sufficient evidence of torture, thereon enabling a detainee's release, absent exceptional circumstances.

40 individuals had Rule 35 reports during their time in detention. Of these, 32 people had one report completed and 8 had two reports. In two cases, the reports were inaccessible to the researchers so data reporting will omit them. One individual had a Rule 35 report done by an external independent doctor when in hospital and the doctor asked for it to be considered as a Rule 35 report. As it was not completed by an IRC doctor and did not use an AOT form but was in email format, it will not be included in the analysis. Thus, data reporting and analysis will be based on 45 Rule 35 reports (for 37 individuals).

The individuals who had a Rule 35 report were in detention from a minimum of 92 days to a maximum of 413 with the average time being 201 days.

For the detainees who did not declare torture at the initial screening, the majority did return to healthcare at a later stage or at a different IRC to declare torture. There were also examples of detainees presenting to healthcare multiple times with a history of torture before a Rule 35 form was completed. On occasions, Rule 35 forms were completed following requests from outside organisations such as visitor groups, detainees' solicitors, Medical Justice doctors and the detainees themselves, rather than being prompted from within healthcare.

## Non disclosure of information in Rule 35 reports

One individual, a trafficked woman, was detained at Yarl's Wood. At 03.30 in the morning, she had her long admission screening. During this short health screening, she was asked if she was a victim of torture. A Rule 35 report was subsequently conducted. However, this was a "Non disclosure" Rule 35 report, whereby the detainee did not disclose or consent to release any further details – but claimed to be a victim of torture.

In these case, the medical practitioner should explain the purpose of providing this information, which is so that UKBA can consider whether the detainee should remain in detention (see *RT v Secretary of State for the Home Department* [2011] EWHC 1792 (Admin) at [32] which makes clear that this information must

be provided to the detainee in order to inform the detainee's decision as to whether to provide consent for the information to be disclosed to UKBA).

Over 2 weeks later, following a "final reminder" from the case management team (CMT) to the UKBA caseowner, a response was written. The individual was not released on the basis that she failed to provide further information regarding the allegation of torture; had a precarious immigration history; and her removal from the UK was being arranged.

This case shows that there was evidently concern on the part of the practitioner who completed the screening that she was a victim of torture. Thus, it was decided to conduct a Rule 35 report.

However, one may adduce the following for the reasons as to why she failed to disclose information:

- a) She was unaware of the purpose of Rule 35 and that it facilitates a review of detention
- b) Having been detained that day and been medically screened at 03.30, she was simply tired.

## Rule 35 Proforma

The proforma for Rule 35 Allegation of Torture (AOT) forms, although varied across centres, shares some common basic prerequisites to complete. As Appendix 1 shows, the form is very basic with few boxes to complete. However, of the 45 reports, 22 of them were incomplete and in one case, even the name of the detainee was missing. The following information was missing in the reports in the sample:

UKBA reference number	11
Whether the legal representative is aware of the issue	8
Who dealt with the form/ Clinician's signature	8
Patient signature	2
Name of patient	1
Clinical information	1

Given the simplicity of the form and the limited information required, it is of concern that 49% of forms were incomplete.

## Body Maps

The purpose of a body map is to visually demonstrate where on the body scars are found.

- In 22 cases, no body map was completed
- In the remaining 22 cases, a body map was attached to the form.
- In one case, there was no need for a body map as the report focused on mental health issues

There is a worrying low number of body maps provided, which would assist caseowners in understanding where scars are located alongside any given description in the clinical notes paying reference to scars.

## Who completes the Rule 35 report?

Rule 35 of the Detention Centre Rule 2001 states:

*(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.*

In Rule 33 (1), it is outlined who a medical practitioner is:

*Every detention centre shall have a medical practitioner, who shall be vocationally trained as a general practitioner and a fully registered person within the meaning of the Medical Act 1983*

Using the Rule 35 reports accessed via the SARs or the healthcare records, the researchers attempted to gauge who completed the Rule 35 reports and whether it was in keeping with legislation. In many cases, the names were blacked out. However, in 26 cases, we were able to confirm the following:

- In 14 cases, the report was completed by a doctor.
- In 12 cases, the report was completed by a nurse.

Thus, of the cases where the role of the individual was known, 46% of Rule 35 reports were completed by nurses, contrary to policy and legislation. This indicates that the healthcare teams were at times uncertain who should be completing the forms and when it was appropriate to complete the forms.

In six cases, it is noted that at least two people were involved in the report, often with one person writing the form and another completing the body map. This division of labour does not seem appropriate for a two-page form dealing with vulnerable individuals. Often highly sensitive information would be disclosed at this time and it would be appropriate that only one qualified staff member attend to the patient.

There were examples where a doctor had recorded an account of torture and an examination in the medical notes but the nurse then completed the actual Rule 35 form omitting information.

In one example the doctor had recorded "Small 2 cm scar post left occipital area of scalp. Also indentation in left cranium... [Detainee] also has small scars on the forehead and on the left hand. These scars [are] consistent with the declared injury of being beaten with a rifle butt." The doctor also recorded psychological symptoms including "low mood, insomnia and suicidal ideation". However the Rule 35 form completed on the same date by the nurse did not document any of this clinical information and made no mention of the scarring or psychological difficulties.

## Clinical Information

Rule 35 AOT forms have a section whereby the medical practitioner should write any relevant clinical information.

Upon reviewing the reports, the following observations were made by the researchers with regards to the technical details. In 9 reports, the medical practitioner did not have enough space for all the comments. In 8 cases, very brief information was provided and one report was simply illegible.

In order to gather background information of torture, it may be helpful that the medical practitioner asks when, where and why the torture took place. However, in 12 of the reports, this information was only partially provided and in four reports any information relating to the background was entirely lacking.

Forms completed at Brook House and Tinsley House use a slightly different AOT form with standardised questions to complete. Whilst this often resulted in more detailed information being provided, there was a focus on the clinical plans to manage the patient's health within the IRC, rather than a description of the clinical findings of the patient's allegation of torture and/or a comment on the appropriateness of detention.

Indeed, what is common across the vast majority of the reports is that the free space of "relevant clinical information" merely repeats a brief account of the patient's torture allegation rather than commenting on clinical observations relating to the allegation in question.

There were many examples of important clinical information that was recorded in the medical notes but was not transferred on to the Rule 35 forms. This was both due to nurses rather than doctors completing the forms and poor continuity of care with different doctors seeing the detainee throughout the detention process.

One detainee first made an allegation of torture to healthcare at his healthcare screening but no Rule 35 was completed at this stage. The detainee presented again three months later, a Rule 35 was then completed but no clinical information was recorded. A second Rule 35 was completed later that month. The detainee in question had multiple psychological symptoms recorded in his consultations such as "symptoms of anxiety and claustrophobia", "breathing problems, unable to sleep, worries, insomnia..." and "depression". The second Rule 35 described scarring but failed to record the psychological difficulties that were documented in the previous consultations and recorded instead "I am unable to ascertain how this is currently affecting him". In this case the doctor who completed the Rule 35 form had not seen the detainee previously and did not appear to have read through his past medical notes when completing the Rule 35 form.

## Lasting effects of the torture

Medical practitioners should note how the torture may be affecting the patient and whether there are any ongoing physical or mental problems as a result of the torture. Aside from scarring, the physical health effects were noted in only 15 reports. The following physical ailments were noted:

Pain in specific body parts (6); Broken teeth (2); testicle pain; bleeding; nerve damage; muscle wasting/deformity; skin rash; broken nose; and lump on head. In one report, a vague comment was made: '*since these events he suffers ongoing physical and mental health related to his kidnap and torture*'. This demonstrates the lack of detail and attention paid to these reports.

In 31 reports, no mental health issues are noted. Of the remaining 14, explanations of the impact of torture on mental health are varied from statements such as "mental torture" to a diagnosis of PTSD.

Two reports note PTSD and one notes a previous suicide attempt. Otherwise, the following descriptions were used in the remaining cases: insomnia, suicide, nightmares, anxiety, depression, flashbacks and low mood.

Nightmares	5
Anxiety	3
PTSD	2
Insomnia	2
Low mood/"alleges depression"	2
Suicide attempt	1
Flashbacks	1
Mental torture	1
Mental health problems	1

In none of the 45 Rule 35 reports were any comments made about the severity of concern regarding an individual's mental or physical health. The closest one may observe is a diagnosis of PTSD although no details were provided on this and thereon no degree of severity indicated.

## Scarring

Scars are an important factor in assisting in credibility findings on torture allegations but in 8 Rule 35 reports, no mention of scarring was made. When contrasted with the findings of the MLRs, 6 of the 8 corresponding MLRs documented multiple scars on each of the individuals. Of the remaining two, one was a victim of sexual violence and did not bear scarring from her experience and the other one did not have a full physical examination.

In one case, where the Rule 35 report stated: "no injuries seen", the MLR found multiple scarring on his body, concluded to be highly consistent, consistent and typical with the account of torture given by the detainee.

Scars were noted in 37 reports. The terminology used when talking about the scars was “claims” or “alleges”. For example, scar xxx “claims caused by xxx”. Thus, no analysis or comment is provided, merely a repetition of what the individual states.

Where scarring was mentioned in the 37 reports, in only 4 were comments made about the scar(s) being consistent with the account given. Interestingly, the one case whereby an individual was released from detention, fell into this category.

In another of the 4 cases where an opinion on the consistency of the scars is expressed, this report came about because the detainee had made a written complaint about his previous Rule 35 report that had taken place 6 days earlier, and explicitly complained about the doctor’s failure to express any opinion. This was then rectified in the second report. In the other two cases, scars were found to be consistent with the account. However, in these 3 cases, release through the Rule 35 process was not secured.

### Expressing an Opinion

Policy guidance and case law have made it clear that a doctor must simply have a concern that an individual is a victim of torture within the Rule 35 process in order to engage the obligation on UKBA to review the detention of the individual. What is striking about the reports is the failure amongst doctors to express an opinion, whether on the state of their mental health or on their scarring, ongoing physical effects from the torture or on the effects of their continued detention.

In four reports, an opinion was expressed about the consistency of the scarring. For example, the detention centre doctor wrote: “Keloid scars on chest do not look like cigarette burns but the other marks on the rest of the body (arms and legs) do. Nothing on back.” In a further 2 cases, PTSD was noted, although as stated earlier no comment about severity was diagnosed.

Of a total of 6 reports of 45 where an opinion was expressed, 5 of them were completed by doctors. With the sixth report, the researchers were unable to identify who completed it as the name was blacked out. However, it is not surprising that all reports where an opinion was expressed and the reports’ authors are identifiable, that they were all doctors.

The example Rule 35 report below demonstrates an inadequate Rule 35 report. It is completed by two nurses at Yarl’s Wood IRC. One completed the body map; the other the basic information on the cover page and the “clinical information”. Neither was qualified to do the report and two people are not needed to complete such a form. The “clinical information” provided is appalling. The researchers at first believed this was written by the detainee but upon closer investigation, it was found to be a staff nurse (who has recently left Yarl’s Wood IRC). The lady was not released as a result of this report.

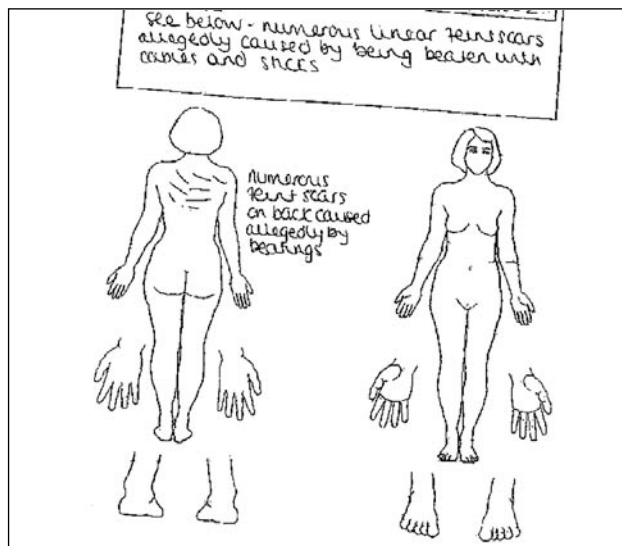
Home Office  
**UK Border Agency**  
 DETENTION CENTRE RULE 35  
 Report of Special Illness or Condition (including torture claims)

To comply with Detention Centre Rules (2001) Rule 35

Please ensure you send a "Receipt of Rule 35" form with this form and file the receipt in the residents' medical records.

(This form is not to be used for allegations of assault within the UK)

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ UKBA Reference No: \_\_\_\_\_



CLINICAL INFORMATION (CONTINUE ON SEPARATE SHEET IF NECESSARY)  
 You are not required to submit a body map.

I WAS BEATEN BY THE OPPOSITION, BY THE G-AMG, THIS IN UGANDA. THIS HAPPENED 2<sup>ND</sup> NOVEMBER 2000 THEY WERE USING ELECTRICAL CABLES AND SHARPS/TICKS, THEY ASSAULTED NUMBER OF PEOPLE, THEY STATED THEY WOULD KILL ELLIOTT, REPORTED MATTER TO POLICE AND CHIEFS, NOTHING HAPPENED, POLICE STATED THEY WOULD INVESTIGATE, REMAINED POUNDING, ELLIOTT LEFT UGANDA IN FEAR OF BEING TORTURED BY OPPOSITION.

### Procedural and Substantive Errors

The analysis of 45 Rule 35 reports demonstrates the inadequacies of the process. These inadequacies are both substantive and procedural.

The root of the procedural errors lies in a number of areas: the design template of the AOT form is inadequate in its present format with a lack of guidance on what should and should not be included; different people are involved in the process (and even in the writing of the form) leading to a disjointed process and an inability to follow up (e.g. on Rule 34 findings); and a lack of training and awareness of who is meant to write the report.

There was a failure to refer to the wider medical notes when completing a Rule 35 report, which would assist

practitioners in offering a more detailed picture and allow them to ask the patient tailored questions about their conditions.

The reports also contained substantive errors. The open section entitled, 'relevant clinical information' lacked detail and uniformity. As the case *R (RT) v SSHD (2010)* showed, medical practitioners must be able to identify signs of torture in order to comply with Rule 35. However, in the majority of cases lasting effects of torture were not noted and there was a failure to express any form of opinion. Furthermore, there was a failure to identify signs of torture and alert individuals not fit for detention.

## Rule 35 Responses

42 out of 45 reports received a response from UKBA. Only one Rule 35 report in the sample secured the release of a detainee. In 3 cases, no review was undertaken.

### Procedural timescales

The asylum process guidance on Rule 35 reports makes clear that the following procedural timescales must be honoured:

1. Healthcare teams must pass on any Rule 35 report immediately to IRC Contact Management Team (CMT) (para 2.1)
2. IRC UKBA CMT must allocate Rule 35 reports within 24 hours of receipt to the relevant casewoner (para 2.2)
3. The UKBA caseowner must respond to Rule 35 reports no later than 2 working days after the day of receipt (para 2.3).

Using the information available, the following findings were made regarding procedural timescales.

#### IRC CMT allocated Rule 35 reports within 24 hours of receipt to the relevant casewoner?

Number of Reports	Deadline met?
27	Yes
5	No
10	Unknown

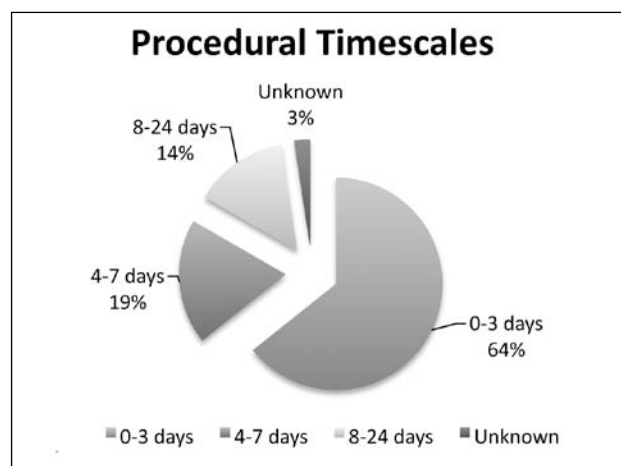
#### UKBA response provided within 2 working days of receipt?

Number of Reports	Deadline met?
28	Yes
6	No
8	Unknown

The high number within the category *Unknown* was often because the Rule 35 receipt sent by CMT was often missing in the SARs. However, below is an analysis of start

to end procedural timescales assessing whether the Rule 35 response was received in 72 hours of the report being written, thus including the deadlines for CMT and UKBA caseowners.

Of the total 42 Rule 35 responses, 14 fell outside the timescales. 27 reports were received within 72 hours of being written and 1 response was undated so one is unable to confirm. Of the 14 responses that were written late, six were received between 4 and 7 days after the report and 6 were written between 8 and 24 days after the report.



Of the 14 reports that were received late, it is possible to assess where the process fell down by examining the dates of the report and the dates of the receipts. In 8 of these cases, this information was available to researchers, and culpability was evenly split. In 4 cases, CMT did not allocate the report in time and in the other 4 cases, the UKBA caseowner did not provide a response in time.

### Acknowledging evidence

In three cases, it is acknowledged by UKBA that the Rule 35 report has provided evidence that the individual is a victim of torture. However, this only secured the release of one of these people.

In one case, the UKBA caseowner commented on the individual's torture and scars as follows: **"However, these are from your time in DRC Congo and not due to you being held in detention in the UK presently"**. The caseowner concluded that detention in this case was appropriate and proportionate: balancing public protection, crime prevention and high risk of absconding outweighs the presumption of liberty.

In the other case where evidence of torture had been acknowledged, the caseowner accepted the individual had been beaten and raped by military officials but stated that the Asylum and Immigration Tribunal (AIT) had found no risk on return, that removal directions would stay in place; and that this evidence does not amount to a fresh claim. '...Because it has been decided not to reverse the decision on the earlier claim and it has been determined



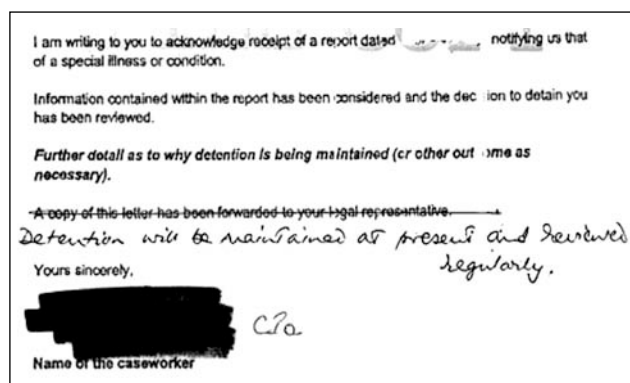
that your submissions do not amount to a fresh claim, there is no right of appeal against this decision.'

In none of the Rule 35 responses was it acknowledged whether continued detention could be injurious to a detainee's health. However, this is in part owing to the fact that the vast majority of reports failed to express any opinion or make any comments about the severity of concern or the possibility of detention being injurious to health.

## Consideration of the evidence contained in the reports

In 14 Rule 35 responses, evidence contained within the report was simply not considered. This was for a number of reasons:

- ▶ In 5 cases, this was because they were third country cases and could supposedly raise concerns in their third country.
- ▶ In 4 cases, detention was upheld as an asylum interview or appeal hearing was upcoming.
- ▶ In 2 cases, detention was maintained as a decision on the case was pending.
- ▶ In a further 2 cases, the evidence was not considered because (i) no evidence about unsuitability for detention was provided; (ii) the casewoner was awaiting a full report in relation to the detainee's medical diagnosis.
- ▶ In the final case, no reason at all was provided. This example is provided below.



## Evidence in Rule 35 reports not being accepted

Of the remaining 25 Rule 35 responses, (in 3 cases evidence was accepted and in 14 cases it was not considered), the evidence contained within the reports was not accepted. This was generally for the following reasons:

- The credibility of the account was disputed (11)
- The medical evidence was disputed (2)
- The credibility of the account *and* the medical evidence was disputed (12)

Where credibility issues were the basis of detention being upheld (11 cases), the following reasons were given:

- ▶ The account of torture has already been considered and refused – this was cited in all 11 cases. Reference was either paid to the initial refusal or the appeal determination in order to highlight that the credibility of the account had already been damaged.
- ▶ Late disclosure – 4 cases

Claims already considered and refused was the most commonly cited reason for dismissing a Rule 35 report. Such findings encouraged caseowners to barely consider, if at all, any clinical findings that may have been made. An example response is as follows: *"Your claimed special condition was previously fully considered in your asylum decisions and it was refused on XXX 2010. You have not provided new evidence to this"*.

In four responses, it was stated that late disclosure of their alleged torture had damaged their credibility. However, there is a wealth of evidence based research in the public domain highlighting the problems individuals who have suffered trauma face in divulging past experiences.<sup>158</sup> This will be considered in the *Discussion* section.

With regards to the medical evidence, the following findings were cited:

- ▶ The report did not state that detention was inappropriate and instead merely repeats the alleged account of torture without making a diagnostic finding – this was cited in 8 of the responses
- ▶ None or not enough medical evidence was provided (3 cases)
- ▶ Lack of independent evidence, 'such as being examined by the Medical Foundation' (now Freedom from Torture) was cited in 2 responses
- ▶ The medical practitioner did not age the scars (1 case)

The standardised "cut and paste" paragraph most often employed is as follows: *'However, it is noted the doctor has not suggested that your detention is inappropriate and there has been no recommendation to release you... The AOT form merely repeats your account of ill-treatment as opposed to making a diagnostic finding about our injuries/symptoms. As a result, the form is not believed to support your account of torture.'*

These responses highlight a failure not solely in the Rule 35 process of adequately reviewing detention, but also in the construction and writing of the Rule 35 reports.

One individual had two Rule 35 reports done whilst held in detention. Both reports were responded to late by the UKBA caseowner. The responses to the two reports are almost identical with the second response providing one additional sentence. The example illustrates the overreliance on standardised paragraphs and some of the typical reasons listed above that are often relied upon to maintain detention.

## Response 1 to Rule 35 report 1:

Information contained within the report has been considered and the decision to detain you has been reviewed, as per Service Order 2013/009.

**HILLI COPY**

It is noted the doctor has not suggested that your detention is inappropriate and there has been no recommendation to release you. It has therefore been decided that detention will be maintained as the AOT form merely repeats your account of ill-treatment as opposed to making a diagnostic finding about your injuries/ symptoms. As a result, the form is not believed to support your account of torture. Additionally this account was considered as part of the asylum application which was refused on [redacted]. The case therefore remains suitable for the Fast Track process.

The suitability of your detention will of course be reviewed should new information come to light.

This response has also been forwarded to your legal representative and to the Healthcare unit to whom you made your report.

## Response 2 to Rule 35 report 2:

Information contained within the report has been considered and the decision to detain you has been reviewed, as per Service Order 2013/009.

**HILLI COPY**

It is noted the doctor has not suggested that your detention is inappropriate and there has been no recommendation to release you. It has therefore been decided that detention will be maintained as the AOT form merely repeats your account of ill-treatment as opposed to making a diagnostic finding about your injuries/ symptoms. As a result, the form is not believed to support your account of torture. Additionally this account was considered as part of the asylum application which was refused on [redacted]. Furthermore on [redacted] an Immigration Judge dismissed the detainee's appeal against our decision. The case therefore remains suitable for the Fast Track process.

The suitability of your detention will of course be reviewed should new information come to light.

This response has also been forwarded to your legal representative and to the Healthcare unit to whom you made your report.

## Removal over safeguarding

In 14 cases, reference was made to an individual's (imminent) removal, in part of the reasoning of not to release from detention. 5 of these reports (for 4 individuals) were third country cases.

Individuals whose claims were being processed by the Third Country Unit of UKBA all received a very similar standardised response. Below is a typical extract:

*'I have been informed that you are concerned about returning to XXXX .... Firstly, I would like to assure you that we are not proposing to remove you back to your country of origin but to a safe third country (France). Consequently, you will be able to raise any issues or concerns you have about your country of origin with the French authorities once returned there. (...) As France has accepted responsibility removal directions are currently being set and you will be informed imminently of your proposed removal date. I am therefore satisfied that your detention remains appropriate.'*

The 14 reports were for 13 different individuals at some point during their detention. In all cases, the individuals have a) been released from detention and b) have not been removed. These individuals ended up being released from detention at varying times following their Rule 35

report, from a minimum of 9 to a maximum of 381 days later. The average length of time between a Rule 35 report being written and the subsequent release of these individuals was 128 days.

The individual who was released only 9 days after his Rule 35 report was released after healthcare deemed him not "fit to fly" for his upcoming removal.<sup>159</sup> He now has refugee status in this country. Two days after his Rule 35 report, he received a negative response stating that detention would be upheld because he was a third country case and he would be able to raise concerns with France, and removal directions were currently being set.

However, the individual was not removed because Brook House healthcare deemed him unfit to fly. In the caseowner's notes located in the SAR, the following is written: 'Given the "not fit to fly" I suggest that detention is no longer merited'. The minute note states: 'Due to the subject's medical grounds, Third Country can no longer run this case. The subject has been diagnosed with a medical mental illness and is suffering from PTSD therefore has become incoherent. Therefore the subject is an unable to be detained and is not fit to fly. Therefore case to go substantive and asylum to be considered substantively'.

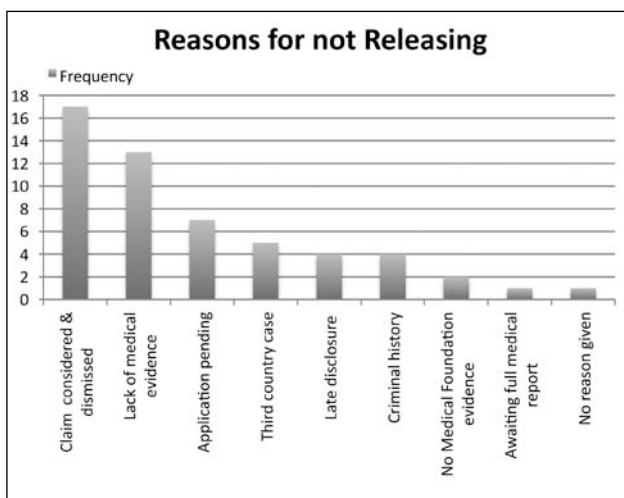
This example raises significant concerns about all ends of the Rule 35 process. Firstly, the doctor who wrote the report did not adequately express an opinion to raise a level of concern to the caseowner reviewing the detention. Instead, a separate correspondence was used just a few days later, demonstrating the perceived inefficiency of the Rule 35 process. Secondly, the case highlights fault with the review end of the process. Using standardised responses, seen in many of the Rule 35 responses involving third country cases, the response fails to adequately review the individual's detention.

## Reasons for not releasing following a Rule 35 report

42 Rule 35 responses were reviewed. One individual was released as a result of the process but the remaining Rule 35 responses all upheld detention. 41 responses were thus analysed, examining the reasons for maintaining detention.

Key themes emerged from the analysis and it became evident that a number of generic reasons and standardised paragraphs were used within the responses. Below is a summary of the main reasons given alongside the number of times that reason was used in any given response. Note that in 13 reports, multiple reasons were given and this is represented in the frequency column of the table below.

Reason	Frequency
Claim has already been considered and dismissed	17
Lack of medical findings/ evidence	13
Application pending (upcoming interview/ appeal)	7
Third country case	5
Late disclosure damaged credibility	4
Criminal history, likely to abscond <sup>160</sup>	4
Failure to provide evidence from Medical Foundation (Freedom from Torture)	2
Awaiting full medical report for diagnosis	1
No reason given	1



## Key Failures Identified in Rule 35 Responses

This investigation shows a plethora of inadequate responses. The key failures identified in the responses are as follows:

1. Failure to understand the purpose of Rule 35 as a release mechanism rather than something part of the substantive claim. For example:
  - a. A report was dismissed because the scars “are from your time in DRC Congo”.
  - b. All reports for third country cases were dismissed on the basis that concerns could be raised in the European country they were being returned to (despite none being returned there).
  - c. Release not facilitated on the basis of an upcoming hearing or decision: this fails to acknowledge any harm caused whilst in detention and subverts the Rule 35 process.
2. Failure to provide adequate reasoned arguments for maintaining detention:
  - a. Dismissing report findings on the basis of an upcoming decision or hearing subverts the Rule 35

process, which should effect the *immediate* release of individuals whose health is being injuriously affected by detention.

- b. Failure to consider evidence in reports and adequately weigh up exceptional circumstances justifying detention. This is in part owing to the lack of guidance as to what constitutes “exceptional circumstances” and results in frequent misapplication. Indeed, in the case of *T (R) v SSHD (2010)*, the Judge found a failure to adequately weigh up the “very exceptional circumstances” regarding victims of torture against the risk of re-offending and the risk of absconding, as per Chapter 55 of the EIG.
  - c. Disconnect between what doctors think they should write and what caseowners think they need to hear for release to be facilitated (for example, detainees are not released because the medical practitioner failed to recommend release when Rule 35 forms do not ask doctors to do this).
  - d. Overreliance on standardised responses. This encourages an inclination to disengage with evidence provided and focus on categorisation.
3. Failure to consider evidence/ Inability amongst caseowners to interpret medical evidence:
    - a. No consideration of evidence based on ill-reasoning and a misunderstanding of the purpose of Rule 35 as a safeguarding tool.
    - b. Dismissing reports because they are not produced by the Medical Foundation indicates a failure to understand that Rule 35 reports may constitute independent medical evidence, as made clear in both policy and legislation. As noted in paragraph 3.2 of the Asylum Process Guidance, ‘Any particularised concerns outlined in a Rule 35 report by a medical practitioner will constitute independent evidence (...)’
    - c. Dismissing reports on the basis of not making “diagnostic findings” is an error from a legal and medical perspective - the threshold in asylum law is not set as high as diagnostic. Medical practitioners do not need to make diagnostic findings but rather raise a concern that the individual may be a victim of torture. It is extremely rare and often impossible, for a doctor to make *diagnostic* findings about scars. The Istanbul Protocol provides a hierarchy of confidence for attributing the likelihood of lesions. This includes consistent, highly consistent, typical and diagnostic, with diagnostic at the top of the hierarchy where the “appearance could not have been caused in any other way”. To apply such a high burden of proof is not simply against published policy, but also clinically problematic and illogical. The Istanbul Protocol states that scars considered “consistent with” torture qualifies as evidence of torture. UNHCR in its fifth report noted problems with credibility assessment (in relation

to claims under DFT) and in particular caseowners making unqualified medical judgments. As a result, UKBA implemented guidance that sought to make explicit that it is not appropriate for caseowners to make medical judgments under any circumstances. The guidance also sought to make clear that it is inappropriate for caseowners to suggest that medical reports will have no evidential value in deciding the asylum claim.<sup>161</sup> However, clearly these ill-informed conclusions continue with a high proportion of Rule 35 reports dismissed on the basis of a failure to make “diagnostic” findings.

- d. One report was also dismissed with an argument made about the failure on the part of the medical practitioner to age the scars. However, once again from a clinical point of view, this is extremely difficult to do.

## Medicolegal Reports (MLRs)

All 50 of the individuals in the sample had a medico-legal report or medical letter conducted by a Medical Justice independent doctor during their time in detention.<sup>162</sup> 48 out of the 50 individuals have now been released. Using the release date of these 48 individuals, the time between release and an MLR report was calculated. On average, it took 123 days to release an individual following the production of an MLR.

When doing a direct comparison of the same 39 individuals who had a Rule 35 report and an MLR and have been released from detention, the following results were found.

- ▶ The average time between a Rule 35 report and eventual release was 171 days.
- ▶ The average time between an MLR report and eventual release was 122 days.

### Did the MLR make a recommendation for release?

In 24 cases (48%), the MLR makes a recommendation for release. Reasons included:

- ▶ Detention was injurious to health
- ▶ To be referred to the Medical Foundation for further assessment and therapy
- ▶ Mental health reasons
- ▶ To access Cognitive Behavioural Therapy (CBT)
- ▶ On the basis of HIV and level of care
- ▶ On the basis of suicide risk

In one woman’s case, the doctor wrote: ‘Detention is negatively affecting her mental state - she states that whenever she sees uniformed guards she is reminded of being raped. (...) In view of her depression, PTSD and scars as evidence of her treatment she should be released from detention.’

Of those for whom release was recommended and who were ultimately released from detention, the average length of time between the date of the MLR publication and being released was 63 days. (This is a much shorter time period than the average time from MLR to release for the total 48 participants, which was 123 days). Of these 24 individuals, 6 of them never had a Rule 35 report done.

### Did the MLR suggest detention was injurious to detainee’s health?

In the majority of cases (26), the independent doctor found that detention was injurious to the patient’s health. Supplementary reasons provided included:

- ▶ Patient’s PTSD is worsening in detention
- ▶ Mental health likely to deteriorate
- ▶ Mental health is deteriorating and is adding to re-traumatisation of previous experiences of detention
- ▶ Suicide risks
- ▶ Not receiving adequate care in the IRC

For example: ‘The immigration detention setting does not provide the therapeutic and supportive environment that is needed to allow recovery in people like Mr X who have severe mental illness.’

In three of these cases, the Rule 35 report had previously been rejected on the basis that the medical practitioner failed to state that detention was inappropriate.

Of the 26 cases where it was deemed that detention was injurious to their health, 24 went on to be released. The average time from the MLR being published to the eventual release date for these 24 people was 66 days.

### Were any comments made on fitness to be removed?

In 14 cases, comments were made within the MLR about fitness to fly. Comments included:

- ▶ Forced removal would have a deleterious effect on mental health
- ▶ Not fit to fly
- ▶ High risk of suicide
- ▶ Lack of support network will have negative effect on mental health
- ▶ Cannot fly without certain medication or prior to having operations/ vaccines

In one report, the doctor wrote: ‘I would think that should a decision be made to return him to Cameroon there is a significant risk that he will make a serious attempt to end his life.’

So far, none of the individuals have been removed. However, a minimum of 27 individuals in the sample have so far received removal directions – 23 of these people

have received more than one set. Furthermore, two individuals are “double backers” – individuals who claimed asylum on torture grounds, were detained, removed, tortured upon arrival, and then managed to return to the UK and claim asylum again. One of these individuals now has humanitarian protection and the other has his case pending.

### Did the MLR criticize the level of care received in the IRC and/or the Rule 35 process?

In 13 MLRs, the independent doctor criticised the level of care delivered by the IRC healthcare team to the patient in question. A summary of the main issues covered are:

1. Problems with the Rule 35 process – unsigned/ report not sent to UKBA/ report not considered by UKBA
2. Failure to conduct Rule 35 (even though notes show they had knowledge the individual was a victim of torture)
3. Poor medical screening and long admission clerking
4. Record keeping: incomplete healthcare notes and discrepancies in the notes
5. Mental health not treated properly: both in terms of medication offered and therapies available
6. Failure to offer full sexually transmitted infection (STI) assessment for rape victims
7. No proper referrals made, for example, for a neurological assessment
8. Medication deprivation
9. Transferring across IRCs was considered in one case to be medically inappropriate and delaying hospital admission

### Criticisms of the Rule 35 process

‘There is a very considerable likelihood that the experience of being detained in the UK is causing severe psychological harm. I believe that this has not been adequately considered by UKBA in relation to the rule 35 report.’

‘Equally, the medical notes from Dover reveal no evidence that the clinicians there have complied with the “rule 35” process which requires them to inform UKBA that there are concerns that a detainee may have been a victim of torture, even though the same notes record ... part of history of beatings at the hands of Sudanese “government officers.”’

‘It is disturbing that during his long admission clerking at Harmondsworth he states was not asked whether there was any history of torture. It is also disturbing that despite psychiatric reports and various UKBA documents recording his accounts of torture, a Rule 35 report was not produced till XXX.’

### Four Key Problems identified in the MLRs:



The results of the data are damning as are the comments noted by some of the independent doctors about the level of care provided to their patients by IRC healthcare teams and the lack of safeguarding through Rule 35. Furthermore, the health outcomes noted by researchers also show signs of deterioration of health coupled with poor clinical management, which are of great concern.

### Mental Health Provision

The MLRs and psychiatric reports for the sample showed high levels of mental health disorder.

The table below shows rates of mental health diagnosis from MLRs and/or psychiatric reports.

Past Mental health	N=50	%
Depressive Disorders	20	40
Deliberate Self- Harm/ Suicidal	16	32
PTSD	32	64
Psychotic Disorders	4	8
Other	4	8
None	4	8

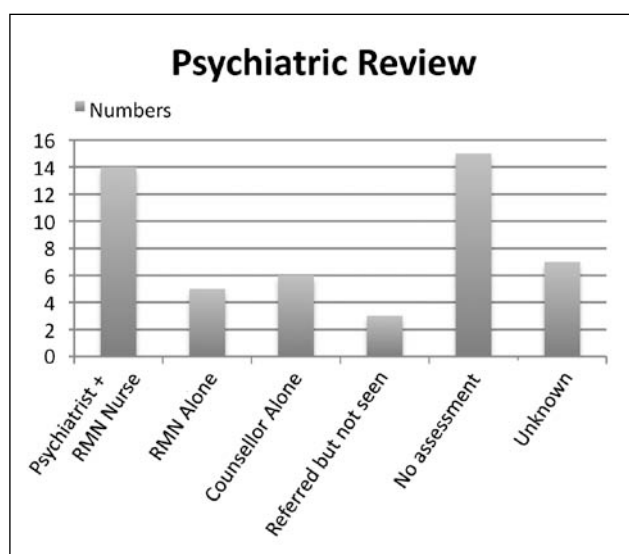
64% of the sample fulfilled the diagnostic criteria for PTSD and 40% were diagnosed with a form of depressive disorder. There were varying degrees of severity within the group with 8 of 32 of detainees classified as having severe PTSD. The majority of detainees had multiple co-morbid conditions such as PTSD and depression.<sup>163</sup> The “Other” group includes mixed anxiety disorders, acute stress reactions and adjustment disorders.

### Psychiatric Assessments

Despite high levels of mental health disorders within the sample, provision of psychiatric support within detention was inadequate. Furthermore, as explained earlier, mental state examinations were not routinely done in the Rule 34 assessment.

The table below shows the proportion of patients that were referred or seen by psychiatric services whilst in detention.

	N=50	%
Psychiatrist + RMN Nurse <sup>164</sup>	14	28
RMN Alone	5	10
Counsellor Alone	6	12
Referred but not seen	3	6
No assessment	15	30
Unknown	7	14



28% of the detainees were seen by a consultant psychiatrist during their detention. Referral to a psychiatrist could be by the IRC GP or by the Registered Mental Health Nurse (RMN). There were long waiting times to see psychiatrists. One detainee was admitted in late March, she did not see an RMN until mid-September that year and only saw a psychiatrist in early October. When she saw the psychiatrist she was diagnosed with Major Depressive Disorder and PTSD. Another detainee who had severe PTSD and was acutely suicidal, for whom the referral should have been urgent, had a 2-month wait from when the first referral was made.

There were also occasions when a detainee should have had psychiatric review but no referral was made. For one detainee who became acutely unwell and was transferred to hospital, a consultant NHS psychiatrist criticised Harmondsworth in his report for not providing "psychiatric assistance in good time."

In the example below, another IRC had difficulty securing a referral to an NHS psychiatrist and seemed to be unsure who should be responsible for reviewing the detainee.

██████████ Physician  
 Seen in GP's surgery  
 entry continued from previous, ██████ told me she tried to arrange joint assessment with Dr S█████ but Dr ██████ has refused to come because Tinsley house detention center is a private organisation. She says DR N██████████, forensic psychiatrist is now off duty and she has tried to arrange with another psychiatrist out of area who is reluctant to come because will not be able to find a bed for admission in the event that the patient is not detainable or needs sectioning.  
 I saw mr ██████ at 1140pm- he refused to be seen in his room, he is now talking through his sutured lips, he became irate and says he will hold the medical staff and security officers responsible if anything happened to him, demanding to have blood tests and injection. he

## Health Outcomes

The detainees' medical notes were also reviewed for indications of deteriorating health or evidence of detention being detrimental to health. The following health categories were considered to be surrogate markers of deteriorating mental or physical health whilst in detention:

- Detainee being placed on ACDT (Assessment Care in Detention and Teamwork) or raised awareness plan
- Hunger striking
- Self-harm – ideation, intent, action
- Suicide – ideation, intent, attempt
- Admission to hospital as an acute emergency
- Documentation in the notes by a medical professional that the detainee was "Not fit to be detained" or "Not fit to fly"

### Raised awareness and ACDT

Raised awareness or ACDT		N=44	%
Raised awareness	Y	11	25
	N	33	75
ACDT	Y	13	30
	N	31	70

### Hunger Striking/ Food Refusal

	N=44	%
Food Refusal	10	23%
No Food Refusal documented	34	77%

Monitoring of detainees on food refusal (hunger-striking) was poor. A minority of centres followed a "Re-feeding syndrome" protocol. There appeared to be no plan for how to proceed if the detainee refused monitoring.

Consequently half the detainees on food refusal required hospitalization after a period of food refusal. Assessments of the detainees' capacity to refuse food were rarely done. One detainee was deemed not to have capacity to refuse food as he was suffering from delusional disorder, but this was only apparent after hospitalisation following a prolonged period of food and fluid refusal. Healthcare were criticised for not referring for a psychiatric assessment early enough.

### Self-harm

Deliberate Self-harm	N=44	%
Ideation/Intent	6	14
Actual Self harm	9	20
None	29	66

### Methods of Self-Harm

Method of self-harm	n=9
Head banging	3
Cutting	2
More than one method	2
Method not specified	2

Incidents of self-harm requiring medical attention were recorded. Some individual detainees repeatedly self-harmed. It is likely rates are higher as some self-harmers will not present for medical attention.<sup>165</sup>

### Suicide

Suicide	N=44	%
Ideation	7	16
Intent	1	2
Attempted	7	16
Non	29	66

There were no completed suicides in the sample. All attempted suicides were by hanging or attempting to tie a ligature around the neck. Four detainees made multiple attempts. Suicide attempts occurred both when detainees were on an ADCT plan and also when detainees had not previously identified to be at risk.

### Acute Hospital Admission

11 of the 44 detainees were transferred to hospital as acute emergencies. Four of the 11 detainees had multiple admissions. The majority of admissions were to A+E for rehydration following a period of food refusal. There were also admissions to acute mental health wards and one admission to intensive care.

### Near Death Event

From the notes there appeared to be one near death event following an attempted suicide. A young male

detainee made a serious suicide attempt by hanging. The event occurred within a few days of arriving at the IRC. He was a young male with poor English language skills. The detainee was found hanging from a height. He was found, unconscious, and had been hanging for an unknown amount of time. He was intubated, ventilated and transferred to Neurological Intensive care for three days. In hospital, he was assessed by a consultant psychiatrist who diagnosed an "adjustment disorder [and] a continued high risk of [completed] suicide aggravated by detention pressures". Following this period of hospitalisation he was returned to detention.

The medical notes for the detainee were incomplete. There was no doctor's Rule 34 assessment and no mental health screening on arrival. The screening process failed to identify that he was at risk of suicide or self-harm. He was therefore not placed on a raised awareness or ACDT care plan. This individual also never had a Rule 35 report done for him, despite his health having clearly deteriorated in detention.

### "Not fit to be detained" or "Not fit to fly"

The table below shows the number of detainees that had "Not fit to be detained" or "Not fit to fly" documented in their notes, recorder by either a member of IRC healthcare or a visiting medical professional.

	N= 44	%
Not fit to fly	12	27
Not documented	32	73
	N=44	%
Not fit to be detained	14	32
Not Documented	30	68

One detainee had that he was "Not fit to be detained" documented five times in his notes and his medical correspondence.

### Effect of Length of detention on Detainee Outcomes

As discussed earlier in this report, international studies have shown length of time in detention was an independent factor positively associated with severity of distress.<sup>166</sup>

A comparison was made between the lengths of detention for those detainees with adverse outcomes (n=26) and those with no adverse outcomes (n=24). The mean length of detention for detainees with adverse outcomes was 188 days compared to 243 days for those with no recorded adverse healthcare outcomes.

## Summary of Key Findings

### Profiles:

50 individuals took part in this study (36 men and 14 women). The majority of individuals in the sample claimed asylum within one week of arrival. 43 individuals cited torture in either their screening, statement of evidence form (SEF) or asylum interview.

### Outcomes:

Only one individual was released through the Rule 35 process. All individuals in the sample have not been removed and all but two have since been released. 14 of the 50 now have leave to remain. A minimum of 17 individuals in the sample are in the process of pursuing an unlawful detention claim.

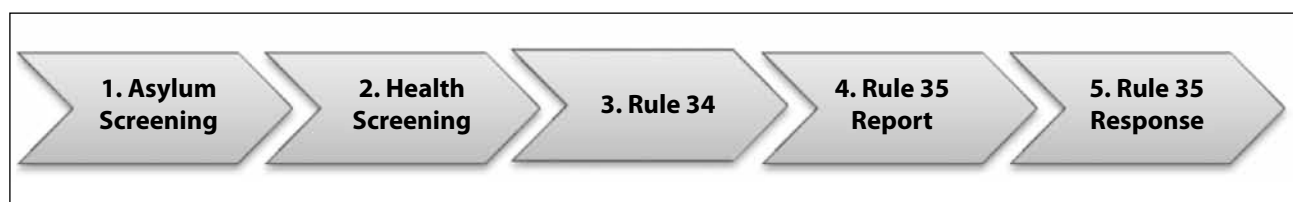
### Health outcomes:

Health outcomes indicate deterioration of health in detention coupled with poor management of their health conditions.

- ▶ 23% of the sample went on hunger strike during detention, of which 50 % of those required hospitalization after a period of time.
- ▶ 34% of the sample experienced suicidal intent/ideation or actual self-harm
- ▶ 11 of the 44 detainees were transferred to hospital as acute emergencies and there was one near death event

### Conclusion:

An analysis of the 50 cases in the sample illustrate start to end process failure. Failures have been highlighted at every stage from asylum screening and healthcare screening to Rule 35 report writing and responses. Indeed, the failures identified in the Rule 35 process are in keeping with the historical criticism it has faced. The Home Office, remains in breach of its own policy.





## Health Screening



- 23% of the screening notes had no time recorded.
- 70% had no first language documented.
- None documented use of interpreter
- 8 screenings noted history of torture but this failed to prompt a Rule 35

## Rule 34



- Rule 34 documents were available for 31 detainees.
- Scars were noted in 2 Rule 34 assessments versus 45 MLRs.
- Only 1 individual had a "full" physical examination
- Only 5 had a "full" mental examination.

## Rule 35 Reports



- 40 individuals had Rule 35 reports done in IRCs
- The process failed to identify a significant number
- 1 individual was released on the basis of Rule 35
- 46% of reports were completed by nurses

## Rule 35 AOT form



- 22 of 45 reports were incomplete. In 22 reports, there was no body map
- Failure to identify signs of torture; Failure to review medical notes
- Failure to express opinion or comment on severity
- Failure to consider impact of detention on detainees' health

## Responses



- 42 of 45 reports got a response
- 36% of responses missed prescribed timeframes
- Credibility of account and/or medical evidence disputed in most cases
- Most common reason for not releasing: Claim already considered and dismissed

## MLRs



- In majority of cases, detention considered injurious to the patient's health.
- 48% cases: makes a recommendation for release.
- Criticisms of IRC healthcare: Rule 35 process; record-keeping; poor mental health treatment; lack of follow up.

## **Breaches of the Minimum Auditable Requirements of the Detention Services Operating Standards manual for IRCs uncovered in this report.**

- 12** Where any procedure or intervention is considered necessary, the Centre must ensure that the detainee is made aware of the reason for the procedure and that fully informed consent is obtained.
- 13** The Centre must ensure that appropriate decisions are made about the use of interpreters or translated materials on a case by case basis. The level of communication must be adequate to ensure correct clinical outcomes. Particular consideration to this should be given in cases where there may be sensitive health issues, issues of confidentiality or the need to obtain fully informed consent.
- 15** As required by Rule 34 of the DC Rules, the centre must ensure that arrangements are in place for detainees to have a physical and mental examination by the medical practitioner within 24 hours of their arrival at the removal centre. The purpose of the initial health assessment is to identify any immediate and significant mental or physical health needs, the presence of a communicable disease and whether the individual may have been the victim of torture.
- 29** The Health Care team must report to the centre manager cases where a detainee's health is likely to be significantly harmed by being detained (Rule 35 (1) refers). In doing so the Health Care team must be mindful of the need to maintain medical confidentiality unless the patient has given consent to disclosure of information. But please see information aside.
- 30** The Health Care team must ensure that systems are in place for informing the centre manager of cases where it is suspected that a detainee has suicidal intentions and ensure that arrangements are made for the person concerned to be observed (Rule 35 (2) refers). In doing so the Health Care team must be mindful of the need to maintain medical confidentiality unless the patient has given consent to disclosure of information. But please see information aside.
- 31** The Health Care team will report, with the patient's consent, to the manager on the case of any detained person where there is concern that the person concerned may have been the victim of torture (Rule 35 (3) refers). But please see information aside.
- 33** On receipt of information as set out under 32 above, the local IS manager must ensure that such information is passed to those responsible for reviewing detention and where the person concerned is an asylum seeker to the caseworking section responsible for considering the application. The IS manager must keep records to this effect. (See too the standard on Case Progress).
- 35** The health care team must obtain, so far as is reasonably practicable, relevant health information from previous healthcare providers. This should be done with the consent of the detainee.
- 36** Where detainees are being transferred to another removal centre or to prison, the Centre must ensure that clinical records are transferred to the receiving centre or prison at the time of transfer.

# Chapter Eight – Case Studies

This chapter is a presentation of 12 case studies. Each case study explores a different theme and shows specific inadequacies relating to the identification, clinical assessment and clinical management of torture survivors.

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.

The case studies presented cover the following key issues:

## Start to end process failure:

1. Fred: tortured, detained, returned, tortured, detained, granted protection
2. Ali: General mismanagement (medical and procedural)
3. Leonardo: Poor healthcare; Inadequate reports and responses

## Screening failures:

4. Anna: Failures in screening
5. Leila: Inadequate health screening

## Rule 35:

6. Hemingway: Failure to do a Rule 35 Report and failure to accurately report the method of release
7. James: Rule 35 process working
8. Oliver and Sam: Failure to do a Rule 35 Report
9. Casper: Third Country Case

## Deterioration in Detention

10. George: Harmful impact of detention
11. Alex: Ignoring medical advice

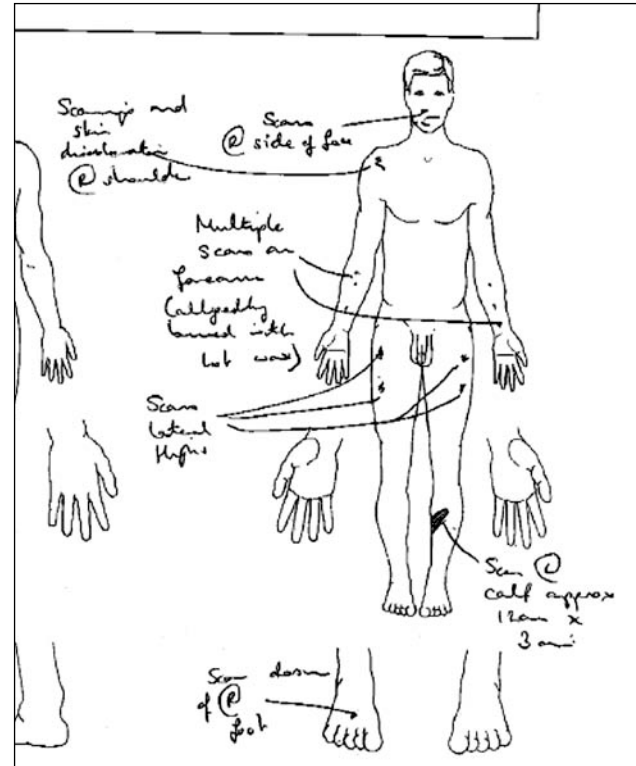
## 1. Fred: tortured, detained, returned, tortured, detained, granted protection

*Having fled torture and sought refuge, Fred was detained for over 2 months and removed back to the country he feared. Upon arrival, he was tortured again. Fred was able to escape again, returning to the UK. UKBA repeated their mistakes for a second time: they ignored his evidence, detained him and refused his application. Eventually he was given humanitarian protection.*

Fred came to Britain having suffered torture in his home country during the civil war. At the age of 16, Fred was targeted owing to his (perceived) political and ethnic affiliations by an opposition group. He suffered torture involving being stripped, tied up, kicked, beaten with rifle butts, burnt with wax and stabbed in the foot.

He applied for asylum in 2009, stating in his screening interview that he had been a victim of torture. He was detained immediately under the DFT process. That month, he had a Rule 35 report done, where the doctor wrote a summary of his alleged torture. He produced a body map and documented the multiple scars on his body.

The response from UKBA reads as follows: "It is noted that the doctor has not suggested that your detention is inappropriate and there has been no recommendation to release you. It has therefore been decided that detention will be maintained as the AOT form merely repeats your account of ill-treatment as opposed to making a diagnostic finding about your injuries/ symptoms. As a result, the form is not believed to support your account of



torture". The response then goes on to state that his case remains suitable for the Fast Track process.

Following that, an independent Medical Justice doctor produced an MLR. This documented his multiple scars

concluding that they were consistent and highly consistent with his account. The gunshot wound was deemed as typical. The doctor noted the after effects of the torture, which included poor appetite; weight loss; insomnia; haemorrhoids and pain on defecation. Depression with suicidal ideation and PTSD were diagnosed.

Despite the medical evidence, Fred was removed. Upon arrival to his home country, he was tortured again. Fred was immediately arrested and beaten by officials. He was stripped, handcuffed, slapped, accused of being a rebel, threatened with death, kicked to the ground and forced to drink urine.

He fled once again, returning to Britain in 2010. In his screening interview, he stated he was a victim of torture and suffered from haemorrhoids and depression. He was detained immediately under the detained fast track process.

The day after being detained, he had a Rule 35 report done. The report did not have a body map, gave a very basic account of his experience, and failed to express an opinion.

The UKBA response failed to consider the evidence and instead dismissed the report, deciding to continue detention. The response stated: "This decision was based on your continued use of deception and the fact that your application is one that may be decided quickly". Thus, because the credibility of his account had previously been rejected, the caseowner dismissed any information, including new medical evidence.

The following month, a second MLR was then produced by an independent Medical Justice doctor. The MLR gave a narrative of the torture he suffered when he was 16 as well as the torture he endured upon being removed by the UK authorities. His scars were documented. When taken together, the doctor asserted that they were typical with the account given. Individually, however, they were consistent and highly consistent with his account. The gunshot wound and burns were described as typical.

Besides the scars, the doctor noted other lasting physical effects from his torture. This included rectal bleeding and haemorrhoids, left hip pain and a limp. He also diagnosed him with PTSD, documented his suicide attempt and head banging and found him to be symptomatic of depression.

*"Mr XXX's history of having been tortured . . . . and then having been returned to XXX and tortured once again, followed by continued intrusive flashbacks, nightmares, low mood and lack of sleep . . . fulfil the criteria for Post-Traumatic Stress Disorder (PTSD) . . . . Mr XXX needs a psychiatric follow-up to assess and treat PTSD, review his treatment for depression and to properly assess any possible suicide risk. He also requires referral for assessment and treatment by the Medical Foundation for the Care of Victims of Torture. (. . .)*

*Mr XX's Campsfield Medical records are incomplete and there are discrepancies from previous health screening questionnaires. A screening questionnaire from Colnbrook detention centre . . . states that Mr XX gave no history of torture or signs of physical injuries. On the same day, Dr X (presumed to be GP) at Colnbrook completed a Detention Centre Rule 35 assessment."*

The doctor concludes with a fierce description of how Fred's repeated account has been consistent, urging for immediate follow-up to his various health problems.

*"Mr XX's consistent history (to several detention centre healthcare staff [see para 15-17], Dr Frank Arnold [see Appendix 3] and myself); his history and symptoms of depression and PTSD (see paras 14 and 21); the difficulties he has faced giving the whole history of the violence inflicted against him (see para 10 and Istanbul Protocol 1999, para 98.vii); taken together with injuries and scarring both highly consistent and typical of a history of torture (see paras 19 and 22); are all typical of someone who has survived rape and torture. This man requires urgent follow-up for his physical and mental health problems. . . He should not be in detention."*

Despite recommending release from detention, Fred was not released until almost two months after this report. Fred was finally granted humanitarian protection.

## Key Failures:

- **Failure to identify protection needs**
- **Disconnect between what the IRC doctors (think they should) write in Rule 35 reports and what UKBA (think they) need to hear to facilitate release**
- **Failure to release individuals with independent evidence of torture**
- **Failure to consider medical evidence in Rule 35 reports and in MLRs**
- **Failure to satisfactorily treat his PTSD and depression**
- **Record keeping: discrepancies in healthcare notes about torture disclosure**

## 2. Ali: General mismanagement (medical and procedural)

Ali fled to the UK having been detained and tortured for his political activities by government officials. He was punched, kicked in the head, his teeth were knocked out and his under chin was lacerated. He was handcuffed and hung from the ceiling, and beaten and whipped while suspended with truncheons. He suffered instrumental rape. Following this, he attempted suicide by cutting his wrist.

He was detained under IS powers for 22 months in Dungavel IRC and then in Harmondsworth IRC. Upon arrival at Dungavel IRC, he claimed to be a victim of torture at his initial screening reception. A Rule 35 report (incomplete and unsigned) was subsequently produced for him. The following day, a Rule 34 form was completed. The clinical examination documents "*Complains feels cold, long term, skin, legs, healthy*". The IRC doctor makes no mention of torture, sexual violence, or his scars as documented by the nurse on the previous day. It is not clear that the doctor examined the patient fully as there was no record of scars noted.

After being in Dungavel IRC for over 6 months, he was seen by an independent Medical Justice doctor. The MLR stated: "*He described a number of mental health problems including low mood insomnia, loss of appetite, anxiety, nightmares and flashbacks... His demeanour while describing the sexual abuse along with the physical sequelae such as peri-anal pain, rectal bleeding was of extreme reticence and distress as would be expected a victim of sexual violence. It may be relevant that many survivors of such experiences (of both sexes) find it difficult to reveal their histories. [He may have] an anal fissure most probably due to anal violation. It would be appropriate to counsel and refer him for a colorectal surgical assessment...*"

The MLR found 10 separate quiescent scars, which were both consistent/ highly consistent with the trauma he described. The MLR also expresses concerns regarding the Rule 35 "*A rule 35 report completed ..... complaint of sexual torture is noted; the scar on the his face is documented but not the scars on his hands. The report is unsigned, and I am concerned no named individual has taken responsibility for bringing these findings to the attention of UKBA.*"

Almost a year later, he was transferred to Harmondsworth IRC. His initial healthcare screening notes document "No history of Torture... No history of mental health problem." During his time there, he continued to present to healthcare with various unresolved psychological and physical symptoms.

A review of his notes indicates several key areas of clinical failures and mismanagement.

### Rule 34/35:

- Failure to provide an adequate medical screening : Harmondsworth noted in his screening that he had no history of mental health and no history of torture. This is clearly incorrect and the IRC should have noted this from the copious medical notes transferred from Dungavel IRC.
- Rule 35 report was not completed by a qualified medical practitioner but a nurse. The Rule 35 report did not include a body map, despite Ali having numerous scars all over his body. No opinion was expressed.
- Rule 35 response – failure to produce one. (Neither the Rule 35 receipt nor response is contained in the SAR or the healthcare notes. The legal representative also has no record of them. One can assume it was never done.)
- A Rule 35 report should have been completed at every IRC admission

### Contravention of NICE guidelines

- Failure to follow NICE guidelines on depression: Ali had never been referred to a psychiatrist despite trying four different antidepressants at varying doses. The NICE guidelines suggest that if a person's depression has not responded to various augmentation and combination treatments, consider referral to a specialist practitioner or service.
- Failure to follow NICE guidelines on PTSD: Ali had not been screened for PTSD despite displaying several of the symptoms. The NICE guidelines suggest, "Screening asylum seekers at high risk of developing PTSD... should be part of the initial refugee healthcare assessment and of any comprehensive physical and mental health screen. All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitization and reprocessing [EMDR])."

### Lack of Continuity of Care

- Ali was transferred across the detention estate from Dungavel to Harmondsworth – this may have a detrimental effect on his care due to lack of continuity of care. For example, on his transfer to Harmondsworth, the healthcare team do not appear to have received/ reviewed/ documented his torture allegations.
- It is not clear from notes if Ali was ever referred to Colorectal specialist for "chronic anal pain, diarrhoea and rectal bleeding" as recommended in the MLR.
- Despite being victim of sexual violence the detainee does not appear to have had any appropriate management for this such as STI screening or specialist psychotherapy as recommended by BASHH UK

### **Interpreting**

- An interpreter was only used on certain occasions. One was not used when completing the Rule 35 or Medical Screening. It is clear from notes that English is limited and most likely not sufficient for discussing complex subjects such as torture and rape.

### **Poor record keeping**

- Healthcare notes are incomplete with poor record keeping, For example, it is unclear if weight/body mass index was monitored despite repeated entries that detainee suffers from poor appetite.
- Ali suffers from chronic leg and ankle pain and it is unclear whether this had been fully investigated. The chronic pain is possibly secondary to Falanga/Falaka (foot whipping) sustained by the detainee during torture. The Istanbul protocol states "Falanga may produce chronic disability. Walking may be painful and difficult."

### 3. Leonardo: Inadequate reports and responses, Inadequate Healthcare and Communication

At the age of 14, Leonardo was stopped at a checkpoint by a different resistance group and was detained, interrogated and tortured. Leonardo was tied to a chair by his captors, beaten with a wire, punched and kicked. His arm was scalded using a hot iron bar, his toenail was pulled out and he also suffered electric torture. After being released his father sent him to the UK.

Whilst in the UK, 11 family members were killed in his home country. In the same year, Leonardo attempted suicide by overdose, was hospitalised and diagnosed with PTSD and depression.

Leonardo was detained under immigration powers at the end of 2010. On his first day under Immigration Service (IS) powers, Leonardo self-harmed by cutting his neck and arms and attempted suicide by hanging. Leonardo thereafter informed UKBA of his depression in his screening interview and of his experience of torture in his asylum interview in January 2011.

Leonardo's time in detention is marked by episodes of self-harm, food refusal, suicidal ideation and suicide attempts. For example, there were 15 self-harm incidents reported, including cutting himself and head banging in his first 70 days of being held under IS powers.

During this period, he attempted suicide on three separate occasions by hanging and also went on hunger strike. The first episode of hunger striking was for five days and the second was for two weeks resulting in acute renal impairment. During this time, he was seen by a consultant psychiatrist and was diagnosed with "Post Traumatic Stress Disorder symptoms together with prominent affective instability and self harm". The treatment plan was to "consider formal psychotherapy to address the emotional impact of trauma".

#### Healthcare Screening

After three months under IS powers in a prison, Leonardo was moved to Harmondsworth IRC. On arrival a health screening questionnaire was completed by a nurse. It is noted that he has a history of depression and is on Sertraline 100mg (an anti depressant). It is noted that he has history of self-harm and that he has seen a psychiatrist whilst in prison. The impression is that "he appears stable". However there is no record of his diagnosis of PTSD, no record of his previous food refusal or suicide attempts. There is no note of the consultant psychiatrist's plan to offer formal psychotherapy. (Note this information should have been available from Prison healthcare records and transferred to Harmondsworth).

There is no record of a Rule 34 Doctor's assessment on

arrival to Harmondsworth. He was not seen within 48 hours of arrival and does not appear to have had a full physical and mental state examination by a doctor when he is seen. He was first seen by a doctor after 4 days in Harmondsworth. The doctor documents "Here since Friday, cannot cope, lots of nightmares, not sleeping well... bangs his head against wall... H/O self harm... Will refer for Psych review".

#### Hunger Striking and Suicidal Attempts/ Intent

From day 4 of his detention until day 18, Leonardo went on hunger strike, refusing all food and fluids. On day 10, the healthcare notes state "Detainee appears slightly dehydrated with cracked lips". His urine shows ++++ ketones (suggestive of starvation). He commenced food and... expressed wish to die to the GP". The GP records "The plan is to continue to monitor (on ADCT) and "refer to psych" if not already done. There is no plan to monitor bloods or urine output at this stage. No protocol for food and fluid refusal appears to be in place.

On day 11 (after 6 days of hunger striking), a letter is written to healthcare by an independent doctor from Medical Justice following a telephone consultation with the patient:

*"I believe his urine output is much diminished, blood tests have shown him to be in renal failure... his weight has dropped from 70.5kg to 64.5kg over past six days. ... He does not want to live... he tried to hang himself last night using bed sheets." The doctor continued, "He is grave and imminent danger as he is refusing all fluids. He is unfit for detention... should be transferred to hospital for rehydration and refeeding and for urgent assessment by a psychiatrist."*

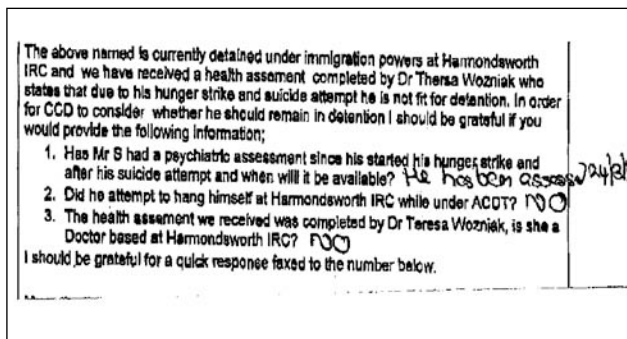
Following this letter and after 7 days of hunger striking, he is referred to A+E on day 12. In A+E he refused treatment, he was not seen by a psychiatric team and returned to Harmondsworth. His blood tests showed Urea at upper limit of normal (in keeping with dehydration) and his urine dipstick was positive for ketones in keeping with starvation. Phosphate levels were not measured, which is important to monitor due to risk of refeeding syndrome.

Upon return from A + E, Leonardo continued to self-harm in detention. In A+E, he refused treatment, he was not seen by a psychiatric team and returned to Harmondsworth. He is described as being "agitated" by a member of the IRC healthcare team.

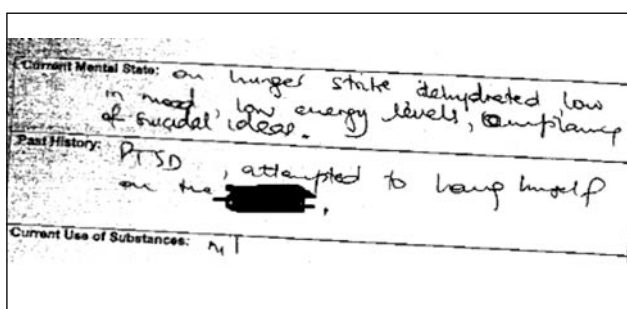
Leonardo continued hunger striking and on day 13, the detention centre doctor documents the detainee refused to sign an advanced directive and stated in the

notes “He is medically fit to be detained”. There is still no full psychiatric assessment or capacity assessment documented in the notes.

A fax (see document below) from healthcare to UKBA states that he had not attempted to commit suicide since being on ADCT.



However, he had in fact attempted suicide on two occasions during this period and one of these episodes is noted in his healthcare notes (extract below). This is a worrying inconsistency and highlights a failure to communicate serious medical problems such as suicidal attempts from healthcare to UKBA.



On day 14 in Harmondsworth, Leonardo is seen by a psychiatrist who diagnosed him with “borderline personality disorder, deliberate self-harm and food refusal”. The psychiatrist advised continued monitoring on the ACDT due to high risk and referral to psychiatric team at Hillingdon Hospital.

On day 17, Leonardo attends A+E for the second time, he is diagnosed with dehydration and treated with IV fluids. He is discharged with a plan to repeat blood tests in 1 week. The following day, he recommenced eating and drinking. The GP wrote “there are no medical concerns at present discharge from healthcare”. There was no plan to monitor his renal function or to monitor electrolytes given the risk of refeeding. Nor is there a plan for continued psychiatric support.

On day 28, a medical report is completed by a second psychiatrist, an independent Medical Justice doctor. “Mr [Leonardo] described several neurovegetative features of depression... He said that he wasn't afraid of dying. He also described multiple attempts at deliberate self-harm including self cutting and banging his head repeatedly. ...

The most likely diagnosis is Post Traumatic Stress Disorder”.

The psychiatrist also expressed that detention is likely to be detrimental to his mental health. “I am of the opinion that in his case owing to his earlier traumatic experiences that detention causes him to experience flashback and other symptoms of PTSD more regularly.”

He concluded, “I do believe that he would benefit from trauma focused psychotherapy and this would be much more likely to be successful if he were not detained”. This echoed the prison psychiatrist's earlier recommendations.

The report however failed to secure his release. By Day 40, he had been sent back to Hillingdon hospital. He was seen by two psychiatrists at Hillingdon hospital who both confirmed his PTSD diagnosis and recommended therapy in the community. This also failed to secure his release.

Furthermore, the monthly detention review that month maintained detention and paid no reference to either is torture or his mental health. On Day 50, he attempted suicide again.

### Rule 35

After 2 months in detention in Harmondsworth, Leonardo had two Rule 35 reports done. Both proformas were incomplete, missing information such as the individual's UKBA reference number or checking whether the legal representative was aware of the issue. Both reports contained body maps.

The first report pays reference to the scars “different scars as below in pictures... Has got different sizes of scar tissue as per picture. He reports that they have resulted from torturing”. No description of his personal history of torture is offered. No comment is made on consistency of scars with the account given or severity of concern. No opinion is expressed. Strikingly there is no mention of mental health issues, nor the numerous suicide attempts he had made, nor his hunger striking. This is despite the fact that the doctor had sight of his medical records, including two reports by consultant psychiatrists diagnosing him with PTSD.

Two days after the first Rule 35 report, Leonardo made a written complaint to the IRC Healthcare Manager about the quality of the report stating that the doctor failed to examine him and failed to express an opinion. Thereon, a second Rule 35 report is completed (6 days after the first).

This second report contains a body map and is annotated with comments about consistency: “scars consistent with trauma”. The clinical information offered details the circumstances and events surrounding his torture with a statement saying: “since these events he suffers ongoing physical and mental health related to his kidnap and torture”. However, no diagnosis is put on the form, there is no mention of previous self-harm/ suicide risk and there is



no description about the severity of concern. Both reports failed to secure release from detention.

The response to the first report was detailed. It covered credibility issues emerging from his screening and asylum interview. It also paid reference to him being on ACDT, a doctor's report of diagnosing him with PTSD and his suicide attempts. The response closes with the following statement: 'In the absence of any independent evidence that you were tortured, such as being examined by the Medical Foundation, it has been decided that you will remain in detention.'

This response does not consider that at this point in time, Leonardo had two reports by independent consultant psychiatrists both outlining his history of torture and his diagnosis of PTSD. There was also a letter from a Medical Justice independent doctor stating that he is "unfit for detention". There were also clear indications that his health was deteriorating in detention. For example, he had been through a period of food and fluid refusal, placed on ADCT due to suicide attempts and attended A+E twice.

The response to the second Rule 35 report simply referred back to the previous response and repeated the above statement. Leonardo thus remained in detention.

After both reports, an independent Medical Justice doctor wrote an MLR. His torture scars were noted as being consistent and highly consistent with his account. He is also diagnosed with PTSD and suicidal ideation. The doctor also noted that the medication prescribed was not appropriate: "He is taking an anti-depressant, Sertraline, but this is not one of the anti-depressants recommended for PTSD, and is not controlling his symptoms of PTSD nor his current depressive symptoms."

Furthermore, criticism is noted with regards to failures in the Rule 34 and Rule 35 process. The doctor noted: "It is disturbing that during his long admission clerking at Harmondsworth he states was not asked whether there was any history of torture." The report continues: "It is also disturbing that despite psychiatric reports and various UKBA documents recording his accounts of torture, a Rule 35 report was not produced till XXX."

The doctor notes that detention is injurious to his health and recommends his release:

*"...immigration detention and fear of being deported to XXX are undoubted factors in exacerbating [Leonardo's] psychological symptoms. Moreover Harmondsworth IRC has informed the UKBA that they are unable to provide this therapy to Mr [Leonardo]. It is clear from his health records that immigration detention has had a detrimental effect on his mental health and it is my opinion that this is likely to improve if he is released from detention."*

In spite of three separate independent doctors expressing concerns that detention was detrimental to Leonardo's health, detention was still deemed appropriate by UKBA.

Leonardo was not released from detention until after almost 6 months under IS powers.

## Key Failures:

- **No Rule 34 completed, i.e. no record of full physical and mental state examination in notes**
- **Not seen by a doctor until 4 days after being in Harmondsworth IRC, contravening Rule 34**
- **Failure to record history of torture both at Screening/ Rule 34 and adequately in the Rule 35**
- **Failure to transfer and/or review the notes/ information/ care plan from prison to IRC resulting in poor continuity of care**
- **Failure to recognise diagnosis of PTSD and provide appropriate support in line with NICE guidelines and failure to treat symptoms of depression adequately according to NICE guidelines**
- **Failure to communicate severity and or nature of detainee's condition from Healthcare to UKBA**
- **Failure of UKBA to respond/act on independent doctors' reports that detention is detrimental to health**
- **Lack of initial psychiatric support (i.e. not seen by psychiatrist until after 13 days in Harmondsworth IRC, despite having deteriorating mental health problems and being acutely suicidal)**
- **Failure of Rule 35 report and response:**
  - o **Inadequate information provided on form**
  - o **No opinion expressed on severity or consistency**
  - o **Failure to record psychiatric diagnosis**
  - o **Not completed in a timely way**
  - o **Failure to understand that Rule 35 reports are capable of constituting independent evidence**
- **Failure to keep accurate records: the application for healthcare notes was denied as the records had been lost - "after an intensive search we have been unable to find the notes".<sup>167</sup>**

## 4. Anna: Failures in Screening

Anna was attacked on the basis of her sexuality. She suffered a severe attack at the hands of multiple individuals and her body bears horrific scarring.

She was found to be eligible for the detained fast track (DFT) process; the Rule 35 process failed to secure her release from detention; and she was detained for almost 5 months. The case shows failures in both the asylum screening process and the health screening induction.

Anna claimed asylum and was subsequently detained the same day at Yarl's Wood IRC as part of the DFT programme in the belief that her claim could be decided quickly.

At neither her asylum screening interview nor at her initial health screening interview did she disclose that she had been a victim of torture. During the asylum screening interview, there is no direct question relating to torture. Instead, Anna stated 'no' in response to whether she had any medical conditions.

Anna had claimed asylum during the day at the asylum screening unit and was then driven to Yarl's Wood IRC. Her asylum screening interview began at 15.24 and ended at 16.15, involving a standardised set of 46 questions plus 7 supplementary questions around her sexuality in 46 minutes. She will then have been transported to Yarl's Wood IRC. The health screening interview had taken place at 01.30. This therefore came at the end of an extremely long day.

The speed of the screening interview (46 minutes), the lack of time and the failure to make appropriate supplementary inquiries all create an inadequate screening process.

It was not until over two weeks later during her asylum interview (where her legal representative was not present)

that Anna revealed that she was a victim of torture. However, this did not prompt a Rule 35 report nor removal from fast track. Instead, Anna did not have time to get a medical report to support her claim and scarring within the rigid DFT timescales, she was refused asylum, her appeal was dismissed and she was thereafter served with removal directions.

Anna raised being a victim of torture at her asylum interview prior to her initial refusal; and thereafter during a Rule 35 examination and during a medical visit by an independent doctor. Following this medical visit, the doctor wrote an MLR, stating that two of Anna's scars, which measure 20cm long, were consistent and diagnostic with her account. However, this failed to secure her release from detention.

Anna was finally released from detention after nearly 5 months. She now has permission to lodge a judicial review on various bases including a challenge to the legality of her detention.

### Key Failures:

- **Initial health screenings that take place in the middle of the night after a long and traumatic day are not conducive to disclosure and can have an unfair negative impact on credibility**
- **Lack of time in the DFT process impedes the gathering of medical evidence**
- **Asylum screening process fails to assess vulnerability or identify protection and safeguarding needs.**

## 5. Leila: Inadequate health screening

Leila fled her home country following sexual torture at the hands of government officials and a forced marriage. She arrived in the UK and claimed asylum on the same day. During her screening interview she disclosed a history of torture and sexual violence. She was detained at Yarl's Wood and spent over four months in immigration detention.

In the initial healthcare screening with a nurse, Leila disclosed a history of torture and multiple rapes. However, no Rule 35 was initiated at this stage. On the screening document the "Physical and emotional state of resident" box was left blank.

Following the initial health screening, the same nurse completed a Rule 35 report. The report merely repeated the detainee's account of torture. It failed to provide any information about the physical or mental effects of the torture on her health. There was no objective professional assessment – for example, commenting on the physical and mental injuries sustained following her torture. No concern or opinion was expressed.

A response was dated four days later (outside the required time frame) and stated that her asylum claim has already been refused and her appeal hearing was upcoming. This reasoning demonstrates a failure to understand Rule 35 as a safeguarding tool. She was not released from detention.

The Rule 34 assessment by the doctor did not provide a detailed mental and physical assessment either. The GP merely recorded "Nil concerns". The history of sexual violence or torture was not addressed by the GP. There was no routine sexual health screening offered to the detainee on arrival. (This would not be in line with the current BASHH national guidelines). The detainee did however have a HIV test after one month in detention but only following her own request.

In a later consultation it was noted that her mental health had deteriorated and that she was suffering from low mood, insomnia, nightmares and suicidal ideation. She was placed on a raised awareness plan and was commenced on antidepressants by the IRC GP.

Following another two months in detention a Medical Justice independent doctor produced a medico-legal report. The doctor found her scars to be consistent with her account of torture. The report noted she was suffering with PTSD and expressing suicidal ideation. The doctor concluded: *"The Istanbul Protocol requires a medical examiner to make an overall evaluation based on the totality of their clinical findings. ... My professional opinion is that there is a substantial likelihood that [Leila] was subjected to the violence she described."*

She was finally released following her successful deportation appeal and now has refugee status.

### Key Screening Failings:

- **Failure to screen mental and physical health adequately in Rule 34 assessment**
- **Rule 35 report completed by a nurse rather than GP**
- **Failure to document clear objective clinical assessment of health concerns in Rule 35 report**
- **Failure to offer STI testing (and psychosocial support if needed) to victims of sexual violence, as advised by BASHH guidelines**

## 6. Hemingway: Failure to do a Rule 35 Report and Failure to accurately report the method of release

Hemingway was in detention for over 5 months. He is a victim of torture with scarring on his legs and thighs and suffers from visual impairment as a result of his trauma. His scarring was found to be consistent with his account of torture and he was also diagnosed with psychotic illness by an independent doctor. During his time held under immigration powers, Medical Justice sent three independent doctors to see him, all of whom called for his release from detention. A Rule 35 report was never produced for him.

After two months in detention, the first independent doctor diagnosed psychotic illness with auditory hallucinations and paranoid thoughts. The doctor wrote: "Given his current condition I believe that it is detrimental to his mental health to detain him at the immigration detention centre.... He requires psychiatric evaluation and treatment as a matter of urgency."

By the following month, Hemingway's mental health continued to deteriorate and he began a hunger strike. A second Medical Justice Doctor was then sent in to visit him. By this point, he had lost 17.5% of his body mass putting him at risk of re-feeding syndrome. The doctor noted in the MLR poor management of his health needs, poor record keeping and a failure to monitor his food refusal and take the necessary blood tests. She concluded that "he cannot be given the care he needs in detention". This failed to secure his release.

Medical Justice sent a number of emails of concern about his health in detention and asked whether a Rule 35 report had been done and if not, requested that one was done. A response was never received about this matter and detention was maintained during the regular monthly reviews.

The subject access request file confirms that healthcare in detention never did a Rule 35 report. However, when Hemingway was admitted into hospital as a result of his hunger striking, a third Medical Justices doctor visited him and wrote a preliminary psychiatric assessment email. This doctor asked for the email to be considered as a Rule 35 report. The email offered a preliminary diagnosis of Persistent Delusional Disorder (ICD F22) and highlighted the negative effect of detention on the patient and outlined Harmondsworth's inability to manage his health.

*'A return to Harmondsworth, which has failed previously to provide psychiatric assistance in good time, despite medical advice to obtain this, would similarly risk exacerbation of his illness. In light of this past experience, it must be doubted whether Harmondsworth has the necessary resources to meet his psychiatric needs.'*

Despite the clear findings of the third Medical Justice doctor and the hospital's own consultant being put to the authorities, Hemingway was discharged from hospital. This was despite the hospital's house doctor and consultant both stating that Hemingway was not psychologically fit to be discharged and should instead be moved to a specialist mental health ward. Hemingway was re-detained in the immigration estate.

Over 5 months after being initially being detained, Hemingway was granted High Court bail on the condition that he be transferred immediately by the authorities to hospital for an urgent psychiatric assessment and treatment. The authorities were ordered to meet the costs of the private medical care.

An analysis of the CID internal case notes shows that the UKBA caseowner recorded the outcome of the Rule 35 report as "released", thus, giving the impression that he is released through the Rule 35 process rather than through the Order of the High Court. This method of data recording is inaccurate and fails to capture that healthcare in detention failed to ever conduct a Rule 35 report despite numerous requests and also falsely gives the impression that he was released through the Rule 35 mechanism.

### Key Failings:

- **Failure to conduct a Rule 35 report despite external requests**
- **Failure to satisfactorily manage his serious mental health issues**
- **Failure to release him despite medical evidence of psychotic illness, clinical recommendations to release him and his continued hunger strike**
- **Inadequate management of food refusal**
- **Failure to keep accurate records**
- **Recording incorrect details on the CID notes will skew future audit results**

## 7. James: Rule 35 process working

James fled to the UK having been detained, interrogated and tortured by government authorities. At his asylum screening interview, he alerted the caseowner to his experience of torture and the medical problems he had.

However, he was placed on the DFT process and sent to Harmondsworth IRC. After one week in detention, he was released from detention and taken off fast track as a result of a Rule 35 report written by a doctor.

James did not have a Rule 34 done. On day 2 of his detention, concerns were raised by Medical Justice to Harmondsworth that regular medication had not been prescribed and that the detainee reported a history of torture, reporting scarring and suffering psychological symptoms. An independent doctor also saw him that day noting he had PTSD and various ongoing physical problems from his torture including lower abdominal/genital pain, headaches, vomiting, and nausea. His scars were found to be “highly consistent” and the cigarette burns were deemed to be “typical” and “consistent”. By comparison, the IRC healthcare records documented no past physical or mental health conditions and no history of torture.

The detainee then first saw an IRC doctor on day 4 of his detention. The notes read as follows: “Says he has a rash on scrotum, examined – not seen. Has itchy large papules on chest, he has had these for many years. I can’t see need for anything else..”

On Day 7 of his detention, a Rule 35 report was completed. The report was barely legible with hardly any information contained in it at all. The account of torture was brief, and did not include where, why and who committed the

atrocities. The doctor made a comment on the scars on his body, stating that the “Keloid scars on chest do not look like cigarette burns but the other marks on the rest of the body (arms and legs) do. Nothing on back.”

A response was received the following day, which facilitated his release from detention. The caseowner wrote: “It is noted that the doctor has noted that the scars on your arms and legs look like cigarette burns. Based on these observations you(r) case is not longer deemed suitable under the Fast Track process and your release is being arranged.” He was subsequently released.

However, upon reviewing the medical notes, it is clear that the Harmondsworth IRC did not believe his account of torture. The medical notes read as follows (as inserted on day 7 of his detention): “Torture form complete...papules on chest- he now says they are from cigarette burns – I doubt this.” No further description of torture is written, no evidence of assessment of mental health by the doctor is undertaken, and the scars are not described further. The notes were not signed.

### Key Points:

- **Failure to identify torture victims promptly and internally**
- **Poor record-keeping**
- **Disconnect between healthcare notes and Rule 35 reporting**

## 8. Oliver and Sam: Failure to do a Rule 35 Report

### Oliver

Oliver was held under UK immigration powers for 14 months at Haslar IRC. During this time, no Rule 35 report was completed despite the detainee reporting a history of torture and having independent supporting medical evidence; multiple scars including a neurosurgical scar, severe PTSD and depression. Concerns were raised by outside agencies such as Medical Justice and Haslar Detainee Visitors group that no Rule 35 had been completed.

Oliver was arrested and detained by his government and subjected to repeated torture. He gave an account of being beaten on the soles of his feet, neck and back by a blunt instrument; he was also given electrical shocks; weights were suspended from his testicles and he was subjected to instrumental rape. He also sustained a severe head injury resulting in a depressed skull fracture; he was admitted to hospital for emergency neurosurgery.

Prior to his detention in the UK he had a report by the Medical Foundation for Victims of Torture. The report outlined his current medical problems secondary to his torture including, dizziness, seizures following a severe head injury, chronic neck and back pain, rectal pain and bleeding, anxiety, insomnia, flashbacks, suicidal ideation and depressive symptoms. The doctor concluded: "having listened to his account and taken into consideration his way of life, experiences, demeanour, and findings on examination, I have no reason to doubt his account."

At his initial health screening it was noted that he had an "old depressed fracture and suffered from insomnia". When asked whether he was a victim of torture, he responded "yes". However, no Rule 35 report was done. The Rule 34 assessment also recorded his account of torture but no reason was documented for not including a Rule 35.

An MLR noted that he had multiple scars, which were either typical or consistent with his account of trauma. He had a depressed skull fracture and neurosurgical scars, which were diagnostic of his account. He fulfilled the diagnostic criteria for PTSD. He was later reviewed by an independent consultant psychiatrist who also diagnosed PTSD.

After 5 months of detention, a befriender from the Haslar Visitors Group wrote the following to the Medical Justice casework manager to raise concerns:

*[Oliver] has requested the rule 35 report and was told he couldn't have one. I have spoken to [Healthcare staff] at the Medical Centre and was told bluntly that she saw no point in her doing one. She said that UKBA already have the Medical Foundation report and that a Rule 35 report was not needed as well. She said that all the reports she*

*had done in the past have made no difference... She also said she didn't want to do the report as she felt it would give [Oliver] false hope.'*

This information was corroborated by the Haslar medical notes, which indicate that there was some confusion about whether it was appropriate to complete a form at all. Below shows an example of a healthcare manager documenting that they would not do a Rule 35 form for a detainee with a known history of torture and scarring as they had contacted UKBA and were informed that it was not "worthwhile" as UKBA were "already aware of past torture". See the excerpt below from the medical notes:

██████████ - Healthcare Centre  
D/W ██████████ UKBA manager at Haslar. MFVTR letter was submitted in ██████████ and was considered, still part of his monthly reports from his caseworker. There is no indication to raise a Rule 35 form.  
Liaising with agency  
No!

██████████ - Healthcare Centre  
Télécon from a member of HVG this evening.  
Requesting that we send a Rule 35 form to UKBA ref Mr ██████████. Advised that UKBA already aware of the torture as MFVTR letter sent to them. I will d/w UKBA manager to ascertain whether or not raising this form would be worthwhile in this case.  
Liaising with agency - Haslar Visitors Group  
No

██████████ - Healthcare Centre  
Informed me last Friday ██████████ that he had been advised from Haslar visitors to have a rule 35. Assured that when he arrived at Haslar and told us about his documentation from Medical foundation they sent his evidence to ukba. Immigration already aware of past torture.

After another 9 months, he was eventually released from detention and has recently been granted asylum.

### Key Failings:

**This example demonstrates an inappropriate refusal by healthcare staff to complete a Rule 35 for a detainee who:**

- disclosed a history of torture on healthcare screening**
- had evidence of both physical and mental problems secondary to torture including a depressed skull fracture**
- had reports from three independent doctors**

**There was also a failure to follow NICE guidelines for the treatment of depression and PTSD.**

## Sam

Sam was detained at Colnbrook IRC for 3 months. He is a victim of torture who was repeatedly beaten; subjected to extreme temperatures and forced exercise; and beaten by electric cables on the soles of his feet. He was kept in solitary confinement with a poor diet and unsanitary conditions.

Prior to being detained at Colnbrook IRC, Sam had two medical reports completed. These reports gave an account of his torture and both concurred that he had PTSD secondary to torture and a depressive illness. The IRC doctors and the UKBA case owner would have had sight of these documents.

At his first medical screening it was noted he was taking regular antidepressants and sleeping tablets but they were not prescribed, as the detainee was unsure of the names of his medications. There is no documentation in the notes that healthcare made any attempt to find this information from his previous GP. His medication was therefore stopped abruptly on arrival into detention. (Stopping his antidepressants suddenly could cause severe withdrawal symptoms and/or could lead to a worsening of his depressive symptoms.)

There was no Rule 34 assessment by a doctor in the notes and there was no consultation recorded in the notes until 15 days after his initial screening when the detainee himself requested his medications to be prescribed.

Although he did not declare torture at the initial health screening there were multiple later indications for a Rule 35 report to be generated. Throughout his medical notes there were allegations of torture and the diagnosis of PTSD was recorded multiple times. For example the IRC doctor wrote *"known PTSD and Depression, currently on Zopiclone and Citalopram".* A consultant psychiatrist in detention noted a history of torture *"He was arrested for suspected terrorism... He was tortured with cold water, physically assaulted..."*

An MLR was completed by an independent doctor and found that he was suffering from severe PTSD, insomnia and recurrent chest pain, highly suggestive of angina. The report advised that in light of his family history of heart disease and stroke, and his recent high cholesterol, he required *"urgent, comprehensive, cardiology review."* The doctor concluded that *"Detention, causing stressful reminders of his alleged torture, appears to be worsening his angina-like symptoms and could lead to an acute coronary syndrome.... I must advise that he be removed from detention forthwith for a full medical assessment and to ameliorate the danger of a possibly worsening heart condition."*

Following release from detention, he was reviewed by another psychiatrist who diagnosed PTSD and Major Depressive Disorder.

The doctor summarized in the report:

*"He travelled to the UK and was detained. I note that the medical record clearly refers to a history of torture as well as to a psychiatric disorder. I do not know why there is no record of a report under rule 35. In my view, this would have been appropriate... I regard both the PTSD and depression as established conditions. They were not caused by detention in the UK, merely exacerbated."*

He was recently granted leave to remain under Article 8.

### Key Failings:

- 1. Failure to complete Rule 34, to obtain past medical records and to prescribe regular medications in good time**
- 2. Failure to complete a Rule 35 when history of torture and diagnosis of PTSD were recorded by both detention centre doctor and an independent psychiatrist.**
- 3. Failure to raise concerns by Rule 35 despite evidence of deteriorating mental and physical health in detention.**

## 9. Casper: Third Country Case

Casper has a history multiple episodes of incarceration and torture in Sri Lanka since 2000. He had previously claimed asylum in France but this asylum claim had been rejected and in 2010, and he was deported to Sri Lanka. Upon arrival in Sri Lanka, he was detained for a month, during this time he was repeatedly beaten with iron bars, burnt with cigarettes and raped.

Prior to his detention, Casper had a known history of severe PTSD and he had made two serious suicide attempts. He was under the care of the local Mental Health Service Crisis team and had been started on an antipsychotic and an antidepressant.

He declared his history of torture and medical problems during his asylum interview and was detained in an IRC for a period of 3 months.

The IRC GP recorded in the medical notes: "Seen with translator, history of PTSD with psychosis, reports intense voices at night... voices of police men telling him to kill himself, images of police and flashbacks of being tortured and raped which took place following his arrest..."

The doctor also noted "several burn marks (compatible with cigarette burns) on both arms, rectangular scars of varying lengths on his back and similar scars on the back of both thighs according to him from metal bars (consistent with history)".

He was also assessed by a consultant psychiatrist whilst in detention, who documented:

*"Mental State examination found him to be incredibly distressed, jittery and jumpy. His speech was rapid. His mood was low and anxious... He was helpless and terrified of being deported. He described flashbacks at night of his torture and auditory hallucinations... My impression is of severe Post Traumatic Stress Disorder which has worsened in detention, I would strongly recommend consideration given to releasing him. He can be linked back up with the Crisis and the Home Treatment Team."*

Despite disclosing his history of sexual violence he was not offered a sexual health screening for HIV or sexually transmitted disease or counselling.

Other detainees were also used as translators for medical consultations on some occasions. This was inappropriate given the highly difficult nature and culturally sensitive issue of discussing mental health issues torture and rape.

An MLR that was completed while he was in detention recorded several scars that were either highly consistent or diagnostic of his account of torture.

A Rule 35 report was produced on his first day in detention but this failed to secure his release. A second Rule 35 report was completed after one month in detention and was noted to be an "update" on the earlier report. This was only completed after a Medical Justice member of staff wrote to the healthcare team responsible for his care asking why a report had not been done for him.

The doctor noted on the second Rule 35 form, "Physically and mentally abused. Burned with hot iron rod on back and thigh. Burnt with cigarettes and kicked in the head with boots. Raped." "He feels dizzy and gets a lot of headaches. Has nightmares, feels anxious, back pain and leg pain. There are scars on his back, thighs and right leg. Also scars on his chest."

Despite being previously described in detail in his medical notes important clinical information was not transferred from the medical notes to the Rule 35 form, such as comments on the consistency of his scarring or the severity of his psychological symptoms. His suicidal ideation and diagnosis of PTSD prior to detention were not mentioned. No conclusive commentary is offered and no opinion is expressed.

The response from UKBA was cursory and did not make any reference to the clinical concerns raised. The wording of the response was standardised and was seen in many of the third country cases:

*"I have been informed that you are concerned about returning to Sri Lanka... Firstly, I would like to assure you that we are not proposing to remove you back to your country of origin but to a safe third country (France). Consequently, you will be able to raise any issues or concerns you have about your country of origin with the French authorities once returned there. Whilst I acknowledge that you are finding it difficult in detention, France has accepted responsibility for your asylum claim. As France has accepted responsibility removal directions are currently being set and you will be informed imminently of your proposed removal date. I am therefore satisfied that your detention remains appropriate."*

UKBA subsequently set removal directions, however the IRC doctor found him not fit to fly given his severe PTSD, chest pain and passing blood from his back passage.

In the CO notes, the following is written: "Given the 'not fit to fly' I suggest that detention is no longer merited." The minute note states: "Due to the subject's medical grounds Third Country can no longer run this case. The subject has been diagnosed with a medical mental illness and is suffering from PTSD therefore has become incoherent. Therefore the subject is unable to be detained and is not fit to fly. Therefore case to go substantive and asylum to be considered substantively."



Casper was eventually released and received refugee status (LTE/LTR).

### **Key Failings:**

- 1. Lack of clinical information recorded on Rule 35**
- 2. Failure to reconcile Rule 35 process with the Dublin Convention on Third country Cases**
- 3. Failure to understand that Rule 35 is a release mechanism relating to safeguarding rather than part of a substantive claim**
- 4. Incorrect to refer to the Rule 35 report as a “concern” of the detainee rather than a clinical concern raised by the IRC doctor**
- 5. The use of standardised paragraphs in the Rule 35 response mean that case owners do not fully consider the content and implications of a Rule 35 report**
- 6. Use of fellow detainees as translators (highly inappropriate given culturally sensitive nature of discussing male rape)**

## 10. George: Harmful impact of detention; mental health deterioration owing to poor screening and poor management

George suffered torture at the hands of the state security forces. Prior to arrival in the UK, George had been diagnosed with schizophrenia and treated with antipsychotic medication in hospital. Upon claiming asylum, he was immediately detained and assigned to the DFT process.

George spent over 3 months in detention. During this time, his health deteriorated significantly. Despite being a victim of torture with a severe and enduring mental illness, he did not have a Rule 35 report completed during his time in detention.

His initial medical screening at Harmondsworth failed to record his medical conditions or his prescribed medication. However, in his home country he had been diagnosed with schizophrenia and had been treated with antipsychotic medication as an inpatient. He was not provided with an interpreter during his initial screening despite having poor English. A nurse performed the health screening and he did not see a doctor on admission for a Rule 34 assessment as he refused. However, it is unlikely that he was explained the purpose of a Rule 34 assessment, which could have elicited valuable information about his mental health and torture, which thereon could have indicated that detention was inappropriate.

As a result of the inadequate screening he was not prescribed appropriate medication for almost two months whilst in detention.

He first saw a doctor 33 days after first being detained. It was noted he was distressed, complaining of hearing voices and requested help. No medication was prescribed; no counselling or support plan was put in place. He was referred to a psychiatrist on a non-urgent basis.

In another consultation he saw a nurse and asked for medication, stating that he was depressed and could not sleep. He explained that he had been on medication for the past 15 years – the nurse referred him to the GP.

A consultant psychiatrist saw him two months after he was initially detained. His condition had deteriorated. It was documented that he appeared “distressed, agitated and refused to sit down”. It was also documented that he was self-harming by banging his head against a wall.

The psychiatrist recorded a diagnosis of possible schizophrenia and advised that he be admitted to the in-patient unit of Harmondsworth IRC, for observation and treatment; he prescribed the anti-psychotic medication olanzapine, and the sedative benzodiazepine, lorazepam. However, instead, he was placed in segregation: this was a key failing in his clinical management.

A Medical Justice doctor wrote an MLR and stated he “has a [documented] history of schizophrenia and currently is showing signs of an acute psychotic episode.” She stated “This might be due to stopping medication at the time of his detention, or to the adverse effect of detention on his mental health, or to both”. She recommended that he be released from detention as detention was having a negative impact on his health: “with the change in his medical condition since his detention, in my opinion Mr XXX should therefore not be detained.”

After around 6 weeks in detention, George began hunger striking and refused monitoring. This suggests further deterioration in his mental state.

Rather than immediately releasing him from the DFT process, he remained in detention whilst his health deteriorated. Removal directions were set twice despite two independent doctors recording that he was suffering from an acute psychotic illness.

George was eventually released after 3 months after newly instructed solicitors made fresh representations on his behalf and issued judicial review proceedings in which he challenged removal directions. He never received a Rule 35 whilst in detention.

### Key Failings:

- 1. Failure to capture physical and mental health issues at medical screening**
- 2. Failure to use an interpreter at the medical screening**
- 3. Failure to explain the purpose of a Rule 34 assessment**
- 4. Failure to keep adequate records when individuals are transferred to IRCs**
- 5. Failure to complete a Rule 35 report**
- 6. Failure to get provide appropriate psychiatric assessment on admission, or satisfactorily treat his serious mental health issues**
- 7. Failure to meaningfully review his detention given his medical condition and supporting medical evidence**

## 11. Alex: Ignoring medical advice

Alex's first asylum claim was refused by UKBA. His representatives withdrew shortly before the hearing of his appeal and he attended the hearing without legal representation and without any medical evidence being submitted on his behalf.

Alex was detained in the UK for a period of 4 1/2 months despite visible scarring on his body and a wealth of medical evidence during this period indicating firstly that he had severe PTSD linked to his traumatic experiences and secondly that continued detention was detrimental to his health.

During this period, Alex was moved around the detention estate starting in Colnbrook, subsequently moved to Tinsley House and then Brook House, before then being returned back to Tinsley House.

His mental health deteriorated significantly in detention as evidenced by notes of psychotic episodes, suicidal ideation and a serious suicide attempt, food refusal, and a prolonged period on ADCT. His physical health also seriously deteriorated and he was transferred to hospital dehydrated, bradycardic and hypotensive secondary to poor oral intake.

A diagnosis of PTSD and depression along with his history of torture were documented on his Rule 34 admission assessment. After 1 month in detention his mental health deteriorated, he appeared extremely distressed and suicidal. He was referred to a NHS consultant psychiatrist who diagnosed severe PTSD. During his time in detention he was reviewed multiple times by the consultant psychiatrist, who wrote multiple letters to the IRC expressing clinical concern about the harmful impact of detention.

Furthermore, a psychotherapist who assessed him whilst in detention also wrote several letters to the IRC expressing concerns. In one letter she wrote, "Detention does not represent a safe place for [Alex], and separation from community support exacerbates the situation. I recommend that he is released to be with those people and seek a specialist psychotherapeutic treatment for trauma'. In later correspondence to the medical team at Tinsley house the psychotherapist wrote "Mr XXX continues to have florid symptoms of PTSD, which will not improve, in my clinical opinion, whilst he is in detention."

A Medical Justice independent doctor wrote to the IRC and also raised concerns: "He is evidently suffering from severe complex post traumatic stress disorder following his experience in the genocide... His flashbacks are precipitated by people banging at the door of his room, by images of Rwanda, and probably by the experience of being incarcerated in general. ...Numerous staff have

expressed concerns about his mental wellbeing... I would have significant concerns that his deportation would result directly in a deterioration in his mental state."

Two Rule 35 reports failed to secure his release. The initial Rule 35 report was completed by a nurse in healthcare and stated: "This gentleman who was very anxious at the time of interview showed scars to his head which were as a result of torture ... Reported to be currently suffering from flashbacks." There is no body map despite Alex having multiple scars including a scar on his forehead secondary to a machete attack. No reference is made of the impact of detention on his health; no severity of concern is expressed.

A Rule 35 response received on the same day reads as follows: "The rule 35 application states that you have scars on your head as a result of your torture in your home country... We do not accept that you are a victim of torture as you have submitted no evidence nor previously claimed to have been ill treated in your home country in any of your applications or legal submissions."

A second Rule 35 report was completed a month later, in which the Doctor records a diagnosis of PTSD. However, the Rule 35 report failed to secure his release. The response received stated: "We are awaiting a full report in relation to your diagnosis... I am awaiting a timescale on the resolution of his representation before further considering your detention again." It also stated: "your medical needs are currently being met'. However, at the same time an independent GP wrote: "I suspect that his ongoing incarceration is exacerbating his mental illness... I feel his incarceration is highly prejudicial to his health."

After around 3 months in detention an IRC GP found him fit to fly and removal directions were set. However, the flight was cancelled after an MP's intervention of concern. Following a failed removal and a serious suicide attempt by attempted hanging, the psychiatric consultant assessed him again. He reiterated: "[He] continues to have depressed mood and severe flashbacks... I strongly recommend that he is released on bail... He needs specialised psychological support for his PTSD symptoms, which is not available in detention."

Due to growing concerns and the lack of apparent response to his previous medical advice he requested that his report be considered a Rule 35 report. He wrote "I am copying this letter to xxx, caseworker at UKBA to consider this under Rule 35 ... in my opinion, further detention will be particularly harmful to him as a ... survivor with a mental illness." The GP forwarded this to UKBA with a covering letter in which he provided his opinion that Alex was not fit to remain in detention.

This report still failed to release him from detention. Instead, his solicitor launched a judicial review against his upcoming removal directions and this finally secured his release.

### **Key Failings:**

- **Failure to properly apply (the then existing) policy that torture victims and people with serious mental illness which cannot be satisfactorily managed in detention should only be detained very exceptionally**
- **Failure by UKBA to release from detention despite Rule 35 and a wealth of medical evidence from diverse sources warning detention is injurious to health**
- **Failure to adequately respond to clinical concerns raised in multiple Rule 35 reports**
- **Inappropriate management in detention, including the use of restraint, locating him in isolation for lengthy periods and the use of handcuffs for external medical appointments**
- **Proceeding with removal in the face of clear evidence that Alex was medically unfit to be removed**

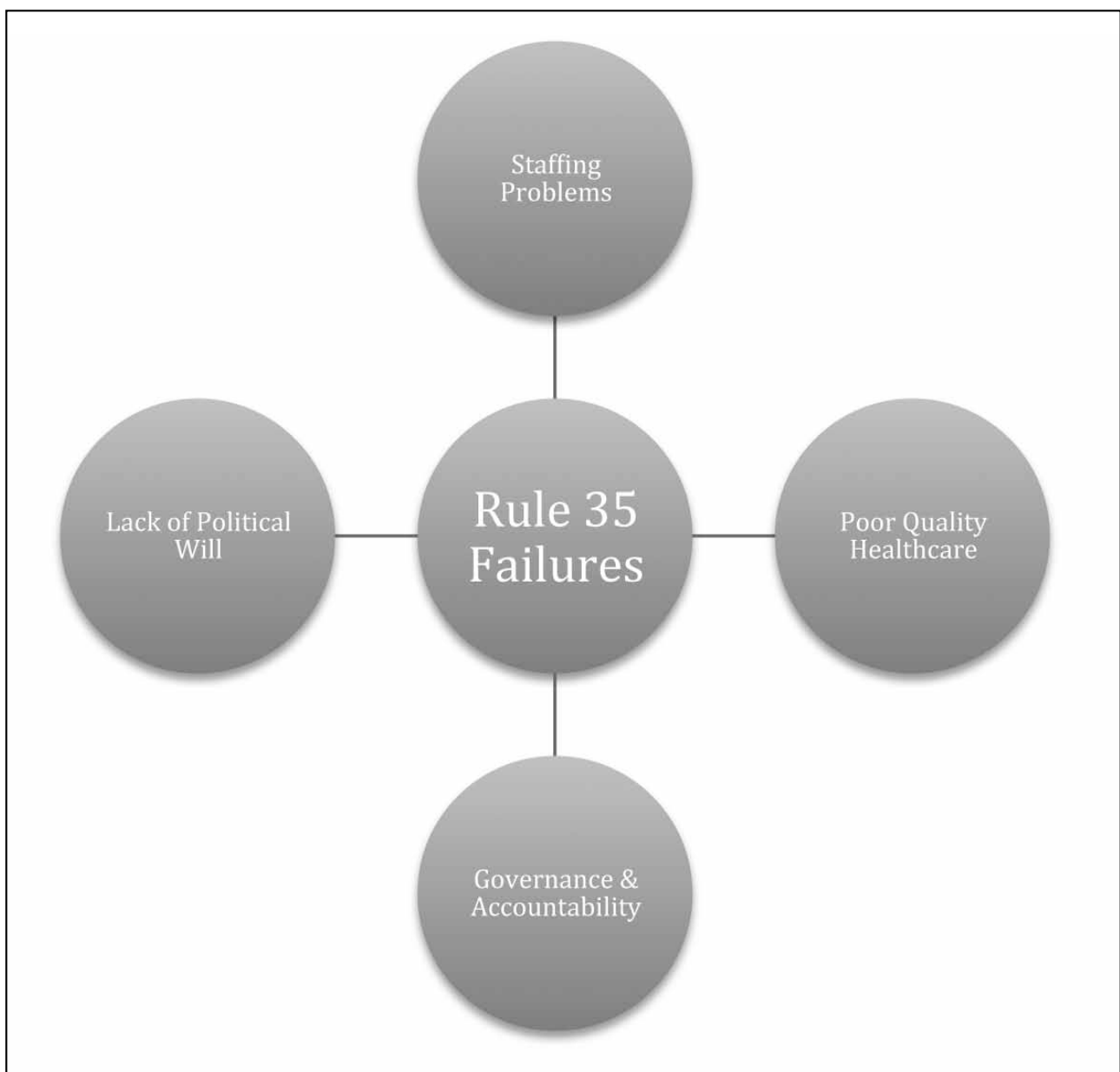
# Chapter Nine – Discussion

An analysis of 50 case files, together with a review of policy documents and independent monitoring reports, all demonstrate the historical, systemic and continuing failures of the Rule 35 process.

The process breaks down at every stage and responsibility falls on all the parties involved. The reasons for process failure are multiple and cut deeper than being solely

administrative. Indeed, the problems that this report has identified, find their roots in the institutions that hold a responsibility within the Rule 35 process: their histories, functioning and objectives are crucial.

As noted in the diagram below, four key themes contribute to the failures in the Rule 35 process.



## 1. Staffing problems – knowledge gaps and attitudinal problems

Competency and attitudes of the staff involved in implementing Rule 35 have been found to be one of the root causes of why Rule 35 fails. There are three important strands within this theme, which will be discussed:

- i. Lack of knowledge and training
- ii. Attitudinal problems: UKBA staff
- iii. Attitudinal problems: healthcare staff

### (i) Lack of knowledge and training

The results point to a flawed understanding of the purpose, aims, and process of Rule 35 amongst staff that are involved in implementing the process, notably UKBA caseowners and IRC healthcare staff.

Healthcare staff had not received formal training in the assessment and management of victims of torture. Therefore, staff appeared to be unclear about their role in determining a detainee's fitness for detention and the impact of detention on their health. There is no clear guidance on what clinically relevant information should be sought and included in the Rule 35 assessments and the lack of training also impairs the staff's ability to offer appropriate support to detainees.

There was a failure to generate Rule 35 reports for some individuals who were known to be torture survivors. This could be for a number of reasons including resource pressures, a lack of knowledge of the process, a misunderstanding over what constitutes torture, as well as the perceived inefficiency of the system itself.

Poorly or partially completed Rule 35 forms and a failure to provide a body map demonstrate a lack of understanding about what information should be contained in the reports. Relevant clinical information was often lacking, in part owing to a failure to refer to the patient's medical notes and undertake a proper examination. Thus, in many cases, the information provided does not assist caseowners in making informed decisions about whether detention is injurious to detainees' health and indeed whether the doctor is concerned a detainee may be a victim of torture.

The case studies show examples of healthcare staff being unclear about their role in initiating a Rule 35, with reports being requested by outside agencies or detainees themselves, rather than being generated through clinical concerns raised within the IRC. Instances where nurses complete Rule 35 reports demonstrate a failure to abide by the Detention Centre Rules 2001 and the Operating Standards. The root of this is likely to lie in a lack of knowledge about the Rules and who should be writing the reports, together with resource pressures.

The results highlight the lack of detail offered in the

reports, the failure to express an opinion and often to even identify signs of torture. This strongly indicates a knowledge deficit of Rule 35 purpose and process and the wider Detention Centre Rules relating to healthcare (Rules 33-37).

This knowledge deficit also extends to UKBA caseowners who are responsible for reviewing detention on receipt of a report. The findings have shown that caseowners fail to understand the purpose of Rule 35; fail to provide adequate or reasoned responses; and are unable to interpret the information in the reports. Indeed, UKBA caseowners are not trained on how to interpret medical evidence, which contributes to this knowledge gap. The over reliance on standardised "cut and paste" paragraphs also suggests a refusal culture where reports are categorised and evidence is ignored. This is in particular noted in third country cases. However, in other cases, ill-reasoned and ill-judged responses are also commonly provided, such as a lack of "diagnostic finding", which sets the burden of proof too high.

The non-existence of a functioning feedback loop, between the doctors completing reports and the caseowners making decisions on detention, perpetuates the cycle of process breakdown. The control management team (CMT) team who are the middlemen between the IRC healthcare teams and UKBA caseowners have been found to miss deadlines and to not identify or follow up on poor reports and/or responses. Thus, where reports do not provide adequate information or responses do not fully address medical concerns there is a failure to communicate on the part of CMT and caseowners. This issue is of vital importance and shall be revisited, but it must be noted that this disconnect contributes to the lack of accountability.

### (ii) Attitudinal problems: UKBA staff

A recurring issue that has come to the fore in the course of this research has been attitudinal problems. This relates to both UKBA caseowners as well as to IRC staff including healthcare staff.

Detainees who completed the questionnaire felt their torture claims had been poorly dealt with by UKBA, in particular in relation to doubting their credibility. One individual wrote: *'The Home Office did not believe me even though I had scars on my body to prove it.'*

This is supported by the responses to Rule 35 reports, which overwhelmingly were dismissed on credibility grounds. Dismissing (torture) claims on the basis of credibility is nothing new. There is a wealth of literature available in the public domain that talk of a "culture of disbelief" that is pervasive in the UKBA institution as well as the failure amongst caseowners to adequately assess credibility.<sup>168</sup>

Malmerg<sup>169</sup> uses theorisations to look at how the UK government describes its policy on the detention of

asylum seekers and how this policy is practised. The analysis is related to a framework of 'humane deterrence', which contains the logic of how states can discourage people from migrating.

Malmberg argues that the policy objective of deterrence relies upon the discourse about mistrusting asylum seekers to uphold the logic of detention. He writes: 'This is evident not only in terms of the validity of an asylum claim, but also when it comes to suspecting that asylum seekers will abscond, which is one of the main grounds upon which detention is legitimised. As mentioned earlier, absconding rates are estimated and guessed at, without any backing of research. This 'culture of disbelief' has become institutionalised in the UK immigration system.'<sup>170</sup>

Drawing from rare access to UKBA staff, the concept of the culture of disbelief was discussed in a 2010 research report. One UKBA caseworker noted the following:

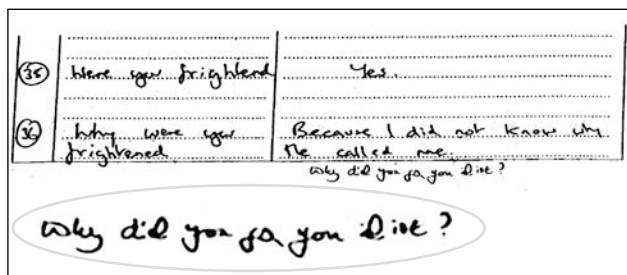
*'If you hear the same story over and over again, it's hard not to, but you kind of become quite cynical to it you know (...) I think it's people's personalities not so much a widespread thing... We should look at things on a case-by-case basis but ... your experience can build up some sort of level of cynicism in each caseworker... I think we're in a job where we, we can get lied to day in day out occasionally and it's really hard, really really hard to get over that (...)'<sup>171</sup>*

A recent study critiquing the concept of the "culture of disbelief" instead talks of a culture of denial. The author states: 'This evidence strongly suggests that disbelief is often one manifestation of a deeper pattern of denial, such as when disbelief is the end result of a prior refusal to engage with the facts of the case.'<sup>172</sup>

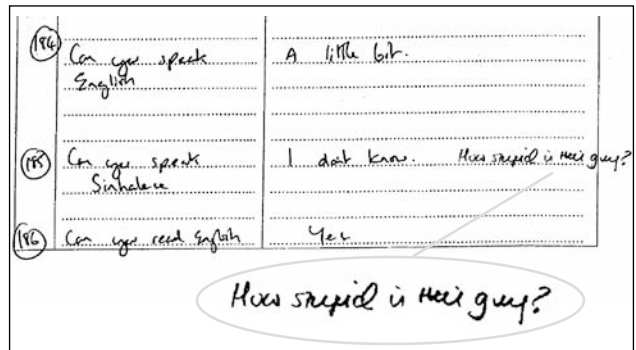
This is useful when examining how Rule 35 reports are dealt with. In the sample, there were a high number of responses that disengaged with the facts and failed to even acknowledge evidence on the basis that the allegations had already been assessed and rejected.

Furthermore, of great concern are the following set of annotations scrawled on one individual's asylum interview records. A copy of this was received through a Subject Access Request. The claimant is a torture victim from Sri Lanka whose claim was rejected by the Home Office.

**"Why did you go you idiot?"**

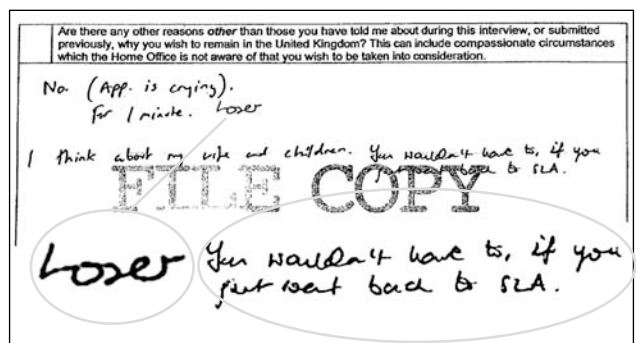


**"How stupid is this guy?"**



**"Loser."**

**"You wouldn't have to, if you just went back to SLA" [Sri Lanka]**



These abusive annotations raise significant concerns about the treatment of asylum seekers and in this case, the fairness of decision-making. When the applicant is crying, he is deemed a "loser" who should go back to his home country. This level of contempt is outrageous.

One whistleblower who worked at UKBA confirmed fears that UKBA staff demonstrated a deplorable attitude towards asylum seekers.<sup>173</sup> However, the Official Secrets Act and the closed nature of UKBA make it very hard to assess the existence and/or the severity of the problem.

Evidence points not only to the inadequate treatment of Rule 35 reports but also to general credibility findings in the initial decision making of victims of torture. Whilst the burden of proof rests with the asylum seeker, it is not always possible to provide evidence to corroborate claims before the initial decision is made. This is particularly the case in DFT/ DNSA cases.

A recurrent theme from the questionnaires was that the decision to detain is made without giving individuals the opportunity to explain their ordeals. One individual stated that s/he was: 'Never given a chance to explain my ordeal before being detained'.

Another wrote: 'The home office should always take time to listen to torture victims before sending them to detention... torture victims should not at anytime be detained because it leads to intrusive thoughts and nightmares and mental breakdown.'

A number of studies highlight the weakness in initial decisions. For example, Asylum Aid found that in the 45 women's cases they examined, 50% of initial decisions were overturned at appeal.<sup>174</sup> Similarly, in 12 cases analysed by the Poppy Project, 8 of 12 were overturned at appeal.<sup>175</sup>

Consideration of UKBA annual statistics paints a similar picture. In 2010, the total initial decisions made were 15,326. Of those, 4,022 were granted asylum or Humanitarian Protection/ Discretionary Leave, a 26% success rate. In 2010, 8,943 appeals were lodged and of these 2,251 or 25% were allowed.

Whilst this report does not seek to examine reasons for poor decision-making, it is important to examine the role of trauma in negative credibility findings: how trauma may lead to late disclosure thereon leading to negative credibility findings. This has played a crucial role in the affairs of the individuals in this sample: within both the decision to detain and maintain detention as well as in the dismissal of evidence contained within Rule 35 reports.

As noted earlier, the screening process is not conducive to identifying victims of torture. Not only do many torture survivors not understand the importance of raising their experience at this early stage but it is likely that many do not feel comfortable disclosing this information to a state official. Furthermore, UKBA caseowners conducting the screening are not trained on identifying torture victims and picking up on non-verbal signs.

It has been well documented that vulnerable individuals, and in particular torture survivors find difficulty in disclosure owing to feelings of pain, shame, stigma and denial.<sup>176</sup> Inconsistencies in accounts are also often deemed an indication of credibility issues rather than as a result of trauma.

Problems with memory recall and inconsistent accounts amongst torture survivors are common. 'Not surprisingly, torture victims may find it almost unbearably hard to discuss such de-socialising experiences. ... Because the pain of torture is inexpressible, attempts to express it may sound unbelievable.'<sup>177</sup>

Late disclosure of torture claims was one reason for the dismissal of a Rule 35 report and is also a common reason for doubting credibility in the determination of asylum claims. One study, based on interviews with 27 asylum seekers found that the majority reported problems of disclosure:

'Participants also reported experiencing psychological symptoms during Home Office interviews, such as dissociative experiences, flashbacks and avoidance behaviours (e.g. avoiding thoughts or feelings associated with the trauma and not being able to remember details), which had an impact on their ability to disclose. In summary, our results indicate

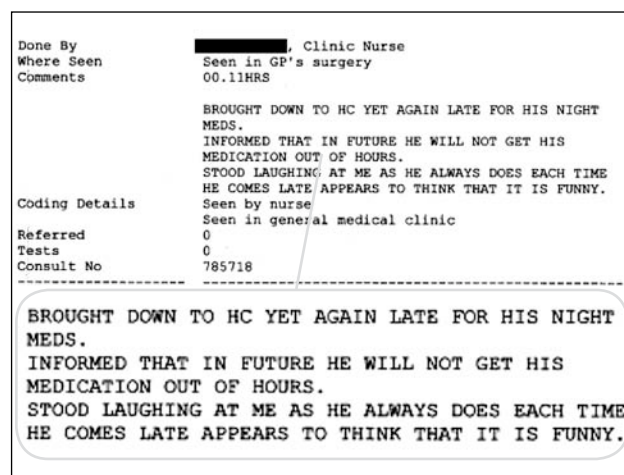
that late disclosure or non-disclosure during Home Office interviews does not necessarily imply a lack of honesty on the asylum seeker's part, and highlight that disclosure is complex and influenced by a variety of factors that need to be taken into account when judging asylum seekers' credibility based on the information they disclose.'<sup>178</sup>

The failure for the Rule 35 mechanism to work and the use of ill-reasoned standardised "cut and paste" responses must be put into context. An analysis of why detention is, for the most part, consistently maintained by the UKBA caseowner needs to be seen within the wider context of a refusal culture or "culture of denial".

### (iii) Attitudinal problems: healthcare staff

Attitudinal problems are also noted amongst IRC healthcare staff. The haphazard and careless reports suggest a blasé attitude towards the Rule 35 mechanism and/ or detainees. From the questionnaire results, it was clear that the detainees in the sample had a negative perception of healthcare staff with some noting inhumane treatment.

As discussed earlier in this report, the attitude of healthcare staff was also criticised in some of the HMIP reports, being described as "brusque" and "inappropriately abrupt". The example below shows an excerpt from a detainee's medical notes where a member of healthcare appears to become frustrated with a detainee:



Medical concerns were routinely ignored and medication was denied in some instances. It was reported that there was a reluctance to give proper standards of care: this included only acting when there was an emergency; no proper medical check-ups; long queues for medication; and long waiting times for specialist appointments. One individual stated: 'The healthcare services ... did not take detainees seriously when they were unwell. ... they wait until your condition is much worse before they refer you for treatment.'

Healthcare staff were described as 'awful', 'stropky', 'rude and unhelpful' with 'deplorable attitudes'. For example, one



individual wrote: *'They don't care and don't think we deserve to be looked after. In their words "Why waste NHS money on people who are about to be deported?"'*

Commentators have noted that a "culture of disbelief" exists amongst IRC healthcare staff.<sup>179</sup> Detention staff may become cynical when faced with new stories of torture and violent persecution. Lack of education and training on torture may make staff more likely to dismiss detainees' symptoms as attention seeking or for secondary gain if they present in an atypical way. Without adequate training and knowledge it is difficult for staff to differentiate those detainees who are genuinely distressed.

Many (ex) detainees felt their mental health problems deteriorated in detention, yet these were not dealt with adequately or professionally by staff. Indeed, what is striking about the Rule 35 forms is that they fail to cross reference any of the medical notes on the individual in question to attempt to either diagnose a patient or give the caseowner a full picture. Very few mentioned any mental health problems despite 43 individuals suffering symptoms of PTSD or depression as noted in the MLRs produced by Medical Justice independent doctors.

The recent HMIP annual report reported on healthcare delivery across IRCs for 2010-11. The following comments were made:

*'The quality of health care was inconsistent. In Harmondsworth, there were many complaints about brusque and uncaring provision, and clinical governance was weak. As elsewhere, the primary mental health needs of the detainee population were not adequately met. (...)*

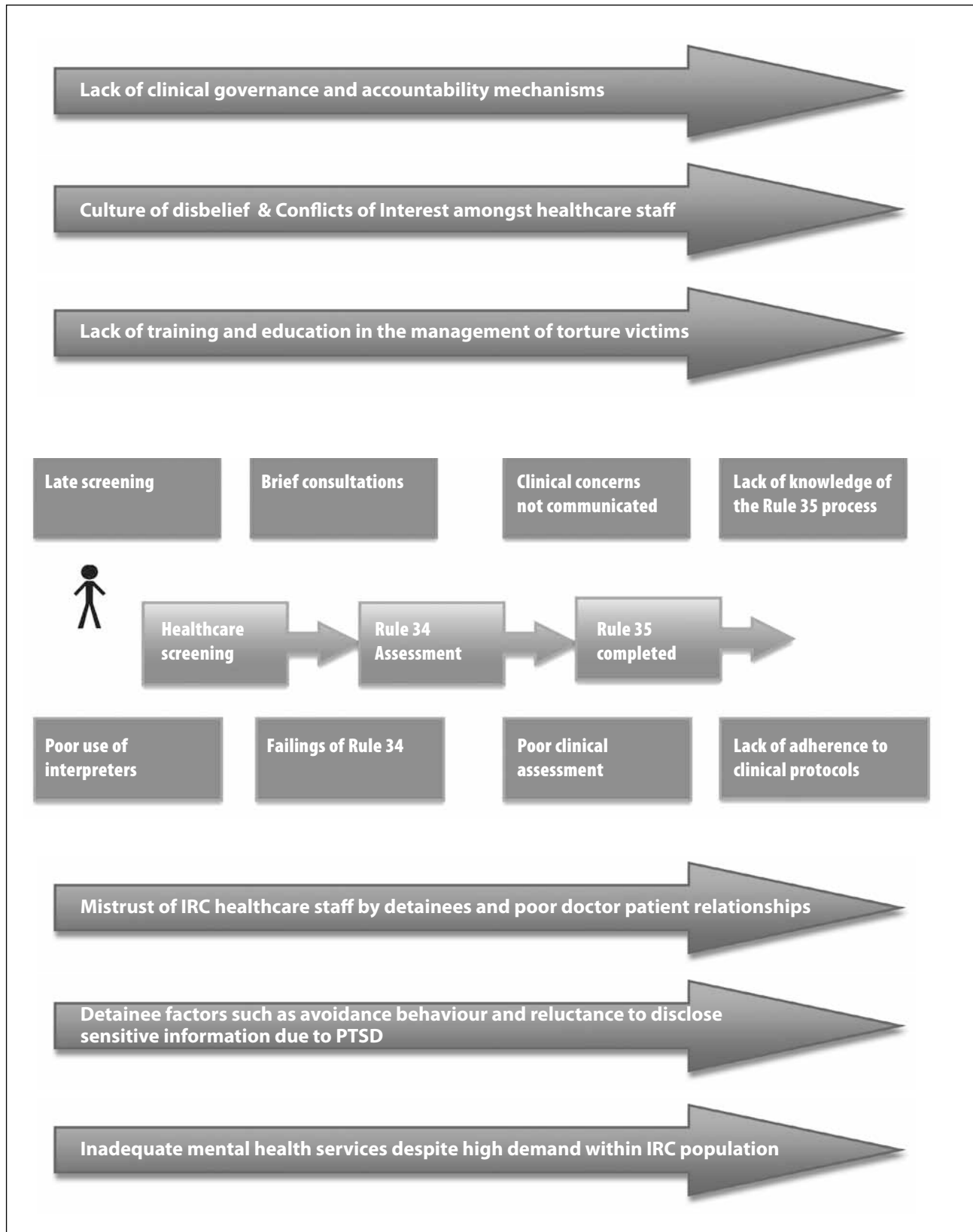
*'the process intended to provide safeguards for detainees who were not fit to be detained and/or had experience of torture did not appear effective. In all inspected centres, we found that 'Rule 35' letters written by doctors to advise UKBA of concerns about detainees' health often received cursory replies or no replies at all from case owner.'<sup>180</sup>*

## 2. Poor Quality Healthcare

The effective implementation of Rule 35 is dependent on the IRC healthcare system in order to safeguard victims of torture. The analysis of the medical notes however highlighted a number of failings that prevented victims of torture from being identified, clinically assessed or

managed adequately. The figure below demonstrates how these factors negatively impacted on the delivery of health services for detainees.

The current healthcare provision for immigration detainees is unsatisfactory. There were poor patient satisfaction rates within the questionnaires and poor documentation and management of detainees' health needs recorded within



the medical notes review. Vulnerable detainees such as torture victims are most likely to be susceptible to the inadequacies within healthcare.

The inadequate healthcare provision in IRCs has been noted by various commentators. Criticisms have included the failure to attend to the needs of vulnerable populations; incorrect medication prescribed; incorrect dosages offered; different medication prescribed that is a cheaper alternative; failure to follow guidelines; and a failure to offer adequate follow up care.<sup>181</sup> Procedural issues also impact on poor healthcare delivery, which includes transfers, poor record-keeping, times of screenings and a lack of interpreters.

### **Failure to meet the needs of detainees**

Detainees within the sample were held for long periods of time and had serious health problems. However, IRC healthcare services were not geared to meet the needs of these detainees. High rates of suicidal ideation, deliberate self-harm, food refusal and hospitalisation within the sample support the assertion that detention itself is likely to be detrimental to their health.

A number of independent doctors criticised the level of care delivered by IRCs in their MLRs. For example, one doctor wrote: 'He was diagnosed ... in December 2010. ... Appropriate treatment was prescribed, but the immigration centre health services failed to ensure that this medication was provided for him during his transfer between various IRCs between December and April.' Health services should be able to alert the detaining authorities and influence the decisions made about detainees through Rule 35 of the Detention Centre Rules. However this process was undermined by a healthcare system that was unable to reliably assess if detention or continued detention might be injurious to health, and specifically to express clinical opinions if there was an allegation of torture.

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. Our results showed that movement between IRCs is commonplace for detainees. This can be disorienting and traumatic. Whilst in some instances, a transfer was for the purposes of more specific healthcare services only available in some centres, in other cases there was no apparent reason.<sup>182</sup>

The IRC should routinely contact previous GPs/ centres for all health records but this was not always done in a timely fashion. As a result, the analysis of the medical notes showed examples of regular medications not being prescribed and demonstrates the potentially detrimental impact of not obtaining background health information. Other problems were noted during the course of analysis about detainee factors impacting access to healthcare.

There is evidence that shows that asylum seekers can be very resistant to talking about significant life events, especially with immigration staff. However within IRC healthcare there is a presumption that if asked if they are vulnerable, i.e. whether they are victims of torture or have mental health problems, detainees will assert that they are.<sup>183</sup>

There were high levels of PTSD within the sample. A feature of PTSD is that sufferers will often try to push memories of the event out of their mind and avoid thinking or talking about it in detail, particularly about its worst moments.<sup>184</sup> PTSD is thought to induce an intrinsically reduced help-seeking behaviour, perhaps as an avoidance manifestation.<sup>185</sup> Studies have shown that participants with higher levels of PTSD were also more inconsistent when giving an account of torture.<sup>186</sup>

Detainees may have been also reluctant to seek help for fear it might adversely impact on their immigration status. When a detainee arrives in detention, it may not be immediately apparent to the detainee that the healthcare professional performing the interview is not employed for detention, but to provide them with healthcare. They may see healthcare screening as an interrogation rather than safe confidential place for advice and support.

There is also a high turnover of staff in some centres, with multiple locum doctors employed. The poor continuity of care further undermines the fragile doctor- patient relationship and may also put the detainees in a difficult position where they regularly have restated their account of torture and symptoms to a new doctor.

The central tenet of all health-care ethics is the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. However 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". They reported this was common problem in immigration detention centres, prisons, and other secure environments. The report found "consequences of dual loyalties can be devastating for patients."<sup>187</sup>

Doctors within UK IRCs are likely to face similar challenges, seeing themselves as part of the 'system'. The doctor may start from a default position of not believing the patient and/or seeing the detainee population as temporary, and thereon provide inadequate care. Indeed, there is a focus on managing acute risk in IRCs rather than addressing the root causes, presumably because the population held is seen as temporary.<sup>188</sup>

In July 2010 in an interview with *The Independent*, Anne Owers, the Chief Inspector of Prisons, also argued 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.<sup>189</sup>

## Inadequate Mental Health Provision

There is a growing body of compelling evidence, which demonstrates how prolonged detention of unspecified duration can be detrimental to the physical and mental health of the detainee.<sup>190</sup>

There were high rates of mental health disorders within our sample population possibly suggesting that the policy instruction that mentally ill persons are normally considered suitable for detention “in only very exceptional circumstances” was not being adhered to, as there were any instances where their conditions were not “satisfactorily managed”. Evidence contained in the MLRs points to a highly critical view of service delivery in IRC healthcare in some cases.

### MLRs noting inadequate healthcare provision

‘A return to Harmondsworth which has failed previously to provide psychiatric assistance in good time, despite medical advice to obtain this, would similarly risk exacerbation of his illness. In light of this past experience, it must be doubted whether Harmondsworth has the necessary resources to meet his psychiatric needs.’

‘She is not receiving adequate care in detention in that her depression and PTSD is not being treated and she has not had a full assessment for HIV and other STIs. Detention is negatively impacting her mental state. She should be released from detention in view of her age, and also to access medical care.’

There is consistent evidence to suggest that asylum seekers and refugees have higher rates of mental health difficulties than are usually 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 & Haslam found high rates of psychopathological disorder among refugees worldwide compared with non-refugee control groups.<sup>191</sup> However, in the UK, the true number of those with mental health conditions in IRCs is unknown because the data is not collected.<sup>192</sup>

Mental health disorders diagnosed in the MLRs and psychiatric assessments commonly included PTSD, depression, suicidal ideation and deliberate self-harm. Despite the seriousness of these diagnoses, provision of mental health care within the centres appeared to be inadequate.

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.<sup>193</sup>

The 2008 CSIP report criticised UKBA’s claim that it is the responsibility of detainees with mental health problems to bring these to the attention of detention centre healthcare staff. The case studies and medical notes showed that detainees were not adequately screened and thorough mental state examinations were not completed. Detainees were not diagnosed early with mental health conditions.

Diagnosis 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.<sup>194</sup> Detainees were often only referred for secondary care after their health had significantly deteriorated and there were long waits for secondary care. The case studies also demonstrated that even when independent medical opinion was sought in some cases, it was not adhered to.

Indeed, in the experience of Medical Justice the management of people with mental illness is inadequate. In-patient care for those with serious mental health needs usually relies on referral to the local primary care trust, as only two IRCs have in-patient facilities. There are delays in arranging psychiatric assessments, delays in arranging transfers to hospital or releasing individuals found to be unfit for detention. The Immigration Minister also recently acknowledged the ‘*unacceptable delays*’ in accessing secondary mental health care for detainees.<sup>195</sup>

## Post Traumatic Stress Disorder

PTSD was the most common diagnosis within the sample. Therefore it is worth looking at how this was assessed and managed in detention in further detail.

The Detention Centre Rules 2001 state 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. However the National Institute of Clinical Excellence (NICE) guidelines for the treatment of PTSD were not routinely followed.

Effective treatment of PTSD can only take place if the disorder is recognised. Assessment of PTSD can present significant challenges as patients avoid talking about their problems even when presenting with associated complaints.

The NICE guidelines advise “those managing refugee programmes should consider using a brief screening instrument for PTSD.” This should be part of the initial refugee healthcare assessment and of any comprehensive

physical and mental health screening. However there was no effective screening for PTSD and the results showed that only four screening assessments made a diagnosis of PTSD compared to 32 of the MLRS.

NICE also advise that when recognising and identifying PTSD, one should ask specific questions in a sensitive manner about both the symptoms and traumatic experiences. Medical practitioners did not routinely address the history of torture within the Rule 34 assessment. A more detailed exploration of prior history of traumatic experiences by the GP at this stage may provide a better basis for suicide and self-harm risk assessments, as well as whether detention may be injurious to the patient’s health.

In the cases where a diagnosis of PTSD was made in detention, NICE guidelines for the management were not followed. For example, as noted in *Chapter 3*, the current first line treatment for severe PTSD is a course of trauma-focused psychological treatment: trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR). However, it is difficult to deliver this type of therapeutic intervention in the detention setting. Drug treatment should not be first line but detainees were regularly started on medication such as anxiety medication or sleeping tablets.

Mental healthcare service delivery in IRCs is not however the only problem. The results show there is poor quality of healthcare in general and this impedes the effective implementation of Rule 35 both in relation to the identification of victims of torture as well as the management of their ongoing health needs.

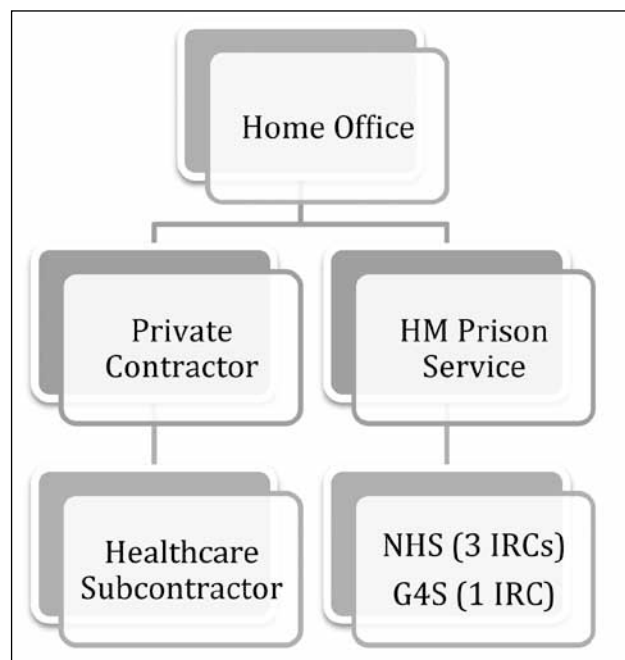
### 3. Governance and Accountability

A fundamental issue that plagues the effective functioning of Rule 35 relates to governance and a lack of accountability. In order to understand why Rule 35 is not working, one needs to situate it in the context in which it operates and examine the mechanisms that place responsibility on the individuals and organisations for implementing the rule. This involves an analysis of UKBA, its contractors and their subcontractors; what rules exist to ensure implementation; and what systems are in place to hold them accountable.

This section will firstly examine the devolution of duty from UKBA to private contractors; it will then consider the impact of this devolution on accountability, in turn examining the complaints procedures in place. The section will conclude with an analysis of the impact of poor governance and lack of accountability on the Rule 35 process.

#### Devolution of Duty

There are 11 IRCs in the UK and their functioning has been contracted out to different service providers, (although Lindholme has now closed). Four are managed by the Prison Service and the remaining seven by different private security companies. G4S, Serco and GEO Group all manage two centres each and Mitie PLC manages one. In each of the IRCs, healthcare provision is subcontracted out to various groups, except those run by Serco where healthcare is run by Serco Health. On top of this, other keys services are contracted out, for example, escorting and removal services and NASS accommodation.



Whilst UKBA holds ultimate responsibility over IRCs, private contractors manage their daily functioning for profit. UKBA has a “contract monitor” on site who is responsible for ensuring contractors abide by their duties. Legal

contracts govern the duties and the relationship between UKBA and the private security companies (and the private security companies and the healthcare services that they subcontract) although for corporate confidentiality reasons, this information is not in the public domain.<sup>196</sup> The Detention Centre Rules 2001 and the Detention Services Operating Standards Manual for Immigration Service Removal Centres should also be applicable to individuals working in IRCs.

The Detention Services Operating Standards Manual states:

'The aim of developing and issuing standards is to improve performance and compliance across the detention estate. (...) The standards are designed to build on the Detention Centre Rules and to underpin the arrangements we have for the management of removal centres. They are important because they provide a means of raising standards and they are also a means of achieving a level of consistency across the removal estate. They are also a public document and this makes transparent the way we expect detainees to be treated and how our centres operate more generally. The standards are subject to review and an important part of this exercise will be the results of the self-audit process and the role of Detention Services personnel in overseeing that process.'

As shown in the *Results*, this report has uncovered 9 breaches of the Operating Standards Manual.<sup>197</sup> Indeed, this manual serves as guidance rather than as designating a legal duty. The judgment of *MT on the application of R v SSHD, GSL UK Ltd and Nestor Healthcare Services plc [2008] EWHC 1788 (Admin)* found that responsibility for the failures of third party contractors in a detention centre when they fail to apply detention centre rules and /or give effect to policy falls on the Home Office rather than the private contractors or healthcare subcontractors.

With regards to the role of Nestor Healthcare Services PLC, the judgment also held in paragraph 47:

'Under that contract its obligation was understood to be to provide general healthcare at the centre, a reactive type role comparable to the services provided by a general practitioner. **It was under no contractual obligation to provide, and did not in fact provide, the 24 hour medical examination to every person as required by rule 34 once that rule was introduced in 2001.** Not only was it not contractually obliged to do that but 24 hour screening, a proactive type service, was more expensive and its resource levels and costings when entering the contract had been on the basis of offering only a reactive type service.'

The Judge concludes in paragraph 54: '(...) where public services are contracted out a public authority may be liable for the failure to perform them if there can be said there is a breach of a non-delegable duty or if the breach has been specifically instigated, authorised or ratified by the public authority.'

It thus remains of great concern that the contractual obligations of private contractors are not available in the public domain. For example, a Scottish Parliamentarian made the following recommendations following a visit to Dungavel IRC where Premier managed the services at the time: 'The lack of accountability for service provision by Premier must be addressed. Information is very difficult for the public to access, as a direct result, it is very difficult to determine if Premier is performing well or not or to investigate any claims about conditions at Dungavel' (Scottish Parliament 2002: 6).<sup>198</sup>

## Lack of Accountability

Whilst channels of monitoring do exist, accountability remains sketchy and transparency levels are weak. What is of great concern is that through the division of labour and the devolution of various responsibilities, it is often unclear where responsibility or culpability falls. As noted by the Refugee Studies Centre:

'...the transfer of liability from the government to the private contractor has contributed to confusion as to which party is responsible when ill-treatment or abuse occurs, often leaving nobody to answer for it. These elements compound the problems for detainees in detention centres run by the private sector.'<sup>199</sup>

This issue comes to the fore with the issue of healthcare and deaths in detention. Between 1989 and 2010, there were 14 deaths in detention.<sup>200</sup> A further three individuals died within one month in 2011.<sup>201</sup>

For some years, Inquest<sup>202</sup> had lobbied to reverse the government's decision to exclude public bodies including prisons and IRCs from the Corporate Manslaughter and Homicide Bill for any deaths in custody. This is particularly important given the growth of private companies managing prisons and IRCs since the 1980s. Despite inquests taking place in the past that may indicate systemic failures, Inquest argued that action is never taken at either individual or senior management level. 'Furthermore the PPO, IPPC and inquests proceedings are not about determining liability and it is disingenuous to present them as doing so.'<sup>203</sup>

In Medical Justice's experience, this lack of accountability and liability rings true. On October 12 2010, Jimmy Mubenga tragically died at the hands of G4S escorting staff who were allegedly restraining him whilst he complained he could not breathe during a forced removal attempt to Angola.

When investigating the situation, the Home Affairs Committee found that they '...are not at all convinced that the UK Border Agency is being effective in making sure that its contractors provide adequate training and supervision of their employees in respect of the use of force. This is a fundamental responsibility of the Agency and is not simply a matter of clauses in contracts or formal procedural requirements.'<sup>204</sup>

In March 2011, following pressure from Inquest and recommendations from the Home Affairs Committee and the IPCC, the government announced that the Corporate Manslaughter and Corporate Homicide Act 2007 will be applied to persons detained in IRCs and that the Act will apply to private contractors. However, it is yet to be determined whether the Corporate Manslaughter Bill may be applied to G4S in the case of Jimmy Mubenga's death.<sup>205</sup>

At the present time no substantive actions regarding liability have been taken, and the G4S staff involved are on bail. It is as yet unknown whether they may face a manslaughter charge. UKBA has terminated its escorting contract with G4S and instead awarded it to Reliance Security Task Management Limited, a security company not without scandal and a history of abuse.<sup>206</sup> However, at this stage it is unclear how many staff from G4S have been transferred directly over to Reliance or whether UKBA has provided adequate supervision and training to Reliance staff.

Furthermore, despite losing its contract for overseas escorting, G4S is still considered a valued firm by the British government. A G4S spokesperson said that it has more than \$1.1 billion in government contracts in Britain, of which only \$126 million derives from the Home Office.<sup>207</sup> In 2011, the same year of Jimmy Mubenga's death, G4S was appointed official security services provider of London 2012 Olympic games and was awarded two prison contracts, the management of Cedars pre-departure accommodation and three work programme regions in the UK.<sup>208</sup> The lack of retribution to these private companies is literally allowing them to get away with murder.

Concerns over the inadequacy of healthcare provision of IRCs have long been voiced by Medical Justice. In 2009, Medical Justice wrote to UKBA about concerns over the Rule 35 process and about the possible misconduct of some IRC healthcare staff. On 10 February 2009, David Wood, then strategic director of UKBA's Criminality and Detention Group, wrote: 'I have also noted that you have referred to a number of alleged misconduct issues by clinicians. As has been discussed before with Medical Justice, *UKBA is not able or prepared to comment on matters of professional competence*. You should raise these in the first instance with the individual concerned, the Head of Healthcare, his or employer and ultimately use the established complaints procedures which are in place through professional bodies such as the GMC.'

This lack of engagement with the monitoring of staff contracted by UKBA is of concern. As noted by the organisation Corporate Watch, governance structures impede accountability: 'Creating two levels of contracts (prime contractors who then sub-contract smaller businesses) is a growing trend in the government's outsourcing of public services. However, it also increases bureaucracy and removes accountability even further away from the government.'

Furthermore, in our experience, UKBA fails to learn lessons even when damning judgments are handed down. In 2011, two landmark court cases found that the circumstances of two individuals' time in detention amounted to inhuman or degrading treatment in breach of Article 3 of the European Convention on Human Rights (ECHR). In both cases, systemic failures to provide adequate healthcare were identified. UKBA failed to learn lessons from these two tragic rulings: at a DUG MSG meeting on 18 November 2011, senior UKBA policy staff present were wholly unaware of the judgments. At the present time, UKBA has still failed to produce any response to these judgments. Furthermore, as noted earlier in this report, there has been yet another third judgment whereby the circumstances of a person's detention breached Article 3.

The failure to implement Rule 35, poor quality healthcare and deaths in detention demonstrate how the government has repeatedly ignored criticisms, failed to learn lessons and take on recommendations. The concern remains, must one wait for unlawful detention legal challenges to address the failure to abide by published policy, poor healthcare provision and deaths in detention?

### **Assaults, Abuse and Inadequate Complaints Procedures**

When considering governance and accountability, an examination of complaints procedures is important. For the year 2010-2011, UKBA received a total of 11,840 complaints.<sup>209</sup> In the sample of 50 cases examined, six individuals made complaints about assaults either in IRCs or during attempted removals. This high proportion is by no means an anomaly, and if anything, this figure is understated.

Despite experiences of racism or assault, few asylum seekers are able to make a complaint or seek redress.<sup>210</sup> The relevant procedures and legal process are complex and not perceived to be independent and there is evidence that those lodging complaints are subject to harassment and further abuse.<sup>211</sup> In its last report, the Home Office's own Complaints Audit Committee reported 'endemic and enlarging problems' in misconduct investigations: 79% of serious misconduct complainants were not interviewed and 65% of responses to them were not defensible. 'We found fundamental problems indicating poor quality control, lack of clear guidance and wasted resources.'<sup>212</sup>

At the present time, Medical Justice still receives a high number of individuals reporting abuse at the hands of IRC and/or escorting staff. However, as was uncovered in the 2008 dossier *Outsourcing Abuse*, there is a reluctance to investigate the reported assaults. The responses instead tend to be superficial and deficient, and allegations are ordinarily denied. In 100% of the cases in the past year where Medical Justice have requested footage of abuse that would have been captured on CCTV on behalf of (ex) detainees, the tape has been damaged, lost, or not shared

on the basis that it would amount to a breach of 40 (3) of the Freedom of Information Act.<sup>213</sup>

HMIP, the Home Affairs Committee, Baroness O'Loan, Medical Justice, Amnesty International UK, Freedom from Torture, a Daily Mirror undercover reporter and the BBC have all raised concerns about enforced removals. This includes instances of racism, the inappropriate use of force and a lack of accountability. The common theme is that severe deficiencies exist over knowledge, accountability and staff training.

However, despite ongoing criticism, problems ensue. The Home Affairs Committee who examined enforced removals in 2012 also highlighted UKBA's failure to learn lessons: 'Where the state has contracted out responsibility for coercion, it retains ultimate responsibility for ensuring that all the checks are in place and working well. It is important that this is understood within the culture of both the Agency and that of its contractors, and not just acknowledged in formal documents. This is one of a number of areas of activity where there appears to be reluctance amongst officials to accept constructive criticism...'<sup>214</sup>

The inadequate complaints system highlights UKBA's reluctance to properly monitor the companies that they contract and hold them accountable. Given the vulnerable population who are held in detention centres or are being forcibly removed, this system, together with the Rule 35 process, needs urgent review to instill the public accountability, which is currently being undermined.

### **Impact of poor governance and lack of accountability on the Rule 35 process**

The problem of Rule 35 is really two fold. Firstly, the fact that it is not working. And secondly, the fact that the government has known it has not been working for years, yet has failed to take the appropriate steps to enable a more efficient functioning.

Year after year, the same criticisms of Rule 35 have been fielded by independent monitoring bodies and NGOs and similar recommendations have been made, but the government has failed to act. Thus, whilst monitoring exists giving a semblance of transparency, recommendations are not binding and rarely is anyone ever brought to account.

One must remember that Rule 35 (3) deals with torture victims: a vulnerable and traumatised population locked up for administrative purposes who should not be detained if there is evidence to support their alleged torture, unless there are exceptional circumstances.

Different groups of people are involved within the Rule 35 process. What the results show is either a lack of knowledge or an indifference to what is needed both in the reports and in the responses. However, because the parties involved are somewhat disconnected and do not seem to appreciate what either party needs to make the

system work, it is often unclear where exactly the process collapses. Thus in turn, it is difficult to pinpoint exactly where to place responsibility and/or culpability.

This issue is further complicated by the devolution of duty. The centres are run by different contractors with inconsistent practice across IRCs. However, a lack of training and knowledge is common across all of them. The use of private security companies and their outsourcing of healthcare services to subcontractors dilutes responsibility and shrouds their accountability. The lack of information about their contracts and in turn, their obligations and accountability against public law is a pressing issue.

Thus, the disconnect that exists between all the parties involved, together with the lack of accountability, have enabled the continued failure of Rule 35 to ensue.

For too long the government has ignored criticisms and has failed to learn lessons. With weak governance structures and a lack of transparency and accountability, what is required to make Rule 35 work is political will. This is because fundamental change needs to take place. This report shows that the issue is not simply administrative process breakdown. Rather, the failure to follow statutory legislation regarding victims of torture in IRCs must be looked at in the political, economic and cultural context. Only through doing this, will proper remedies be found.



## 4. Lack of Political Will

This section will examine how the failure to implement Rule 35 is linked to the priorities of the organisations involved.

The key aims as defined within the Home Office Business Plan 2011-2015 are to secure borders and reduce immigration.<sup>215</sup> This is manifested through tighter border controls, a decrease in asylum applicants per year and the increasing use of immigration detention. By contrast, for private security companies, their primary priority is profit and thereon winning and maintaining contracts.

The government's commitment to detention and removal is reflected in the huge sums of money they invest in this. In the year 2010-2011, £205,830,000 was spent on detention and removal. Of this figure, £44,002,000 was spent on the Immigration Group; £2,994,000 on the Border Force; and £156,696,000 by the Criminality and Detention Group.<sup>216</sup>

The overall aims and priorities of these two players (UKBA and private security companies) arguably reinforce each other. The growth of the immigration estate and an increasingly severe detention policy goes hand in hand with the increased use of private security companies managing the centres.

In 2008, despite falling numbers of asylum applicants, the government announced a 60% rise in immigration detention places, which would facilitate greater numbers of removals. The Immigration Minister at the time, Liam Byrne, stated: "We now remove an immigration offender every eight minutes - but my target is to remove more, and remove them faster."<sup>217</sup>

Whilst UKBA 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.

'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.'<sup>218</sup>

This is echoed by the Prison Reform Trust who argue in relation to the wider prison estate: 'With the profit motive expanding across the custodial estate, 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.<sup>219</sup> Indeed, there is a great concern that the pursuit of profit may come at the expense of service delivery, such as adequate healthcare staffing. It is of interest that the average cost of detention per night has fallen from £120 as reported in 2010 to £103 in 2011.

As explained earlier, despite widespread abuse committed by the private security companies who manage IRCs, their businesses are still booming. The reach of these companies is outstanding, providing diverse services to the UK government and overseas. For example, G4S is the second largest private employer in the world.

However, these companies have been plagued with scandal. To paint a brief picture using examples from Australia (the largest user of private security companies for immigration purposes), GEO group lost its contract in Australia in 2003 after a commission found detained children were subjected to cruel treatment. G4S has been condemned for lethal neglect and abusive use of solitary confinement and in 2007 were ordered to pay \$500 million for inhumane treatment after ignoring the cries of detainees locked in a scorching van that left them so dehydrated, they had to drink their own urine.<sup>220</sup> Finally, Serco had been fined \$4million in early 2011 for contract breaches and Christmas Island, which they manage, has been plagued with problems.<sup>221</sup>

Despite all this, the UK government continues to award contracts to these companies. The poor quality healthcare and the failure to abide by published statutory legislation together with a lack of will to rectify pre-identified historical problems demonstrate a belligerent attitude toward asylum seekers and victims of torture.

Criticisms have been fielded for almost ten years and various reported judgments have highlighted UKBA's failure to comply with its own policy. However, UKBA has failed to act and problems ensue. The "audits" have been farcical with the first one "lost" and the second one, failing to consider anything substantive.

The primary aims of the parties involved conflict with the principles of Rule 35. Whilst Rule 35 is presented as a safeguard, its successful implementation is trumped by wider political and economic goals, thus making it little more than a fig leaf.

# Chapter Ten – Conclusion

This report exposes the injustice that victims of torture face in immigration detention in the UK. The primary safeguarding mechanism that applies to this group of people fails to work.

The 50 people featured in this report underwent horrific experiences and have medical evidence supporting their account. They fled to this country in pursuit of sanctuary. Instead, they were detained for administrative purposes and the safeguarding mechanism that should identify and release them, failed to do so in all but one example.

Everyone in the sample suffered from ongoing physical and/or mental effects owing to their torture. However, the overall standard of healthcare that they received whilst in detention was overwhelmingly poor. Furthermore, individuals reported inhuman treatment at the hands of IRC staff.

As the case of *RC v Sweden* showed, the duty lies with the State to ascertain facts relating to torture.<sup>222</sup> This report shows that the State has failed to do this.

Immigration detention is no place for victims of torture. The healthcare is inadequate and the environment is not conducive to wellbeing. Many individuals in the sample reported psychological symptoms and suicidal ideation with a high proportion of independent doctors recommending their release on the basis that it was injurious to their health. Indeed, as many (ex) detainees described, detention was a “second torture”, bringing back memories of their incarceration in their home countries and provoking re-traumatisation.

As explained in the findings, the Rule 35 process fails at every stage and prior to it: this includes the asylum screening, the IRC healthcare screening and Rule 34, Rule 35 report writing, and the UKBA Rule 35 response. Errors in the application of Rule 35 were both procedural and substantive. Furthermore, in some cases, the Rule 35 process was completely by-passed, failing to identify people altogether.

IRC healthcare staff demonstrated a lack of knowledge and awareness of Rules 33-35 of the Detention Centre Rules 2001. Reports were sometimes incomplete and in some cases written by nurses. There was a failure to consider medical notes in conjunction with report writing and a failure to express opinion or indicate severity for the most part. UKBA caseowners demonstrated a failure to understand the purpose of Rule 35; often failed to consider evidence or were unable to interpret medical evidence; and were unable to provide adequate reasons for maintaining detention.

The evidence collected in this report points to four key reasons as to why the safeguarding mechanism fails to work. Firstly, staffing problems were noted amongst UKBA caseowners and IRC healthcare staff with competency and attitudinal problems coming to the fore. Secondly, the overall quality of healthcare delivered in IRCs was substandard- thus attributing to the problem of firstly identifying victims of torture, but also treating them effectively. Particular problems to note include disruptions to medication, poor mental health care, and a failure to abide by guidelines for victims of sexual violence.

The third reason underpinning the ill functioning of Rule 35 relates to governance and accountability. As explained, the devolution of duty and the division of labour within the Rule 35 process serve to confuse roles and shroud accountability. Finally, the failure to rectify the repeatedly pre-identified problems in the process, together with the government’s wider policy goal of detaining and removing more and more asylum seekers, demonstrates the lack of political will on the part of the government to commit to their duties.

Indeed, one of the most disturbing elements to this report is the absolute disregard on the part of the Home Office to undertake previous recommendations emerging out of a catalogue of criticisms that have pointed to the chronically dysfunctional nature of Rule 35 from Medical Justice and others. Independent inspectorates, official bodies and NGOs have made repeated recommendations to no substantive effect. There have also been numerous reported cases, where Judges have condemned the Home Office for failing in its duties and departing from its published policies, as well as a number of concerns raised in the House of Lords on this subject. Still, problems have ensued.

This report has uncovered systemic failures on the part of UKBA and its contractors to follow statutory law and provisions. It has also uncovered instances of racism and serious clinical breaches, which are of great concern. Medical Justice repeats many of the recommendations previously made by others and builds on them. We urge that all parties involved in the implementation of Rule 35 take note of the recommendations of this report and put them to effect immediately.

Channels of accountability must be strengthened. It is not enough for the government to simply revise policy documents and guidance or even implement training. What is needed is for the rule to work and for external parties to be able to see that the rule is functioning effectively through monitoring, regular transparent reporting and auditing. Victims of torture with independent evidence should be released, absent

exceptional circumstances. Only when this is done, will UKBA be meeting its statutory obligations.

In the words of one former detainee: 'Detaining people who are trafficked and tortured is wrong... we need help not to be tortured again, please stop detaining people who have been trafficked and tortured!'

# Chapter Eleven – Recommendations

Medical Justice has found that the harm being caused by detention centres is so widespread that the only solution is to close them down. Whilst IRCs continue to operate, we call for meaningful change that will protect the medical rights of immigration detainees. The findings of this report demonstrate that the medical needs of torture victims are not met in detention. The existing safeguards fail to identify and release victims of torture, where appropriate. Instead, many languish in detention while their health deteriorates.

Our key request is that the government simply: Implements Rules 34 and 35 of the Detention Centre Rules 2001 and demonstrates this through an independent audit of the Rule 34/35 process, which assesses its effectiveness. The audit should review outcomes and the quality of all reports and responses over a 3 month period and should be published no later than December 2012.

## General:

- ▶ Rule 35 should be made applicable to all detainees held under immigration powers, for example, in prisons, hospitals, short-term holding facilities and pre-departure facilities.
- ▶ Removal of UKBA's responsibility of detention – as warned by Dame Anne Owers, the former Chief Inspector of Prisons, there may be a conflict between forced removals and the proper care of individuals held in immigration detention, as demonstrated through the “fundamentally unsafe” centres and alleged brutal treatment of detainees.<sup>223</sup>

## Healthcare Screening:

- ▶ Where detainees arrive late at night, only an emergency screening assessment should take place. The full screening can be continued in the morning after the detainee has rested.
- ▶ In accordance with NICE guidelines, patients should be screened for PTSD.

## Implementation of Rule 35:

- ▶ Review and implement previous recommendations laid out by HMIP regarding Rule 35 and adopt all the recommendations for Rule 35 that Medical Justice has made in its consultation submissions.
- ▶ If an individual is released for other reasons such as bail while a Rule 35 response is pending, the CID notes should reflect this. At present, caseowners input “released” under the Rule 35 process, which does not reflect reality and will distort future audit data. Thus, an additional option of “released through other means” should be offered in the CID database.

## Training:

- ▶ Develop a publicly available action plan of who is getting trained, where and when: transparency of training and supervision.

## Rule 35 Audits:

- ▶ Publish the anonymised raw data from the audit that was published in February 2011.
- ▶ Respond to and take on Medical Justice's advice on the methodology of the next audit as noted in our correspondence.
- ▶ The next UKBA audit of Rule 35 should be devised and conducted by an independent body. It should review the outcomes and the quality of all reports and responses over a 3 month period and should be published no later than December 2012.
- ▶ Provide Medical Justice and relevant stakeholders with regular reporting on Rule 35 information (reports submitted and outcomes).

## Record-keeping:

- ▶ UKBA should collect statistics on people with mental health conditions and make them publicly available.
- ▶ Rule 35 data should be centrally stored and regularly shared on the UKBA website.

## UKBA Policymakers:

- ▶ Revise Section 55.10 of the EIG in light of the judgment of R (HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 (Admin).
- ▶ All patients diagnosed with PTSD and indeed any mental illness should not be detained, (absent exceptional circumstances) – the environment is not conducive to recovery and the treatments such as CBT or EMDR are unavailable in IRCs.
- ▶ Respond to and publish lessons learnt from the cases of R (BA) v Secretary of State for the Home Department [2011] EWHC 2748 (Admin); R (S) v SSHD [2011] EWHC 2120 (Admin); and R (HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 (Admin) immediately.

## UKBA General:

- ▶ Do not detain torture survivors under DFT– this may require lowering the standard of proof, excluding *potential* torture victims, as it is unlikely at this stage that there would be independent evidence.
- ▶ Detention reviews should incorporate the medical situation and pay attention to MLRs. Caseowners should note if there is a recommendation for release or a concern that detention is injurious to health. Caseowners should consider health outcome variables, such as if the detainee has been placed on raised awareness or ACDT; food refusal; self-harm; suicidal ideation/intent; and hospital admissions.
- ▶ Periodically review the number of unlawful detention cases involving medical issues and make this information available in public domain.
- ▶ Once an individual has been found to be unfit for detention through Rule 35 or other means, their release should be immediate.

## Governance and accountability:

- ▶ The process of formal commissioning of healthcare by NHS should be accelerated.
- ▶ HMIP have made recommendations that have been consistently ignored. Systems need to be put in place that ensure UKBA is made accountable where recommendations are not implemented.
- ▶ HMIP should conduct a themed inspection on Rule 35, including the impact of the proposed training. This should feed into an independent inquiry, which takes evidence from relevant experts such as doctors, lawyers, NGOs, (ex) detainees and requires UKBA and IRC operators to give evidence and be cross-examined by independent experts appointed to serve the inquiry.
- ▶ Any investigations, including those carried out by UKBA or the IRC operator/ healthcare provider regarding the deaths or near deaths of individuals in detention should be made publicly available and not withheld because they are deemed to be the property of the IRC operator.
- ▶ More robust complaints procedures should be developed. The quality of responses should also be audited on a regular basis externally and independently.
- ▶ An independent investigation into the quality of healthcare should be conducted – researchers should have medical expertise and review live files. It should involve an audit of all IRC healthcare facilities using the GMC Good Medical Practice 2012 and IRC Operating Standards as the framework for assessment. NHS audit standards should also be used with a focus on mental healthcare; medication delivery; external appointments; record keeping; and attitudes of staff towards detainees.

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[http://www.asgi.it/public/parser\\_download/save/cedu\\_41827\\_09032010.pdf](http://www.asgi.it/public/parser_download/save/cedu_41827_09032010.pdf)

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R (S) v SSHD [2011] EWHC 2120 (Admin) (5 August 2011).

<http://www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html>

Lumba (Congo) and Mighty (Jamaica) v Secretary of State for the Home Department

[2011] UKSC 12, [2011] 2 WLR 671, 23 March 2011

[http://www.supremecourt.gov.uk/decided-cases/docs/UKSC\\_2010\\_0063\\_Judgment.pdf](http://www.supremecourt.gov.uk/decided-cases/docs/UKSC_2010_0063_Judgment.pdf)

Kambadzi v Secretary of State for the Home Department [2011] UKSC 23, 25 May 2011

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# APPENDIX

## Appendix 1 – Rule 35 AOT Forms

**DETENTION CENTRE RULE 35**  
**Report of Special Illness or Condition (including torture claims)**

To comply with Detention Centre Rules (2001) Rule 35

(This form is not to be used for allegations of assault within the UK)

First Name	Surname	Date of Birth	UKBA Reference No

The above named detainee states that he/she\* is subject to a special illness or condition (including a torture claim\*); this has been reported

to.....in..... (Member of staff and location)

The detainee's legal representative is aware of this issue

Y / N\*

An appointment has been made with the Doctor in the centre to address the detainee's healthcare needs.

I ..... hereby give my consent to the Health Care staff to release medical information to the UK Border Agency with regard to my allegation of a special illness or condition.

Signed

Date

This form has been dealt with by

Name

Signed

Date

**\*Delete as applicable**

This form must now be passed to the UK Border Agency Manager in the Centre. A copy must also be placed on the detainee's medical record.

A copy of this form will be forwarded by the UK Border Agency Manager to the case-owner with responsibility for reviewing the decision to maintain detention.

The UKBA Manager will confirm that the detainee's case has been reviewed in light of this information and that a response is sent to the detainee and his/her legal representative. A copy of the response will also be placed on the detainee's medical record once received.

# Fax

IRC ADDRESS

**Tel:**  
**Fax:**  
**Web:** ukba.homeoffice.gov.uk

To  
Detained Casework -  
CC  
Fax number

From  
Tel number  
Date  
Detainee's details  
Pages

---

## **DETENTION CENTRE RULE 35**

Dear Colleague,

I am attaching a copy of a report which has been provided by Healthcare in accordance with Rule 35 of the Detention Centre Rules 2001 with regards to a special illness or condition (including torture claims).

In accordance with Detention Centre Order 03/2008 would you please:

- Ensure this report is brought to the immediate attention of the relevant senior officer with responsibility for reviewing the decision to maintain detention.
- Forward a copy of the reports to the relevant case owner or caseworker for consideration.
- Fax back part 2 of this pro-forma confirming that where a decision has been made to maintain detention, that the report has been considered as part of that decision. This action must take place no later than 2 working days, starting from the following working day that the fax was received.
- Ensure that a copy of part 2 of this pro-forma is additionally sent to the detainee's legal representative and the doctor raising the report.

Yours faithfully,

## **DETENTION CENTRE RULE 35**

Dear **Name of Detainee**

I am writing to you to acknowledge receipt of a report dated DD/MM/YYYY notifying us that of a special illness or condition.

Information contained within the report has been considered and the decision to detain you has been reviewed.

***Further detail as to why detention is being maintained (or other outcome as necessary).***

A copy of this letter has been forwarded to your legal representative.

Yours sincerely,

**Name of the caseworker**

# Appendix 2 – Rule 34 Screening Proforma

Resident Name .....

Bringing service to life CID Reference .....



## RULE 34 GP Assessment Within 24 Hours of admission

Past Medical History:

Current Medication:

Physical and Mental Assessment (Continue in medical notes if required):

Outcome:

Known Allergies:

Malaria Prophylaxis Prescribed Yes Not Required\* \*Delete as applicable

Pregnant  
Under 5 years of age

Malaria Prophylaxis must be prescribed to all at risk groups so that it is available to the point of departure.

Name ..... Position.....

Signature..... Date.....

# Appendix 3 – Diagnostic Criteria for PTSD

## **Diagnostic Criteria for PTSD, as defined in ICD–10 (World Health Organization, 1992), code number F43.1 (6,29)<sup>224</sup>**

### **2.3.1 Diagnostic criteria for PTSD**

The ICD–10 diagnosis of PTSD requires that the patient, first, has been exposed to a traumatic event, and second, suffers from distressing re-experiencing symptoms. Patients will usually also show avoidance of reminders of the event, and some symptoms of hyperarousal and/or emotional numbing. The ICD–10 research diagnostic criteria for PTSD are as follows

- (A) The patient must have been exposed to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.
- (B) There must be persistent remembering or ‘reliving’ of the stressor in intrusive ‘flashbacks’, vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.
- (C) The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.
- (D) Either of the following must be present:
  - (1) inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
  - (2) persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
    - (a) difficulty in falling or staying asleep
    - (b) irritability or outbursts of anger
    - (c) difficulty in concentrating
    - (d) hypervigilance
    - (e) exaggerated startle response.
- (E) Criteria B, C, and D must all be met within 6 months of the stressful event or the end of a period of stress. (For some purposes, onset delayed more than by 6 months may be included, but this should be clearly specified.)

The DSM–IV diagnosis of PTSD is stricter, in that it puts more emphasis on avoidance and emotional numbing symptoms. It requires a particular combination of symptoms (at least one re-experiencing symptom, three symptoms of avoidance and emotional numbing, and two hyperarousal symptoms). In addition, DSM–IV requires that the symptoms cause significant distress or interference with social or occupational functioning. Several studies have found that trauma survivors who experience most, but not all, DSM–IV symptoms of PTSD show significant distress and need treatment (e.g. Blanchard et al, 2003b).

In contrast to the ICD–10 definition, a DSM–IV diagnosis of PTSD further requires that the symptoms have persisted for at least 1 month. In the first month after trauma, trauma survivors may be diagnosed as having acute stress disorder according to DSM–IV, which is characterised by symptoms of PTSD and dissociative symptoms such as depersonalisation, derealisation and emotional numbing. The ICD–10 diagnosis does not require a minimum duration. For the purposes of this guideline, we include PTSD symptoms that occur in the first month after trauma. A special section on early intervention (Chapter 7) is dedicated to the management of these early PTSD reactions.

# Appendix 4 – Hansard Timeline

September 2003	<p><b>Joint Commission on Human Rights Inquiry into Human Rights and Deaths in Custody</b></p>	<p><b>Response:</b> JCHR report procedure clarified; confidentiality should not impede transfer of information. Raised concern: problem</p>
	<p><b>Problem:</b> No clear procedure for passing medical reports from GP to Centre Manager to the Immigration Service. Reports do not reach the Immigration Service file. (Bail for Immigration Detainees written evidence)</p>	
	<p><b>Problem:</b> No mechanism in place to identify torture victims in detention to review fitness to detain. (Medical Justice written evidence, supported by HMIP reports on IRCs)</p>	
4 Dec 2004	<p><b>Problem:</b> Lack of provision of information; evidence that health staff did not pass on medical information to detention centre managers. (Joint Committee Third Report)</p>	
21 Mar 2006	<p><b>Problem:</b> Black box – no information available on Rule 35 reports submitted. (Harry Cohen in House of Lords Question and answer)</p>	
September 2006	<p><b>Joint Commission on Human Rights Tenth Report - Written Evidence</b></p>	<p><b>Response:</b> Store files centrally at each detention centre.</p>
	<p><b>Problem:</b> Healthcare staff competency; it is not clear that health professionals are alert to or competent to detect signs of previous trauma or torture.</p>	
	<p><b>Problem:</b> Lack of monitoring &amp; follow-up mechanism: No clear systems for monitoring or following up report 35s passed onto IND.</p>	
	<p><b>Problem:</b> Opaque decision-making: No Reasons for detention and progress of cases are sparse - not provided to detainees.</p>	
8 January 2007	<p><b>Problem:</b> Lack of responsibility: Confusion around case responsibility in IND.</p>	
13 March 2007	<p><b>Problem:</b> no response from IND [UKBA] after sending Rule 35 reports (Joint Commission on Human Rights Tenth Report - Written Evidence HM Chief Inspector Anne Owers)</p>	<p><b>Response:</b> "Staff have been instructed to ensure the procedures under Rule 35 (Detention Centre Rules) are processed and details logged. A standard reporting form has been introduced and its use will be monitored. Stuart Hyde will review a selection of cases to see how the system is working, especially in terms of the IND consideration of and response to torture allegation reports. (Liam Byrne, MP Minister of State)</p>
12 July 2007	<p><b>Problem:</b> concern about application of procedures: processing and logging details of Rule 35 reports (JCHR, Inquiry arising from Yarl's Wood Detention Center)</p>	
12 July 2007	<p><b>UK Borders Bill – proposed amendments</b></p> <p><b>Recommendation:</b> Include time limit within which UKBA must respond to report made by medical practitioner. Response: Included in Operational documentation (12 July 07)</p>	
11 Oct 2007	<p><b>Recommendation:</b> Make victims of torture automatically exempt from detention. (11 Oct 2007) <b>Response:</b> Rejected on grounds of needing to prove torture. 4 exceptional circumstances are given here</p>	<p><b>Response:</b> It is important that the doctor should know that the report has been received by the relevant agency staff and I agree that this should be done promptly. It may be that the response to the doctor should go beyond a simple acknowledgement. The agency will look at the current guidance to see what more could be said, subject to any issue of confidentiality. For example, the response could indicate to the doctor whether the information about the claim of torture is already known to the BIA and has been considered or whether it is being considered as part of the individual's asylum application. The guidance should also make clear the need for a prompt response to the doctor's report. (Lord West of Spithead)</p>
11 Oct 2007	<p><b>Recommendation:</b> Include in the bill the requirement to detail specific action taken for each Report 35, "the chief inspector has drawn attention to the failure in all immigration and removal centres to respond radically to the Rule 35 letters." (11 Oct 2007)</p>	



23 November 2007	<p><b>Recommendation:</b> Identify individual who is responsible for detainee.</p>	<p><b>Response:</b> case owners are clearly responsible for considering Rule 35 letters.(Lord West of Spithead)</p>
	<p><b>Recommendation:</b> Independent audit of procedures.</p>	<p><b>Response:</b> rejected – HMIP regularly inspect all removal centres and has ample opportunity to look at issues such as Rule 35 letters.</p>
	<p><b>Borders, Citizenship and Immigration Bill</b></p>	
September 2008	<p><b>Problem:</b> Rule 35 reports not being implemented. 46 cases should not have been in detention. (Memo by Dr Charmian Goldwyn)</p>	
October 2008	<p><b>Problem:</b> identification and collection of information from detainees is flawed; detained interviewed within 2 hours of arrival, usually by nurse, issues with this include the short time to collect sensitive information. (Memo by Dr Charmian Goldwyn)</p>	
20 Aug 2009	<p><b>Recommendation:</b> Responsibility for healthcare should be given to the NHS. (Memo by Medical Justice)</p>	
	<p><b>Recommendation:</b> Obligation for the Secretary of State to consider factors which may weigh in favour of bail...previous experiences of torture...should be included in the Bill. (Memo by Medical Justice)</p>	
4 Nov 2009	<p><b>Problem:</b> The process is opaque. Greater transparency is needed. More stringent checks should be carried out by immigration officers prior to making a decision to place a person in detention. (Lord Sheikh)</p>	<p><b>Response:</b> Where there is only a claim of torture detention maybe appropriate in following circumstances:  <i>"It may be appropriate in order to effect removal, or while a person's identity and claim are being established... Detention may be appropriate where a person presents a risk of abscond-some people have done that in the past when being held-or where an asylum application is capable of being done very quickly, which has been touched on as well."</i> (Lord West of Spithead)</p>
9 Nov 2009	<p><b>Problem:</b> Lack of independent oversight- issue of an administrative independent reviewer (Lord Hylton)</p>	<p><b>Response:</b> need to review and respond.</p>
February 2011	<p><b>Problem:</b> Detainees are not always asked at the reception interview whether they have suffered torture. (Lord Hylton)</p>	<p><b>Response:</b> It is up to the clinician's discretion. Rule 35 does not require them to ask every</p>
March 2011	<p><b>Recommendation:</b> Has the Secretary of State asked UKBA to undertake an audit on rule 35 Reports (Damien Green)</p>	
	<p><b>Recommendation:</b> Will the complete and unedited version of the Rule 35 audit become available?</p>	

# Appendix 5 – Questionnaire Template

**1. Are you a victim of torture?**

Yes  No

**2. Did you tell the Home Office that you were a victim of torture?**

Yes  No

If no, please state why:

**3. Were you asked by the detention centre healthcare team whether you are victim of torture?**

Yes  No

**4. Did you tell the healthcare team at the detention centre that you were a victim of torture?**

Yes  No

If no, please state why:

**5. How do you feel that your claim of torture was dealt with by the Home Office?**

Dealt with well

Dealt with adequately

Dealt with poorly

Dealt with very badly

Please state below any comments:

**6. How do you feel that your health concerns related to your experience of torture were dealt with by healthcare teams in detention?**

Dealt with well

Dealt with adequately

Dealt with poorly

Dealt with very badly

Please state below any comments:

**7. Can you explain the overall standard of healthcare in detention?**

Good

Adequate

Poor

Very bad

Please state below any comments:

**8. What was the impact of being in detention on your mental health?**

Negative impact

No impact

Positive impact

Please state below any comments:

**9. What was the impact of being in detention on your physical health?**

Negative impact

No impact

Positive impact

Please state below any comments:

**10. Please use the space below to write any other comments you may have about your time in detention. Feel free to continue over the page.**

# Endnotes

- 1 The Migration Observatory, The University of Oxford, *Briefing: Immigration Detention in the UK*, 08/03/11. Note that this figure does not include persons detained in police cells, Prison Service establishments, and those detained under both criminal and immigration powers. <http://www.migrationobservatory.ox.ac.uk/briefings/immigration-detention-uk>
- 2 Burnett, A. Peel, M. (2001). 'The health of survivors of torture and organised violence'. *BMJ*, 322, pp.606-609
- 3 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>
- 4 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment <http://www.un.org/millennium/law/iv-9.htm>
- 5 See for example the following reports. Burnett A, Peel M. (2001) 'Asylum seekers and refugees in Britain. The health of survivors of torture and organised violence'. *BMJ*, 322, pp.606-9  
Freedom from Torture (2009) *Justice Denied: The experience of 100 torture surviving women seeking justice and rehabilitation* [http://www.freedomfromtorture.org/sites/default/files/documents/Justice\\_Denied.pdf](http://www.freedomfromtorture.org/sites/default/files/documents/Justice_Denied.pdf)  
AVID (2011) *Vulnerable groups in Immigration Detention: Mental Health*, March 2011. <http://www.aviddetention.org.uk/images/avid%20mental%20health%20briefing%20310311%20for%20det%20forum%20work.pdf>
- 6 *R (D and K) v SSHD* [2006] EWHC 980 (Admin)
- 7 Except for four individuals for whom we already had their recent SAR file available.
- 8 UK Border Agency, *Requests for Personal Data*. <http://www.ukba.homeoffice.gov.uk/navigation/personal-data/>
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- 11 Hunt, S. and Bhopal, R. (2004) 'Self report in clinical and epidemiological studies with non-English speakers: the challenge of language and culture', *J Epidemiol Community Health* 2004; 58:618-622. <http://jech.bmj.com/content/58/7/618.full>
- 12 UK Border Agency, *Enforcement Instructions and Guidance*, Ch.55 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary>
- 13 Bruegel, I. and Natamba, E. (2002) *Maintaining Contact: What happens after detained asylum seekers get bail?* South Bank University.
- 14 Bail for Immigration Detainees, *Facts and Figures: Absconding*. <http://www.biduk.org/302/why-is-immigration-detention-deemed-necessary/absconding.html>
- 15 <http://www.indymedia.org.uk/en/2008/05/399156.html>
- 16 Independent Asylum Commission (2008) *Fit for Purpose yet? The Independent Asylum Commission's Interim Findings*. <http://www.independentasylumcommission.org.uk/>
- 17 Detention Action (2011) *Long-term immigration detention - a waste of money and lives?* Briefing paper, July 2011. <http://detentionforum.files.wordpress.com/2010/06/detention-forum-briefing-papers-june-20112.pdf>
- 18 The Migration Observatory, The University of Oxford, *Briefing: Immigration Detention in the UK*, 08/03/11 <http://www.migrationobservatory.ox.ac.uk/briefings/immigration-detention-uk>
- 19 *ibid.*
- 20 AVID (2011) *Immigration Detention: Size of the Detention Estate*, 15 July 2011 <http://www.aviddetention.org.uk/images/detstatsjune2011.pdf>
- 21 AVID have recently learned of the opening of a 'self contained' facility for women in Colnbrook IRC.
- 22 As of May 2011, Tinsley House should only be used to hold families who have not yet entered the UK (border cases) or where there is a criminal case.
- 23 A new wing for men at Yarl's Wood has just opened in February 2012.
- 24 The Migration Observatory, The University of Oxford, *Briefing: Immigration Detention in the UK*, 08/03/11 The Migration Observatory, The University of Oxford, *Briefing: Immigration Detention in the UK*, 08/03/11 <http://www.migrationobservatory.ox.ac.uk/briefings/immigration-detention-uk>
- 25 UK Border Agency, *Annual Report and Accounts 2010-11*. Note that the remaining funds are spent by the International Group and Corporate Services. <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/annual-reports-accounts/annual-report-10-11.pdf?view=Binary>
- 26 FOI Reference 21020 to Medical Justice, received on 11/1/12
- 27 Hansard. "Immigration: Detention Centres Questions by Baroness Warsi." Lord Hansard text for 4 February 2010 (pt 0002). House of Commons, London, 2010. Included in this figure are costs incurred by incidents such as fires in IRCs or individuals suing for unlawful detention. <http://www.parliament.the-stationery-office.co.uk/pa/ld200910/ldhansrd/text/100204w0002.htm>
- 28 The Migration Observatory, 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>
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- 30 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](http://www.asylumaid.org.uk/data/files/publications/137/Solihull_Pilot.pdf)
- 31 Bail for Immigration Detainees (2009) *Out of Sight, Out of Mind: Experiences of immigration detention in the UK*. <http://www.biduk.org/162/bid-research-reports/bid-research-reports.html>
- 32 FOI 21020 submitted by Medical Justice on 8/12/11. The total cost for removals was £47,109,000 of which £30,345,000 was spent by the Immigration Group and £16,763,000 was spent by the Criminality and Detention Group.
- 33 Migration Observatory, The University of Oxford, *Briefing: 'Deportation, Removal and Voluntary Return from the UK'*, 6 September 2011 <http://migrationobservatory.ox.ac.uk/briefings/deportations-removals-and-voluntary-departures-uk>
- 34 FOI 15320. <http://www.homeoffice.gov.uk/about-us/freedom-of-information/released-information1/foi-archive-immigration/13520-failed-asylum-seekers-uk/>
- 35 FOI 20543. The six charter flights in question took place on the following dates: 30th August 2007, 13th February 2008, 31st March 2008, 27th March 2009, 27th October 2010 and 16th February 2011

- 36 The Guardian, *£12m paid in asylum seeker claims*, 15 August 2011 <http://www.guardian.co.uk/uk/feedarticle/9797669>
- 37 Section 33 outlines the five exceptions to a deportation order and include when an order would contravene Convention rights or the UK's obligation under the Refugee Convention.
- 38 See *Hardial Singh* principles whereby detention under the Immigration Acts is limited to the period reasonably necessary for the machinery of deportation or removal to be carried out. *R v Governor of Durham Prison ex parte Hardial Singh* [1984] 1 WLR 704
- 39 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 55 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary>. The six reasons outlined are as follows: You are likely to abscond if given temporary admission or release; There is insufficient reliable information to decide on whether to grant you temporary admission or release; Your removal from the United Kingdom is imminent; You need to be detained whilst alternative arrangements are made for your care; Your release is not considered conducive to the public good; I am satisfied that your application may be decided quickly using the fast track asylum procedures. Guidance goes on to propose the 14 factors, which form the basis for the reasons for the decision to detain.
- 40 See *R v Governor of Durham Prison ex parte Hardial Singh* (1984) 1 WLR 704; *R (I) SSHD* (2002) EWCA Civ 88 and *Lumba v SSHD* (2011) UKSC 12
- 41 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 55 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary>
- 42 In 2010, UKBA changed its policy to include the detention of mentally ill persons so long as their condition is "satisfactorily managed within detention". However, as outlined in the section on *Case Law*, this policy changed was found to be unlawful in the case of *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin).
- 43 The decision *R (BA) v SSHD* [2011] EWHC 2748 (Admin) at [183]-[184] makes clear that even where a detainee is currently stable, if there is medical advice that detention is likely to cause deterioration to a point where the illness is unlikely to be manageable in detention, UKBA are required to apply the "very exceptional circumstances" policy at that stage. It is of course for the courts to say what UKBA's policies mean and UKBA are required to follow any guidance provided by the courts.
- 44 UK Border Agency, *Enforcement Instructions and Guidance*, Chapter 55 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary>
- 45 The Home Office (1998) *White Paper: Fairer, Faster and Firmer – A Modern Approach to Immigration and Asylum*; Para 12.4 <http://www.archive.official-documents.co.uk/document/cm40/4018/4018.htm>
- 46 Section 55.8a of the EIG also draws attention to Rule 35 of the Detention Centre Rules 2001.
- 47 Detention Centre Rules 2001. <http://www.legislation.gov.uk/uksi/2001/238/article/35/made>
- 48 House of Lords, 15 July 2002. <http://www.publications.parliament.uk/pa/ld200102/ldhansrd/vo020715/text/20715-20.htm>
- 49 UK Border Agency, *Asylum Process Guidance, Detention Rule 35 Process*, 15/6/11 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/detention/guidance/rule35reports.pdf?view=Binary>
- 50 UK Border Agency, *Detention Service Order 03/2008, Special Illnesses and Conditions (including torture claims)* <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/detention-services-orders/special-illnesses-conditions.pdf?view=Binary>
- 51 UK Border Agency, *Detention Services Operating Standards manual for Immigration Service Removal Centres*, January 2005 [http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/immigrationremovalcentres/operatingstandards/operatingstandards\\_manual.pdf?view=Binary](http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/immigrationremovalcentres/operatingstandards/operatingstandards_manual.pdf?view=Binary)
- 52 UK Border Agency, *Detention Service Order 03/2008, Special Illnesses and Conditions (including torture claims)* <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/detention-services-orders/special-illnesses-conditions.pdf?view=Binary>
- 53 See for example: *Bail for Immigration Detainees (2005) Fit to be detained: Fit to be detained? Challenging the detention of asylum seekers and migrants with health needs.* <http://www.biduk.org/162/bid-research-reports/bid-research-reports.html>. Also see the cases of *OM (Algeria) v SSHD* [2010] EWHC 65 (Admin) and *T, R (on the application of) v Secretary of State for the Home Department* [2010] EWHC 668 (Admin) (03 February 2010)
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- 70 This section draws on the following recent reports by HMIP. Report on a full announced inspection of Brook House Immigration Removal Centre (15 -19 March 2010); Report on an unannounced short follow-up inspection of Campsfield House Immigration Removal Centre (16 - 18 May 2011); Report on a full announced inspection of Colnbrook Immigration Removal Centre (17 - 21 November 2008); Report on a full announced inspection of Dover Immigration Removal Centre (24 - 28 May 2010); Report on an announced inspection of Dungavel House Immigration Removal Centre (21 - 25 June 2010); Report on an announced inspection of Harmondsworth Immigration Removal Centre (11 - 15 January 2010); Report on an unannounced short follow-up inspection of Haslar Immigration Removal Centre (31 May - 3 June 2011); Report on an unannounced short follow-up inspection of Lindholme Immigration Removal Centre (17 - 20 January 2011) ; Report on an unannounced short follow-up inspection of Oakington Immigration Reception Centre (2 - 5 August 2010); Report on an announced inspection of Tinsley House Immigration Removal Centre (7 - 11 February 2011) ; Report on an announced inspection of Yarls Wood Immigration Removal Centre (4 - 8 July 2011)
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- 102 The review is focused on the most recent report for each of the 11 IRCs at the time of research; Colnbrook 17-21 November 2008, Lindholme 16-20 February 2009, Haslar 20-24 April 2009, Campsfield House 5-9 October 2009, Yarl's Wood 9-13 November 2009, Brook House 15-19 March 2010, Dover 24-28 May 2010, Dungavel 21-25 June 2010, Harmondsworth 2-5 August 2010, Oakington 2-5 August 2010, Tinsley House 7-11 February 2011 and Tinsley House 13-15 July 2009. They are available at: <http://www.justice.gov.uk/publications/inspectorate-reports/hmi-prisons/immigration-removal-centre-inspections/index.htm>
- 103 HMIP Reports do not report on the same criteria for each detention centre, nor do the reports always follow up on what was recommended previously, so there is a lack of HMIP information on some criteria in this review. HMIP comment only on process and not service and this is one part of an overall system.
- 104 Information from discussions and inquiries in the House of Lords as well as legal hearings is also cited in this thematic review.
- 105 <http://www.publications.parliament.uk/pa/ld200607/ldbills/100/amend/ml100-ir.htm>
- 106 <http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/71011-0003.htm>
- 107 An audit undertaken in 2009-10 by UKBA found late responses to be the primary failing.
- 108 Halsar, Campsfield, Yarl's Wood, Brook House, Dover, Dungavel, and Tinsley House IRCs are noted for late responses and Colnbrook, Lindholme, Dover, Dungavel, Harmondsworth, and Oakington IRCs are noted for lack of any response from UKBA.
- 109 Home Affairs Committee, Borders and Citizenship Bill, Written Evidence, Memorandum submitted by Dr Charmian Goldwyn <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhaff/425/425we32.htm>
- 110 House of Lords, March 21 2006
- 111 The recommendations can be found in the HMIP IRC reports, for example Tinsley House, December 22 2009.
- 112 Brook House, Dover, Dungavel, Harmondsworth, and Tinsley House. Some improvement was noted in Brook House and Tinsley House but issues remained.
- 113 <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110628/text/110628w0002.htm>
- 114 D and K, R (on the application of) v Secretary of State for the Home Department & Ors [2006] EWHC 980 (Admin). This case will be discussed in the chapter on case law.
- 115 House of Lords, 24 October 2006, Column 1077. <http://www.publications.parliament.uk/pa/ld199697/ldhansrd/pdvn/lds06/text/61024-0001.htm>
- 116 UKBA, *Detention Centre Rule 35 Audit*, 4 February 2011 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/reports/detention-centre-rule-35-audit/det-centre-rule-35-audit?view=Binary>
- 117 <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110301/text/110301w0001.htm>
- 118 <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhaff/929/11040502.htm>
- 119 FOI 21312. 'As both requests were submitted on the same day on the same subject we are treating them as one request'.
- 120 It would be incorrect to look at the responsibility of healthcare services as legal cases have found UKBA to be accountable for implementation. See *MT on the application of R v SSHD, GSL UK and Nestor Healthcare Services plc (2008)*. It was found that responsibility would fall on the SSHD rather than its subcontractors. See para 54.
- 121 D and K went to the Court of Appeal under the name HK Turkey [2007] EWCA Civ 1357. The judgment in the Court of Appeal changes little or nothing of what was said by Davis J. In the case of HK Turkey v SSHD, the Supreme Court held that the decision to detain HK under the DFT process was lawful. Further, that despite his allegations of torture, his application could be speedily resolved. In paragraph 25, the Judges concluded that '... a mere assertion of torture could not be sufficient to render a case unsuitable for fast track procedure, there could be no obligation on the respondent to have a medical examination'.
- 122 Exemplary damages are only awarded in the event of "arbitrary, outrageous and/or unconstitutional" action by agents of the state.
- 123 The Judgment of the Court of Appeal in Anam is awaited.
- 124 The transfer only took place on 6 August 2011 after the court intervened on 26 July 2010.
- 125 See paragraph 82.
- 126 See paragraphs 111-115.
- 127 Paragraph 241.
- 128 See paragraphs 165-176
- 129 UKBA, *Enforcement Instructions and Guidance*, Chapter 55. <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary>
- 130 See paragraphs 162-185.
- 131 See paragraph 182.
- 132 See paragraphs 210-214.
- 133 See paragraphs 215-217.
- 134 The Secretary of State must intend to deport the person and can only use the power to detain for that purpose; Detention should only occur for a period that is reasonable in all the circumstances; If, before the expiry of the reasonable period, it becomes apparent that the Secretary of State will not be able to effect deportation within a reasonable period, he should not seek to exercise the power of detention; SSHD should act with diligence and expedition to effect removal.
- 135 See paragraphs 102-148 where the following elaborations were made: A refusal of voluntary repatriation is only relevant in limited circumstances and the period of detention considered does not start only once appeal rights have been exhausted, which is what had been found in earlier cases; the relevance of the pursuit by a claimant of appeals against deportation depends on the facts; Reoffending is relevant.
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- 137 BASHH (2011) *UK National Guidelines on The Management of Adult and Adolescent Complainants of Sexual Assault 2011*. Clinical Effectiveness Group British Association for Sexual Health and HIV. [www.bashh.org/documents/3275](http://www.bashh.org/documents/3275)

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- 139 UKBA (2009), *DFT & DNSA– Intake Selection (AIU Instruction)*. <http://www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/detention/guidance/dftanddnsaintakeselection?view=Binary>
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- 142 Date detained is the date from which individuals were held under IS powers.
- 143 Hansard: 10 October 2011, c81W <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111010/text/111010w0003.htm>
- 144 <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary>
- 145 Detention Action (2011) *Fast Track to Despair - The Unnecessary detention of asylum seekers*. Available at: <http://www.irr.org.uk/pdf2/FastTracktoDespair.pdf>
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- 148 Human Rights Watch, *Fast-Tracked Unfairness: Detention and Denial of Women Asylum Seekers in the UK*, January 2010 <http://www.hrw.org/sites/default/files/reports/uk0210webwcover.pdf>
- 149 Independent Chief Inspector of the UK Border Agency, *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](http://icinspector.independent.gov.uk/wp-content/uploads/2012/02/Asylum_A-thematic-inspection-of-Detained-Fast-Track.pdf)
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- 160 In four cases, detention was considered appropriate and proportionate: it was considered that balancing public protection, crime prevention and the risk of absconding outweighed the presumption of liberty. In these instances, the exceptional circumstances that would normally render a person unsuitable for detention played a role.
- 161 UK Border Agency, *Quality Initiative Project 5<sup>th</sup> Report, March 2008 – UKBA Response and Action Plan* <http://webarchive.nationalarchives.gov.uk/20100503160445/http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/reports/unhcrreports/responses/response5.pdf?view=Binary>
- 162 Where an individual had two MLRs done by two independent doctors, the latest MLR is used in all areas of data reporting.
- 163 Comorbidity is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.
- 164 RMN (Registered Mental Health Nurse)
- 165 Cohen J. Safe in our hands?: a study of suicide and self-harm in asylum seekers, *J Forensic Leg Med.* 2008;15:235–244
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People do suffer from their own origin country, and  
flee to face another torture, Detention to my point  
of view it's a torture itself.

**Burnt and beaten with sticks and cables in her home country.  
Detained at Yarl's Wood Immigration Removal Centre (IRC)**

4) Torture victims should not at anytime be  
detained because it leads to intrusive thoughts,  
nightmares and mental breakdown.

**Suffered beatings, kicks, cigarette burns, water torture and was held in solitary  
confinement in his home country. Fled to Britain and was detained for 7 days.**

SURVIVING TORTURE AND SURVIVING  
DETENTION IS EQUALLY VERY HARD EXPERIENCE.  
I WON'T FORGET NEITHER AS THEY ARE LIKE WOUNDS  
IN MY HEART I COULDN'T TALK TO ANYONE ABOUT IT.

**Detained and tortured by government authorities in his home country.  
Granted protection on human rights grounds.**

All I can say is that, people who have gone through torture  
should never be ignored, pls I am pleading for justice for all the  
cases of victims of torture who are still held by the home office

**Victim of torture and trafficking. Detained in Yarl's Wood IRC for 334 days.**

the detention centre floor and the noises were similar to the  
noises and sounds where I was tortured so it made me feel  
like I was in the same place

**Detained and tortured in his home country. He was tied up, burnt with  
cigarettes and hot metal rods, beaten and kicked in head.**

**Medical Justice**  
seeking basic rights for detainees

**Medical Justice**

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